MSISDD99V5e.DOC

MEDICAID STATISTICAL INFORMATION SYSTEM

(MSIS)

Tape Specifications and Data Dictionary

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1. INTRODUCTION

1.1 General Overview

This document provides State Medicaid agency staff with the information they need to prepare and submit MSIS tape files. This document:

- defines terms;
- identifies responsibilities;
- describes the record layouts of the five primary MSIS data files; and
- characterizes data formatting requirements and validation rules.

This document is a reference for the creation of quarterly Eligibles and Claims tape files. The record formats and data element specifications presented must be accurately observed. The record formats and editing rules established in this document are the basis of CMS's tape file validation procedures. Any tape file that is found to contain errors in excess of the tolerances documented in the following sections is returned to the state for correction and resubmission.

1.2 Terms and Abbreviations

Term/Abbreviation	Description
ANSI	American National Standards Institute
CMS	Centers for Medicare and Medicaid Services (formerly CMS)
CMSO	Center for Medicaid and State Operations
COBOL	Common Business Oriented Language
DSN	Data Set Name
EBCDIC	Extended Binary-Coded-Decimal Interchange Code
EPSDT	Early and Periodic Screening Diagnosis and Treatment
FFY	Federal Fiscal Year
FFYQ	Federal Fiscal Year Quarter
HCFA	Health Care Financing Administration
IBM	International Business Machines, Inc.
MSIS	Medicaid Statistical Information System
MMIS	Medicaid Management Information System
OIS	Office of Information Services
OS	Operating System

1.3 Tape Delivery Schedules

Quarterly Eligible and Claims files should be submitted to CMS on the following schedule:

			* * * * * DUE DATES * * * * *	
FILE TYPE	FFY REPORTING QUARTER		REGULAR	DELAYED
ELIGIBLE	1st	(10/01-12/31)	02/15	04/15
	2nd	(01/01-03/31)	05/15	07/15
	3rd	(04/01-06/30)	08/15	10/15
	4th	(07/01-09/30)	11/15	12/15
CLAIM-XX	1st	(10/01-12/31)	02/15	
	2nd	(01/01-03/31)	05/15	
	3rd	(04/01-06/30)	08/15	
	4th	(07/01-09/30)	11/15	

There are two different schedules for the submission of Eligible files. The choice of schedule determines how the State will provide corrections to their Eligible records to the CMS. The earlier (REGULAR) due date requires the State to submit correction records as individual records included with their Eligible file submission. If the State cannot submit correction records but must wait until they have updated their Eligible files before submitting their Eligible data, they must use the delayed (DELAYED) due date.

1.4 MSIS Tape Administrative Procedures

a. Prepare a "MSIS Foreign Tape Login" form (Attachment 1) for each shipment of tapes sent to the CMS for MSIS processing. Complete one (1) line entry for each reel being shipped. If you are shipping more than 18 reels of tape, use as many forms as necessary, but be sure to fill in the page number at the top right of the form. Each line entry contains:

VOLSER	-	the tape volume serial numbers for all accompanying tapes
DATASET NAME (DSN)	-	complete the dataset information below for each tape file being shipped
MW00.__	-	Enter your two digit State abbreviation (USPS State abbreviations)
YR____.	-	Enter the reporting century and year for this file entry (e.g., 1999, 2000 ...., etc.)
QTR__.	-	Enter the reporting quarter for this file entry (one of: 1, 2, 3, 4)
. _____	-	Enter the file type: CLAIMIP, CLAIMLT, CLAIMOT, CLAIMRX or ELIGIBLE.

REEL # of N	-	the sequence number of the reel within a multiple reel file. For example, a five-volume file would be represented as 1 of 5, 2 of 5, ... 5 of 5.
SLOT #	-	Do NOT fill in this column. This is for use by the CMS Data Center Tape Librarian.

Note: Specifications for the VOLSER NO and DATASET NAME entries can be found in the Header Record Specifications, section 4.3.

b. Fill in your state's name, sign and date the form.

See Attachment 2 for a sample of a completed "MSIS Foreign Tape Login" form.

c. Enter the total number of records being submitted for each file type.

d. Label each reel with an External Tape Label that identifies the tape as belonging to the MSIS project. Include on the label the state name, the DSN, the total number of records submitted on all reels for any of the file types and the reel number. Provide the record count on the tape login form, if possible. It is not necessary to include it here. Exhibit 1 is a sample of an External Tape Label.

Exhibit 1

MSIS EXTERNAL TAPE LABEL
STATE: CALIFORNIA

DSN: MW00.CA.YR1999.QTR4.CLAIMOT

REEL # 1 OF 24 TOT RECS=34,000,000

MSIS Tape Label

e. Pack tapes carefully in a secure container and send them, with a copy of the "MSIS FOREIGN TAPE LOGIN" form, to:

Centers for Medicare and Medicaid Services
CMS Data Center
Attn: Tape Library
7500 Security Boulevard
Baltimore, MD 21244-1850

f. Mail a copy of the completed MSIS FOREIGN TAPE LOGIN form(s) to:

Centers for Medicare and Medicaid Services
MSIS Tape Control
N2-17-07
7500 Security Boulevard
Baltimore, MD 21244-1850

1.5 MSIS Contacts for Assistance

MSIS has a central E-mail address:

MSIS@CMS.HHS.GOV

Questions may also be directed to the following individuals:

MSIS State Participation and Project Management:

Betty Kern
Elizabeth.Kern@CMS.HHS.GOV
(410) 786-0141

MSIS technical contact

Kathy Ranshous
Kathy.Ranshous@ CMS.HHS.GOV
(410) 786-0958

2. NOTATION CONVENTIONS

A number of standard notation conventions are used throughout this document:

a. Literal Character Strings, when required, must be spelled out exactly as displayed. In this document, literal character strings are always displayed enclosed in double quotes, as in "YR" or "QTR". Alphabetic characters that appear in literal strings are always in Upper Case.

b. User Supplied Variables take on values that depend on the user's specific application. Variables whose values may include any alphanumeric character (any valid EBCDIC character) are represented by unquoted strings of X's (e.g., XXXX). Numeric variables, whose values can include only the characters {0, 1, 2, 3, 4, 5, 6, 7, 8, 9, +, -}, are represented by unquoted strings of 9's (e.g., 99999). Alphabetic characters used to specify user supplied variables are always in Upper Case. The discussion of the IBM Standard Tape Label internal dataset name in Section 4.1 illustrates these rules.

c. In the specifications of edit criteria, the Boolean operators "and" and "or" are written AND OR to distinguish them from the more normal uses of these words. In this context, AND OR are used to connect and visually distinguish the terms that comprise the logical expressions of specific validation edits.

   Example: The edit criterion: "the value of BASIS-OF-ELIGIBILITY is in error if:

   Value <> '0' AND DAYS-OF-ELIGIBILITY = "0"

   means that an error exists if BASIS-OF-ELIGIBILITY is not zero in any month in which there are no days of eligibility.

d. When relationships between fields that occur monthly are specified, it is understood, unless otherwise stated, that all field values refer to the same month. Thus, in the previous example, it would be assumed that BASIS-OF-ELIGIBILITY and DAYS-OF-ELIGIBILITY were evaluated for the same month, since there is no indication that any other condition is required.

e. For each MSIS file, record layouts are presented in two different orders in this document:

   -Physical record layouts reflect the order in which fields are physically stored in file records.

   -Logical record layouts reflect the order in which fields are edited by the validation program. This ordering determines both the sequence and content of many of the edit criteria described in the data dictionary.

   Relational edits involve comparisons of values in two or more fields. These are evaluated when, based on the field order in the logical record layout, the validation program encounters the last field referenced by the edit criterion.

f. Alphabetized ordering is used in the Data Field/Element Specifications sections to facilitate locating individual field descriptions.

g. Error codes are specified as three digit numbers throughout this document. Referring back to the discussion in Section 1.1, the error codes summarized in Appendix A can result from two kinds of edits.

   1. Simple field edits involve only the value of a single field value. These edits result in very specific, detailed error messages that are represented in the Validation Report by the same three digit numbers that appear in Appendix A.
   2. Relational edits result in more generic error messages. The detailed, field specific information about each error condition is contained in the Data Field/Element Specifications sections. The Validation Report provides the necessary reference to the appropriate data dictionary error and the edit condition that failed.

3. CODING DATA FIELDS

3.1 Field Initialization

- Numeric fields should be initialized to 0.
- Each byte of every alphanumeric field should be initialized to a space character.

3.2 Valid Field Values

Valid Field Values must satisfy two sets of criteria. They must:

- conform to the "COBOL PICTURE" clause specified for each field; and
- lie within certain pre-defined ranges that are established based on Medicaid program rules and other, logical requirements.

3.3 COBOL PICTURE clauses

These are concatenations of:

- the literal string "PIC ";
- one or two characters indicating the type of data stored in the field;
- a number enclosed in parentheses indicating the length of the field;

Examples of COBOL PICTURE clauses used in this document:

- PIC X(3) describes an alphanumeric field of length 3;
- PIC S9(6) describes a signed numeric field of length 6.

3.4 Indicating Inappropriate and Invalid Data

The MSIS system has established a convention to indicate not applicable and invalid data by filling fields with numbers that are all eights or all nines.

A data field filled with eights specifies "not applicable" in the context of a particular record. For example, suppose an ELIGIBLE file record has the field DUAL-ELIGIBLE-FLAG = 0, meaning that the Medicaid eligible is not a Medicare beneficiary. In all CLAIMIP (inpatient hospital claim file) records submitted for this recipient, the fields MEDICARE-DEDUCTIBLE-PAYMENT and MEDICARE-COINSURANCE-PAYMENT should be filled with Hex F8s since these data fields are not relevant for this record.

A data field filled with nines indicates that the field require valid entries and contain invalid data. For example, DATE-OF-BIRTH must contain a valid value in all ELIGIBLE file records. If DATE-OF-BIRTH is not known, the field is filled with nines. Filling a field with nines always results in a validation error that counts against the error tolerance established for the field.

Each byte in either of these types of alphanumeric fields contains a "9" or an "8". For example:

- a field filled with nines formatted as X(3) contains 999

- a field filled with eights formatted as S9(5) contains +88888;

3.5 Field Justification

All alphanumeric fields are to be left justified and numeric fields are to be right justified.

3.6 Date Fields

Date fields must be in the format CCYYMMDD for any of the Eligibility or Claims files, as specified in the data dictionary page for each such field, where:

CC is the 2 digit century (19, 20)
YY is a 2 digit year (85, 86, 87, . . .)
MM is the month (01, 02, . . ., 12)
DD is the day (01, 02, . . ., last valid day in month)

3.7 Blank Fields Are Illegal

Alphanumeric fields can never, legally, be completely filled with spaces, unless a string of space characters is logically defined as a valid value. After initialization any such field must be either filled with a value that lies within the set of acceptable values defined for that field, contain eights (888...) or contain nines (999...).

3.8 Validation Edits

MSIS edits can be grouped in two major categories. Data validation edits and distributional checks. Tapes will not be accepted until all edits fall within tolerances, and all distributional anomalies have been resolved.

3.8.1 Data Validation Edits

Data validation edits can be grouped into four categories:

- tests to see if numeric fields contain non-numeric data;
- tests for eight or nine filled fields, which indicates that a field was not applicable in the context of a particular record or could not be filled with valid data;
- tests on a value to see if it falls within the range established for the data element;
- relational tests that compare values of two or more data elements for consistency or according to a rational or formula;

Each State receives a Validation Report from the MSIS system for every file submitted to CMS. The error messages that are used in the report are found in Appendix A of this document. These messages refer to the field specific edit specifications that are presented in the Data Field/Element Specifications sections of this document. These edit specifications are applied to the data submission in the order listed in this document during validation (see Section 2.e). Therefore, if the error message displayed was a result of the fourth edit, then the first three edits passed successfully. Moreover, the validation process terminates and the remaining edits listed are not performed.

In some cases the error messages in Appendix A are identical to their corresponding field specific messages. For edits involving comparisons of two or more field values or relational edits, the messages in Appendix A are generic descriptions. These generic descriptions relate to several, more detailed, field specific messages that all use the same error number.

When a numeric field (PIC 9) is found to contain non-numeric data, an 810 series error is assigned and the field is reset to a default value. The non-numeric test is the first edit performed on each numeric field.

The degree to which States submit valid data values or fill fields with nines is edited next. This editing is next in order to determine the degree the States have problems supplying valid data. The validation program obtains a count of the number of cases in which valid data was not available for each data field.

In addition to the error codes listed in the data dictionary there are special error codes, 99* series, which indicates an informational error, only. Errors 99* occur when a relational edit is applied against a field flagged as in error by an earlier edit. Recall that relational edits are performed only when the last field involved in the relation is encountered. By the time a particular relational edit is performed, the system will have already checked whether any of the other fields in the relation were in error. If an error is found in a relational edit that includes any field already found in error, the relational error is flagged with code 99*. This prevents a single error from being counted more than once during validation.

NOTE: Field error tolerances which appear within the dictionary are the default values. Adjustments are based on special state circumstances.

3.8.2 Distributional Checks

Distributional checks involves a set of manual and automated analytical summaries of the data. These checks evaluate means, ranges, frequency distributions, and payment totals against expected ranges of outcomes, including historically reported ranges.

4. TAPE FORMATS

MSIS tape files must be created to the specifications presented in the following subsections. All references to "tapes" applies to both 6250BPI (or 1600BPI) magnetic tape and to 3480 and 3490 type magnetic cartridges, whichever the State prefers to use. However, please note that 3490 Magnetic Cartridges have proven to be more reliable and less expensive to use. States desiring a waiver of any of the requirements below must submit a "Formal Request for Exception" to the appropriate MSIS Project Management Representative for approval.

4.1 Dataset Name Specifications

Create tapes with IBM OS Standard Labels

- The internal dataset name (DSN) is MW00.XX.YR9999.QTR9.XXXXXXXX, where:

"MW00" is a literal value;

XX is the state's two character Post Office abbreviation. A complete list of Post Office abbreviations is included in the STATE-ABBREVIATION data element description located in the Header Record Data Field/Element Specification subsection of this document;

"YR" is a literal value;

9999 is the four digit Federal Fiscal Year (FFY) covered by the file (e.g., "1996")

"QTR" is a literal value;

9 is the FFY quarter covered by the file. The FFY quarters are defined as follows:

Quarter 1 - October 1 through December 31
Quarter 2 - January 1 through March 31
Quarter 3 - April 1 through June 30
Quarter 4 - July 1 through September 30

XXXXXXXX is a valid MSIS file type:

CLAIMIP (inpatient hospital claims)
CLAIMLT (long term care claims)
CLAIMOT (other, non-institutional claims)
CLAIMRX (prescription drug claims)
ELIGIBLE (eligible file)

Example: California's FFY 1993, Quarter 4 tape file of non-institutional claims would have a Standard Label with the Internal Dataset Name "MW00.CA.YR1993.QTR4.CLAIMOT ".

-The internal volume serial number format is XX9999, where:

XX is the state's two character Post Office abbreviation.

9999 is a sequentially assigned number between 0001 and 9999.

Example: A valid volume serial number might be "CA1234".

4.2 Record Length Specifications

Record Length depend on file type, as follows:

File Name	Record Length
ELIGIBLE	375
CLAIMIP	725
CLAIMLT	200
CLAIMOT	175
CLAIMRX	175

4.3 HEADER Record Specifications

The first data record of every MSIS tape file is a Header Record. The Header Record contains file identification information required for accurate validation of the tape and to facilitate further processing.

4.3.1 HEADER Record - Physical Data Record Layout

The following table specifies the record layout and COBOL PICTURE clauses for the Header Record. The COBOL PICTURE clauses obey ANSI standard rules, which are summarized in Section 3.3. The Start and End Positions specify the exact location of each field in the record.

HEADER RECORD SUMMARY

FIELD NAME	COBOL PICTURE	<--- POSITION ---> START	END
FILE-NAME	X(8)	01	08
FILE-STATUS-INDICATOR	X(1)	09	09
FILLER	X(2)	10	11
STATE-ABBREVIATION	X(2)	12	13
DATE-FILE-CREATED	9(8)	14	21
START-OF-TIME-PERIOD	9(8)	22	29
END-OF-TIME-PERIOD	9(8)	30	37
SSN-INDICATOR	9(1)	38	38
FILLER (ELIGIBLE)	X(337)	39	375
(CLAIMIP)	X(687)	39	725
(CLAIMLT)	X(162)	39	200
(CLAIMOT)	X(137)	39	175
(CLAIMRX)	X(137)	39	175

There are no error tolerances associated with Header fields. A single Header field validation error will cause the entire file to be rejected.

4.3.2 HEADER Record - Logical Data Record Layout

The following table summarizes the fields in the HEADER file record in the order in which fields are processed by the validation program (see Section 2, paragraph [e]):

FILE-NAME
FILE-STATUS-INDICATOR
STATE-ABBREVIATION
DATE-FILE-CREATED
START-OF-TIME-PERIOD
END-OF-TIME-PERIOD
SSN-INDICATOR

4.3.3 HEADER Record Data Field/Element Specifications

This subsection presents detailed specifications for the fields in the MSIS Header Record. Header Record fields are listed in alphabetical order in this subsection. Each data element description includes the content specifications, an example of a proper entry, and a description of the edit criteria applied during the MSIS validation process. Edit criteria are presented in the order in which they are applied.

Note that since every Header Record field must contain valid data, Header fields are never filled with eights or nines.

HEADER RECORD

Data Element Name: DATE-FILE-CREATED

Definition:The date on which the file was created.

Field Description:

COBOL PICTURE	Example Value
9(8)	19870115

Coding Requirements:

- Date must be in CCYYMMDD format.
- Date must be equal to or later than date in END-OF-TIME-PERIOD.

Error Condition	Resulting Error Code
1. Value is Non-Numeric	814
2. Value is not a valid date	102
3. Value is < End-of-Time-Period	501

HEADER RECORD

Data Element Name: END-OF-TIME-PERIOD

Definition: Last date of the reporting period covered by the file to which this Header Record is attached.

Field Description:

COBOL PICTURE	Example Value
9(8)	19871231

Coding Requirements:

Date must be in CCYYMMDD format.

Federal fiscal quarters end on December 31, March 31, June 30, and September 30.

For ELIGIBLE File submissions, END-OF-TIME-PERIOD must always contain a quarter ending date (12/31, 3/31, 6/30, 9/30).

For CLAIMIP, CLAIMLT, CLAIMOT, and CLAIMRX File submissions, however, END-OF-TIME-PERIOD reflects the date on which the state closes its fiscal accounting records for the quarter. Several states close their books on dates other than the last day of each month or quarter. Therefore, MSIS allows reporting quarters to end on any date between the fifteenth day of the third month of the quarter and the fifteenth day of the following quarter.

Example: The Tape Label Internal Dataset Name indicates that the reporting quarter is Quarter 3 of federal fiscal year 1989. The actual start and end dates of this quarter are April 1, 1989 and June 30, 1989, respectively. END-OF-TIME-PERIOD may be any date between June 15, 1989 and July 15, 1989 inclusive.

It is essential that states assure that claims for days on or near the quarterly fiscal cutoff date are counted in one and only one quarter.

Error Condition		Resulting Error Code
1.	Value is Non-Numeric	814
2.	Value is not a valid date	102
3a.	For ELIGIBLE File submissions - Value is <> quarter ending date	203
	OR	
3b.	For CLAIM-IP, CLAIM-LT, CLAIM-OT, and CLAIM-RX File submissions - Value is < 15th day of last month of reporting quarter OR Value is > 15th day of the first month of the following reporting quarter	203
4.	Value is > DATE-FILE-CREATED	501

HEADER RECORD

Data Element Name: FILE-NAME

Definition: The name of the file to which this Header Record is attached. The name of the file also specifies the type of records contained in the file.

Field Description:

COBOL PICTURE	Example Value
X(8)	CLAIMOT

Coding Requirements:

Valid Values	Code Definition
ELIGIBLE	Eligibles File
CLAIMIP	Inpatient Claim/Encounters File - Claims/encounters with TYPE-OF-SERVICE = 1, 24, 25, or 39. (Note: In CLAIMIP, TYPE-OF-SERVICE 24 and 25 refer only to services received on an inpatient basis.)
CLAIMLT	Long Term Care Claims/Encounters File - Claims/encounters with TYPE-OF-SERVICE 02, 04, 05 or 07 (all mental hospital, NF services). (Note: Individual services billed by a long-term care facility belong in this file regardless of service type.)
CLAIMOT	Other Claims/Encounters File - Claims/encounters with TYPE-OF-SERVICE 08 through 13, 15, 19 through 22, 24 through 26, 30, 31, 33 through 38.
CLAIMRX	Pharmacy Claims/Encounters File - Claims/encounters with TYPE-OF-SERVICE 16.

Error Condition	Resulting Error Code
1. Value is not one of the allowable file names listed above	201
2. Value is different from file name contained in the Tape Label Internal Dataset Name	402

HEADER RECORD

Data Element Name: FILE-STATUS-INDICATOR

Definition: The test or production status of the file. All files should be production ONLY. Test files will no longer be accepted by CMS.

Field Description:

COBOL PICTURE	Example Value
X(1)	P

Coding Requirements:

Valid Values	Code Definition
P or Space	Production File - ELIGIBLE Production Files must contain: - one record for each person who was eligible for Medicaid during the reporting quarter; - for each person who was granted retroactive eligibility during the reporting quarter that covered a portion of a prior quarter, one record must be included for each quarter covered; and - records correcting prior quarter records that contained errors, if any. CLAIMIP, CLAIMLT, CLAIMOT, and CLAIMRX Production Files must contain: - one record of the appropriate claim/encounter type, for every separately adjudicated line item of every claim processed during the reporting month; and - one record for every adjustment to a prior quarter claim/encounter that was adjudicated during the reporting quarter.

Error Condition	Resulting Error Code
1. Value is not “P” or Space	201

HEADER RECORD

Data Element Name: SSN-INDICATOR

Definition: Indicates whether the state uses eligibles' social security numbers (SSN) as MSIS-IDENTIFICATION-NUMBERs.

Field Description:

COBOL PICTURE	Example Value
9(1)	1

Coding Requirements:

Valid Values	Code Definition
0	State does not use SSN as MSIS-IDENTIFICATION-NUMBER
1	State uses SSN as MSIS-IDENTIFICATION-NUMBER

Section 5.1 provides a detailed explanation on the use of this field in conjunction with the States' unique personal identification number.

Error Condition	Resulting Error Code
1. Value is Non-Numeric	814
2. Value is < 0 OR Value is > 1	203

HEADER RECORD

Data Element Name: START-OF-TIME-PERIOD

Definition: Beginning date of the Federal Fiscal Quarter covered by this file.

Field Description:

COBOL PICTURE	Example Value
9(8)	19861001

Coding Requirements:

Date must be in CCYYMMDD format.

Federal fiscal quarters begin on October 1, January 1, April 1, and July 1.

For ELIGIBLE File submissions, START-OF-TIME-PERIOD must always contain a quarter starting date (10/1, 1/1, 4/1, 7/1).

For CLAIMIP, CLAIMLT, CLAIMOT, and CLAIMRX File submissions, however, START-OF-TIME-PERIOD reflects the date on which the state opens its fiscal accounting records for the quarter. Several states open their books on dates other than the first day of each month or quarter. Therefore, MSIS allows reporting quarters to start on any date between the fifteenth day of the third month of the previous quarter and the fifteenth day of the current reporting quarter.

Example: The Tape Label Internal Dataset Name indicates that the reporting quarter is the Quarter 3 of federal fiscal year 1999. The actual start and end dates of this quarter are 4/1/1999 and 6/30/1999, respectively. START-OF-TIME-PERIOD may be any date between 3/15/1999 and 4/15/1999 inclusive.

It is essential that states assure that claims for days on or near the quarterly fiscal cutoff date are counted in one and only one quarter.

Error Condition		Resulting Error Code
1.	Value is Non-Numeric	814
2.	Value is not a valid date	102
3a.	(For ELIGIBLE File submissions) - Value <> quarter starting date	203
	OR	
3b.	(For CLAIMIP, CLAIMLT, CLAIMOT, and CLAIMRX File submissions) - Value < 15th day of last month of previous calendar quarter OR Value is > 15th day of reporting quarter	203

HEADER RECORD

Data Element Name: STATE-ABBREVIATION

Definition: U. S. Postal Service abbreviation for the state submitting the file.

Field Description:

COBOL PICTURE	Example Value
X(2)	ND

Coding Requirements:

Must be one of the following U.S. Postal Service State abbreviations:

AL = Alabama	KY = Kentucky	OH = Ohio
AK = Alaska	LA = Louisiana	OK = Oklahoma
AZ = Arizona	ME = Maine	OR = Oregon
AR = Arkansas	MD = Maryland	PA = Pennsylvania
CA = California	MA = Massachusetts	PR = Puerto Rico
CO = Colorado	MI = Michigan	RI = Rhode Island
CT = Connecticut	MN = Minnesota	SC = South Carolina
DE = Delaware	MS = Mississippi	SD = South Dakota
DC = Dist of Col	MO = Missouri	TN = Tennessee
FL = Florida	MT = Montana	TX = Texas
GA = Georgia	NE = Nebraska	UT = Utah
GU = Guam/Am Samoa	NV = Nevada	VT = Vermont
HI = Hawaii	NH = New Hampshire	VI = Virgin Islands
ID = Idaho	NJ = New Jersey	VA = Virginia
IL = Illinois	NM = New Mexico	WA = Washington
IN = Indiana	NY = New York	WV = West Virginia
IA = Iowa	NC = North Carolina	WI = Wisconsin
KS = Kansas	ND = North Dakota	WY = Wyoming

Error Condition	Resulting Error Code
1. Value is not one of those listed above	201
2. Value is different from State abbreviation contained in the Tape Label Internal Dataset Name	402

5. MSIS ELIGIBLE FILE

The first record in this file must be the Standard Header Record (See Section 4.3). The ELIGIBLE file contains:

- one record for each person who was eligible for Medicaid for at least one day during the reporting quarter covered by this file; or who, at State option, is being included as a non-Medicaid SCHIP record;

- one record for each individual for whom retroactive eligibility was established during the reporting quarter and, for each prior reporting quarter covered by the retroactive eligibility;

- corrections to ELIGIBLE File records submitted in prior quarters. Note: All correction records must be submitted as complete records. Do not submit records that contain valid values only in the corrected fields. Correction records will completely replace the eligible record previously provided.

5.1 Unique Personal Identifiers

MSIS identifies eligibles by means of a unique personal identification number that is assigned by the State. Some States use social security numbers as unique personal identification numbers. All other States create their own unique identification numbers according to some systematic scheme that is approved by CMS. Therefore, there are two alternatives for providing the personal Identification number to MSIS (MSIS-ID). Those States using the SSN as the MSIS-ID are identified as SSN-States while those States that create the MSIS-ID are called Non-SSN States. A discussion of these alternatives, how the MSIS-ID should be provided to MSIS, and the three inter-related fields used to provide this information follows. This discussion is provided at this time to afford a better understanding on the use of these interrelating fields and the use of the MSIS-ID in MSIS. Additional information pertaining to the specific fields and their edit criteria will be found on the appropriate field definition pages.

All States must provide available SSNs on the eligible file, regardless of the use of this field as the unique MSIS identifier.

Non-SSN States will assign each eligible only one permanent MSIS-ID in his or her lifetime. When reporting eligibility records it is important that the SSN-INDICATOR in the Header record be set to 0 and the MSIS-ID for each record be provided in the MSIS-IDENTIFICATION-NUMBER field; if the MSIS-IDENTIFICATION-NUMBER is not known then this field should be filled with nines. The MSIS-ID identifies the individual and any claims submitted to the system.

- Provide the SSN in the SOCIAL-SECURITY-NUMBER field; if the SSN is not available the SOCIAL-SECURITY-NUMBER field should be filled with nines. Set the SSN-INDICATOR in the header record to 0. This setting indicates the manner in which the State assigns IDs for the validation program.

Once unique permanent personal identification numbers are assigned to eligibles, they must be consistently used to identify that individual, even if the individual is re-enrolled in a subsequent time period.

SSN States will use the SOCIAL-SECURITY-NUMBER field to provide the MSIS-ID when a permanent SSN is available for the individual. For these States the SSN-Indicator in the header record will be set to 1 and the MSIS-IDENTIFICATION-NUMBER in the eligible record should be blank.

- If the SSN is not available for an individual and the State has assigned a temporary identification number to the individual, the SOCIAL-SECURITY-NUMBER field should be left filled with eights and the temporary identification number should be provided in the MSIS-IDENTIFICATION-NUMBER field. When the individual is eventually assigned an SSN the State should report the SSN (now the individuals' ID) in the SOCIAL-SECURITY-NUMBER field and, for at least one (1) quarter, provide the temporary identification number in the MSIS-IDENTIFICATION-NUMBER field. This will enable CMS to establish a link between the SSN and the temporary identification number.

Four examples are provided concerning the rules for filling in the SSN-INDICATOR, SOCIAL-SECURITY-NUMBER, and MSIS-IDENTIFICATION-NUMBER fields:

(1) The State uses the SSN as an MSIS unique identifier AND the eligible had a valid SSN at the time eligibility was first established.

SSN-INDICATOR =	1
SOCIAL-SECURITY-NUMBER =	Eligible's valid SSN
MSIS-IDENTIFICATION-NUMBER =	Spaces

(2) The State uses the SSN as an MSIS unique identifier AND the eligible does not have a valid SSN (the State assigned a temporary ID).

SSN-INDICATOR =	1
SOCIAL-SECURITY-NUMBER =	888888888
MSIS-IDENTIFICATION-NUMBER =	Temporary identification number assigned to Eligible

(3) The State uses the SSN as an MSIS unique identifier AND the eligible had previously been assigned a temporary ID, but has now been assigned a valid SSN.

SSN-INDICATOR =	1
SOCIAL-SECURITY-NUMBER =	Eligible's valid SSN
MSIS-IDENTIFICATION-NUMBER =	Temporary identification number assigned to Eligible (This should be carried for at least one quarter)

(4) The State does not use the SSN as an MSIS unique identifier AND the eligible has had the same, state-assigned, permanent identification number since eligibility was established.

SSN-INDICATOR =	0
SOCIAL-SECURITY-NUMBER =	Eligible's valid SSN.
MSIS-IDENTIFICATION-NUMBER =	State-assigned unique identifier

5.2 ELIGIBLE File Record Types

When the period of eligibility covered by a record is within the reporting quarter specified for the file, the record is a Current Quarter record (TYPE-OF-RECORD = 1). Only one record per eligible can be a Current Quarter record in one ELIGIBLE file. Do not include records flagged as "current quarter" for persons who were not eligible for Medicaid for at least one day during the reporting quarter. MSIS will evaluate the first 500 records in a file to ensure the Current Quarter records fall within the reported quarter. If more than 50% do not, the file is rejected without further evaluation.

The ELIGIBLE file may contain one or more records for an individual for whom eligibility was established during this reporting quarter, retroactive to a prior quarter (TYPE-OF-RECORD = 2). Include one record for each prior quarter for which retroactive eligibility was established.

The ELIGIBLE file may contain any number of Correction records that correct/update enrollment records submitted to CMS in prior quarters' files (TYPE-OF-RECORD = 3). Note that only one correction should be submitted for any particular prior quarter. If more than one correction record addresses the same reporting quarter, only the last one in the file will be effective.

When you submit correction or retroactive records for a prior quarter, those records must be coded using the specifications that were in effect as of the quarter of eligibility being reported. Do not report retroactive records with coding that is acceptable in the current quarter but was not permitted in the prior quarter for which the correction/retroactive record is being reported.

5.3 Sorting Rules

The ELIGIBLE file must be sorted in standard EBCDIC ascending collating sequence as follows:

For Non-SSN States -

- the primary sort key is MSIS-IDENTIFICATION-NUMBER (ascending);
- the secondary sort key is FEDERAL-FISCAL-YEAR-QUARTER (ascending);
- the tertiary (minor) sort key is TYPE-OF-RECORD (descending).

For SSN States -

- the primary sort key is SOCIAL-SECURITY-NUMBER (ascending);
- the secondary sort key is MSIS-IDENTIFICATION-NUMBER (ascending);
- the tertiary sort key is FEDERAL-FISCAL-YEAR-QUARTER (ascending);
- the fourth (minor) sort key is TYPE-OF-RECORD (descending).

The following example illustrates the sorting sequence of ELIGIBLE file records for FFY 1987, Quarter 2, for a Non-SSN State:

RECORD-NUMBER	MSIS-ID-NUM	FFYRQ	TYPE-OF-RECORD
01	34567584323569	872	1
02	45673848569310	863	2
03	45673848569310	864	3
04	45673848569310	872	3
05	45673848569310	872	2
06	54667484958110	872	1

A single ELIGIBLE file should never contain two records with the same MSIS-IDENTIFICATION-NUMBER (or SSN) and FEDERAL-FISCAL-YEAR-QUARTER. By implication, this means that there will never be two records for the same eligible in the same quarter that have different values of TYPE-OF-RECORD. Thus, the third sort key has no effect on a properly constructed file. It is included only to help identify incorrect records. Improperly sorted files will be returned to the State.

5.4 ELIGIBLE File - Physical Data Record Layout

The following table summarizes the fields in the ELIGIBLE file record in the order in which they physically occur in each record (see Section 2, paragraph [e]). Fields whose values remain fixed for an entire quarter are referred to as "root" fields; fields that vary monthly are listed separately for each month.

ELIGIBLE RECORD SUMMARY

FIELD NAME	COBOL PICTURE	- POSITION - START	END	DEFAULT ERROR TOLERANCE
ROOT FIELDS				
MSIS-IDENTIFICATION-NUMBER	X(20)	01	20	0.1%
DATE-OF-BIRTH	9(8)	21	28	0.1%
DATE-OF-DEATH	9(8)	29	36	5.0%
SEX-CODE	X(1)	37	37	2.0%
RACE-ETHNICITY-CODE	9(1)	38	38	2.0%
SOCIAL-SECURITY-NUMBER	9(9)	39	47	2.0%
COUNTY-CODE	9(3)	48	50	5.0%
ZIP-CODE	9(5)	51	55	5.0%
TYPE-OF-RECORD	9(1)	56	56	2.0%
FEDERAL-FISCAL-YEAR-QUARTER	9(5)	57	61	0.1%
QUARTERLY-DUAL-ELIGIBLE-FLAG	9(2)	62	63	2.0%
HIC-NUMBER	X(12)	64	75	5.0%
MSIS-CASE-NUMBER	X(12)	76	87	0.1%
RACE-CODE-1	9(1)	88	88	5.0%
RACE-CODE-2	9(1)	89	89	5.0%
RACE-CODE-3	9(1)	90	90	5.0%
RACE-CODE-4	9(1)	91	91	5.0%
RACE-CODE-5	9(1)	92	92	5.0%
ETHNICITY-CODE	9(1)	93	93	5.0%
FILLER	X(9)	94	102	

ELIGIBLE RECORD SUMMARY

FIELD NAME	COBOL PICTURE	- POSITION - START	END	DEFAULT ERROR TOLERANCE
MONTHLY FIELDS				
MONTH 1:				
DAYS-OF-ELIGIBILITY	S9(2)	103	104	2.0%
ELIGIBILITY-GROUP	X(6)	105	110	2.0%
MAINTENANCE-ASSISTANCE-STATUS	X(1)	111	111	0.1%
BASIS-OF-ELIGIBILITY	X(1)	112	112	0.1%
HEALTH-INSURANCE	9(1)	113	113	5.0%
TANF-CASH-FLAG	9(1)	114	114	2.0%
RESTRICTED-BENEFITS-FLAG	9(1)	115	115	5.0%
PLAN-TYPE-1	9(2)	116	117	5.0%
PLAN-ID-1	X(12)	118	129	5.0%
PLAN-TYPE-2	9(2)	130	131	5.0%
PLAN-ID-2	X(12)	132	143	5.0%
PLAN-TYPE-3	9(2)	144	145	5.0%
PLAN-ID-3	X(12)	146	157	5.0%
PLAN-TYPE-4	9(2)	158	159	5.0%
PLAN-ID-4	X(12)	160	171	5.0%
SCHIP-CODE	X(1)	172	172	5.0%
INCOME-CODE	X(2)	173	174	5.0%
WAIVER-TYPE-1	X(1)	175	175	5.0%
WAIVER-ID-1	X(2)	176	177	5.0%
WAIVER-TYPE-2	X(1)	178	178	5.0%
WAIVER-ID-2	X(2)	179	180	5.0%
WAIVER-TYPE-3	X(1)	181	181	5.0%
WAIVER-ID-3	X(2)	182	183	5.0%
DUAL-ELIGIBLE-CODE	**9(2)**	**184**	**185**	**2.0%**
FILLER	**X(8)**	**186**	**193**	

ELIGIBLE RECORD SUMMARY

DEFAULT

FIELD NAME	COBOL PICTURE	- POSITION - START	END	ERROR TOLERANCE
MONTHLY FIELDS				
MONTH 2:				
DAYS-OF-ELIGIBILITY	S9(2)	194	195	2.0%
ELIGIBILITY-GROUP	X(6)	196	201	2.0%
MAINTENANCE-ASSISTANCE-STATUS	X(1)	202	202	0.1%
BASIS-OF-ELIGIBILITY	X(1)	203	203	0.1%
HEALTH-INSURANCE	9(1)	204	204	5.0%
TANF-CASH-FLAG	9(1)	205	205	2.0%
RESTRICTED-BENEFITS-FLAG	9(1)	206	206	5.0%
PLAN-TYPE-1	9(2)	207	208	5.0%
PLAN-ID-1	X(12)	209	220	5.0%
PLAN-TYPE-2	9(2)	221	222	5.0%
PLAN-ID-2	X(12)	223	234	5.0%
PLAN-TYPE-3	9(2)	235	236	5.0%
PLAN-ID-3	X(12)	237	248	5.0%
PLAN-TYPE-4	9(2)	249	250	5.0%
PLAN-ID-4	X(12)	251	262	5.0%
SCHIP-CODE	X(1)	263	263	5.0%
INCOME-CODE	X(2)	264	265	5.0%
WAIVER-TYPE-1	X(1)	266	266	5.0%
WAIVER-ID-1	X(2)	267	268	5.0%
WAIVER-TYPE-2	X(1)	269	269	5.0%
WAIVER-ID-2	X(2)	270	271	5.0%
WAIVER-TYPE-3	X(1)	272	272	5.0%
WAIVER-ID-3	X(2)	273	274	5.0%
DUAL-ELIGIBLE-CODE	**9(2)**	**275**	**276**	**2.0%**
FILLER	**X(8)**	**277**	**284**	

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ELIGIBLE RECORD SUMMARY

FIELD NAME	COBOL PICTURE	- POSITION - START	END	DEFAULT ERROR TOLERANCE

MONTH 3:				
DAYS-OF-ELIGIBILITY	S9(2)	285	286	2.0%
ELIGIBILITY-GROUP	X(6)	287	292	2.0%
MAINTENANCE-ASSISTANCE-STATUS	X(1)	293	293	0.1%
BASIS-OF-ELIGIBILITY	X(1)	294	294	0.1%
HEALTH-INSURANCE	9(1)	295	295	5.0%
TANF-CASH-FLAG	9(1)	296	296	2.0%
RESTRICTED-BENEFITS-FLAG	9(1)	297	297	5.0%
PLAN-TYPE-1	9(2)	298	299	5.0%
PLAN-ID-1	X(12)	300	311	5.0%
PLAN-TYPE-2	9(2)	312	313	5.0%
PLAN-ID-2	X(12)	314	325	5.0%
PLAN-TYPE-3	9(2)	326	327	5.0%
PLAN-ID-3	X(12)	328	339	5.0%
PLAN-TYPE-4	9(2)	340	341	5.0%
PLAN-ID-4	X(12)	342	353	5.0%
SCHIP-CODE	X(1)	354	354	5.0%
INCOME-CODE	X(2)	355	356	5.0%
WAIVER-TYPE-1	X(1)	357	357	5.0%
WAIVER-ID-1	X(2)	358	359	5.0%
WAIVER-TYPE-2	X(1)	360	360	5.0%
WAIVER-ID-2	X(2)	361	362	5.0%
WAIVER-TYPE-3	X(1)	363	363	5.0%
WAIVER-ID-3	X(2)	364	365	5.0%
DUAL-ELIGIBLE-CODE	**9(2)**	**366**	**367**	**2.0%**
FILLER	**X(8)**	**368**	**375**	

The error tolerance describes, for each field, the maximum allowable percentage of records submitted that may have missing, unknown, or invalid codes. Error rates in excess of the error tolerance level for **any** field will cause the entire file to be rejected.

5.5 ELIGIBLE File - Logical Data Record Layout

The following table summarizes the fields in the ELIGIBLE file record in the order in which fields are processed by the validation program (see Section 2.0. paragraph [e]). NOTE: Monthly fields are edited collectively in month order.
(ex. DAYS-OF-ELIGIBILITY Month 1, DAYS-OF-ELIGIBILITY Month 2, DAYS-OF-ELIGIBILITY Month 3)

	FIELD-TYPE
MSIS-IDENTIFICATION-NUMBER	(Root)
DATE-OF-BIRTH	(Root)
DATE-OF-DEATH	(Root)
SEX-CODE	(Root)
RACE-ETHNICITY-CODE	(Root)
RACE-CODE-1	(Root)
RACE-CODE-2	(Root)
RACE-CODE-3	(Root)
RACE-CODE-4	(Root)
RACE-CODE-5	(Root)
ETHNICITY-CODE	(Root)
SOCIAL-SECURITY-NUMBER	(Root)
COUNTY-CODE	(Root)
ZIP-CODE	(Root)
TYPE-OF-RECORD	(Root)
FEDERAL-FISCAL-YEAR-QUARTER	(Root)
HIC-NUMBER	(Root)
MSIS-CASE-NUMBER	(Root)
DAYS-OF-ELIGIBILITY	(Monthly)
ELIGIBILITY-GROUP	(Monthly)
MAINTENANCE-ASSISTANCE-STATUS	(Monthly)
BASIS-OF-ELIGIBILITY	(Monthly)
TANF-CASH-FLAG	(Monthly)
RESTRICTED-BENEFITS-FLAG	(Monthly)
PLAN-TYPE-1	(Monthly)
PLAN-ID-1	(Monthly)
PLAN-TYPE-2	(Monthly)
PLAN-ID-2	(Monthly)
PLAN-TYPE-3	(Monthly)
PLAN-ID-3	(Monthly)
PLAN-TYPE-4	(Monthly)
PLAN-ID-4	(Monthly)
HEALTH-INSURANCE	(Monthly)
SCHIP-CODE	(Monthly)
INCOME-CODE	(Monthly)
WAIVER-TYPE-1	(Monthly)
WAIVER-ID-1	(Monthly)
WAIVER-TYPE-2	(Monthly)
WAIVER-ID-2	(Monthly)
WAIVER-TYPE-3	(Monthly)
WAIVER-ID-3	(Monthly)
DUAL-ELIGIBILE-CODE	**(Monthly)**

5.6 ELIGIBLE File - Data Field/Element Specifications

The following pages contain detailed specifications for each data element (field) in the MSIS ELIGIBLE file record. In this section, the data elements are listed in alphabetical order.

For each data element, edit criteria are presented in the order in which they are applied during validation. All edits performed on monthly data elements are executed independently for each month in the reporting period. Unless stated otherwise, edits involving two or more monthly data elements always relate data for the same month.

ELIGIBLE FILE

Data Element Name: BASIS-OF-ELIGIBILITY

Definition: Monthly Field - A code indicating the individual's Basis of Eligibility as of the last day of the month referenced.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(1)	0.1%	4

Coding Requirements:

Valid Values	Code Definition
SEE ATTACHMENT 3 FOR DEFINITIONS OF MSIS CODING CATEGORIES	
0	Individual was not eligible for Medicaid at any time during the month
1	Aged Individual
2	Blind/Disabled Individual
3	Not used
4	Child (not Child of Unemployed Adult, not Foster Care Child)
5	Adult (not based on unemployed status)
6	Child of Unemployed Adult (optional)
7	Unemployed Adult (optional)
8	Foster Care Child
A	Individual covered under the Breast and Cervical Cancer Prevention and Treatment Act of 2000
9	Eligibility status Unknown (counts against error tolerance)

Submit records only for people who were eligible for Medicaid for at least one day during the FEDERAL-FISCAL-YEAR-QUARTER, or who are included at State option as non-Medicaid SCHIP individuals.

Error Condition	Resulting Error Code
1. Value is '9'-filled	301
2. Value not equal to '0', '1, '2', '4', '5', '6', '7' or '8' or 'A'	203
3. Relational Field in Error	999
4. Value <> '0' AND DAYS-OF-ELIGIBILITY = +00	502
5. Value = '0' AND DAYS-OF-ELIGIBILITY <> +00	502
6. Value = '8' AND MAINTENANCE-ASSISTANCE-STATUS <> '4'	503
7. (Value = '6' OR Value = '7') AND MAINTENANCE--ASSISTANCE-STATUS <> '1'	503

ELIGIBLE FILE

Data Element Name: BASIS-OF-ELIGIBILITY (continued)

Error Condition	Resulting Error Code
8. Value = 'A' AND MAINTENANCE--ASSISTANCE-STATUS <> '3'	503
9. Value = '1' AND DATE-OF-BIRTH implies Recipient was NOT over 64 on the first day of the month	996
10. (Value = '4' OR Value = '6' OR Value = '8') AND DATE-OF-BIRTH implies Recipient was NOT under 21 on the first day of the month	997
11. Value is = '1', '2', '4', '5', '6', '7' , '8', or 'A' in any month later than the month that included DATE-OF-DEATH	504

ELIGIBLE FILE

Data Element Name: COUNTY-CODE

Definition: Root Field - FIPS code indicating eligible's county of residence.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(3)	5.0%	037

Coding Requirements:

Use the National Bureau of Standards, Federal Information Processing Standards (FIPS) numeric county codes for each State.

Value = 000 if the eligible resides out-of-State.

If code is missing or unavailable, 9-fill.

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 9-filled	812
2. Value is 999	301
3. Value is not a valid county code for this State AND Value <> 000	201

ELIGIBLE FILE

Data Element Name: DATE-OF-BIRTH

Definition: Root Field - Eligible's Date of Birth

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(8)	0.1%	19670312

Coding Requirements:

Date format is CCYYMMDD (National Data Standard).

If a complete, valid date is not available fill with 99999999.

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 00000000	810
2. Value is 99999999 - Reset to 00000000	301
3. Value is not a valid date	102
4. Value is > END-OF-TIME-PERIOD in Header Record AND SEX-CODE <>"U'	506

ELIGIBLE FILE

Data Element Name: DATE-OF-DEATH

Definition: Root Field - Eligible's Date of Death

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(8)	5.0%	19670313

Coding Requirements:

Date format is CCYYMMDD (National Data Standard).

If Eligible is deceased, and a complete, valid date is not available, set field = 99999999 (counts against error tolerance)

If Eligible is not deceased, set field = 88888888.

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 00000000	810
2. Value is 99999999 - Reset to 00000000	301
3. Value is not a valid date - Reset to 00000000	102
4. Relational Field in Error	999
5. Value is < DATE-OF-BIRTH OR - Reset to 00000000 Value is > DATE-OF-BIRTH + 125 years	505
6. Value is > DATE-FILE-CREATED in Header Record - Reset to 00000000	501

ELIGIBLE FILE

Data Element Name: DAYS-OF-ELIGIBILITY

Definition: Monthly Field - The number of days an individual was eligible for Medicaid during each month of the quarter.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
S9(2)	2.0%	+30

Coding Requirements:

Valid values are +00 through the total number of days in the month referenced.

If invalid or missing, fill with +99.

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to +00	810
2. Value is +99 - Reset to +00	301
3. Value is < +00 OR Value is > number of days in the month referred to.	203
4. Relational Field in Error	999
5. Value is > +00 in any month later than the month that	504

ELIGIBLE FILE

Data Element Name: DUAL-ELIGIBLE-**CODE**

Definition: **Monthly Field** - Indicates coverage for individuals entitled to Medicare (Part A and/or B benefits) and eligible for some category of Medicaid benefits.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(2)	2.0%	00

Coding Requirements:

Valid Values	Code Definition
00	Eligible is not a Medicare beneficiary
01	Eligible is entitled to Medicare- QMB only
2	Eligible is entitled to Medicare- QMB AND Medicaid coverage including RX **(Medicaid drug coverage criterion only applies through December 2005)**
3	Eligible is entitled to Medicare- SLMB only
4	Eligible is entitled to Medicare- SLMB AND Medicaid coverage including RX **(Medicaid drug coverage criterion only applies through December 2005)**
05	Eligible is entitled to Medicare- QDWI
06	Eligible is entitled to Medicare- Qualifying individuals
08	Eligible is entitled to Medicare- Other Dual Eligibles (Non QMB, SLMB,QWDI or QI) with Medicaid coverage including RX **(Medicaid drug coverage criterion only applies through December 2005)**
09	Eligible is entitled to Medicare – Other Dual Eligibles
99	Eligible's Medicare status is unknown.

00. Eligible Is Not a Medicare Beneficiary - The individual is not entitled to Medicare coverage.

Medicare Dual Eligibles - The following describes the various categories of individuals who, collectively, are known as dual eligibles. Medicare has two basic coverages: Part A, which pays for hospitalization costs; and Part B, which pays for physician services, lab and x-ray services, durable medical equipment, and outpatient and other services. Dual eligibles are individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit.

01. Qualified Medicare Beneficiaries (QMBs) without other Medicaid (QMB Only) - These individuals are entitled to Medicare Part A, have income of 100% Federal poverty level (FPL) or less and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for full Medicaid. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and Medicare deductibles and coinsurance for Medicare services provided by Medicare providers.

02. QMBs with Medicaid Coverage (QMB Plus). These individuals are entitled to Medicare Part A, have income of 100% FPL or less and resources that do not exceed twice the limit for SSI eligibility. Through 2005, individuals in this group qualify for one or more Medicaid benefits including prescription drug coverage. Effective 2006, they qualify for one or more Medicaid benefits that do not include prescription drugs. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and Medicare deductibles and coinsurance, and provides one or more Medicaid benefits. **QMB individuals with prescription drug coverage are included in this group through December 2005. Beginning in January 2006, Part D provides drug coverage for these individuals, and Medicaid drug benefits are not required for an individual to be reported in this group.**

October 2004

ELIGIBLE FILE

Data Element Name: DUAL-ELIGIBLE-**CODE** (continued)

03. Specified Low-Income Medicare Beneficiaries (SLMBs) without other Medicaid (SLMB Only) - These individuals are entitled to Medicare Part A, have income of 100 -120% FPL and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only.

04. SLMBs with Medicaid Coverage (SLMB Plus). These individuals are entitled to Medicare Part A, have income of 100-120% FPL and resources that do not exceed twice the limit for SSI eligibility. Through 2005, individuals in this group qualify for one or more Medicaid benefits including prescription drug coverage. Effective 2006, they qualify for one or more Medicaid benefits that do not include prescription drugs. Medicaid pays their Medicare Part B premiums and provides one or more Medicaid benefits. **SLMB individuals with prescription drug coverage are included in this group through December 2005. Beginning in January 2006, Part D provides drug coverage for these individuals, and Medicaid drug benefits are not required for an individual to be reported in this group.**

05. Qualified Disabled and Working Individuals (QDWIs) - These individuals lost their Medicare Part A benefits due to their return to work. They are eligible to purchase Medicare Part A benefits, have income of 200% FPL or less and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays the Medicare Part A premiums only.

06. Qualifying Individuals (QIs) - There is an annual cap on the amount of money available, which may limit the number of individuals in the group. These individuals are entitled to Medicare Part A, have income of 120 -135% FPL, resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only with 100% Federal funding.

08. Other Dual Eligibles with Medicaid Coverage (Non QMB, SLMB, QDWI or QI) - These individuals are entitled to Medicare Part A and/or Part B and are eligible for one or more Medicaid benefits including prescription drug coverage. They are not eligible for Medicaid as a QMB, SLMB, QDWI or QI. Typically, these individuals need to spend down to qualify for Medicaid or fall into a Medicaid poverty group that exceeds the limits listed above. Through **December 2005**, individuals in this group qualify for one or more Medicaid benefits including prescription drug coverage. **Beginning in January 2006, Part D provides drug coverage for these individuals, and Medicaid drug benefits are not required for an individual to be reported in this group.** Medicaid pays for Medicaid services provided by Medicaid providers, but only to the extent that the Medicaid rate exceeds any Medicare payment for services covered by both Medicare and Medicaid. Payment by Medicaid of Part B premiums is a state option.

09. Other Dual Eligibles (e.g, Pharmacy + Waivers; states not including prescription drugs in Medicaid benefits for some groups) – Special dual eligible groups not included above, but approved under special circumstances. This code is to be used only with specific CMS approval.

NOTE: If the quarter being reported is prior to FY 2006, Quarter1, or if the reporting quarter is FY 2006, Quarter 1 or later and includes retroactive or correction records for a prior quarter, the quarterly dual-eligible-flag must be completed.

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 9-filled	812
2. Value is 99	301
3. Value is < 00 OR Value = 7 OR Value is > 09 AND <99	203
4. Relational Field in Error	999
5. **If Value={01, 03, 05, OR 06} AND MAINTENANCE-ASSISTANCE-STATUS <>"3"**	503

January 2006

ELIGIBLE FILE

Data Element Name: ELIGIBILITY-GROUP

Definition: Monthly Field - The composite of eligibility mapping factors used to create the corresponding Maintenance Assistance Status (MAS) and Basis of Eligibility (BOE) values. Examples of such mapping factors include:

- State eligibility group or aid category
- Payment status
- Disability status
- Family status
- Person code
- Money code

This field should not include information that already appears elsewhere on the Eligible-File record even if it is part of the MAS and BOE algorithm (e.g., age information computed from DATE-OF-BIRTH or COUNTY-CODE).

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(6)	2.0%	10A01

Coding Requirements:

Concatenate alpha numeric representations of the eligibility mapping factors used to create monthly MAS and BOE. In the example above, state x uses three fields, in addition to age, to determine MAS and BOE. The fields are a two-byte alpha numeric aid category (i.e., 10), a one-byte alpha numeric money code (i.e., A) a two-byte person code (i.e., 01).

State needs to provide composite code reflecting the contents of this field (e.g., bytes 1-2 = aid category; bytes 3 = money code; bytes 4-5 = person code). If six bytes is insufficient to accommodate all of the eligibility factors, the state should select the most critical factors and include them in this field.

Value = 000000 for individuals who were not eligible for at least one day during the month.

Value must be one of the valid codes submitted by the State. (States must submit lists of valid State specific eligibility factor codes to CMS in advance of transmitting MSIS files, and must update those lists whenever changes occur.)

For this field, always report whatever is present in the State system, even if it is clearly invalid. Fill this field with "9"s only when the State system contains no information.

ELIGIBLE FILE

Data Element Name: ELIGIBILITY-GROUP (continued)

Error Condition	Resulting Error Code
1. Value = “999999"	301
2. Value does not appear on the list of valid codes submitted by the State.	201
3. Relational Field in Error	999
4. Value is <> “000000" AND DAYS-OF-ELIGIBILITY = +00 AND SCHIP-CODE<>”3"	502
5. Value = “000000" AND DAYS-OF-ELIGIBILITY NOT = +00	502
6. Value is > “000000" in any month later than the month that included DATE-OF-DEATH	504

ELIGIBLE FILE

Data Element Name: ETHNICITY-CODE

Definition: Root Field - A code indicating if the eligible has indicated an ethnicity of Hispanic or Latino.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(1)	5.0%	1

Coding Requirements:

Use this code to indicate if the eligible's demographics include an ethnicity of Hispanic or Latino. This determination is independent of indication of RACE-CODE (1-5).

Valid Values	Code Definition
0	Not Hispanic or Latino
1	Hispanic or Latino
9	Ethnicity Unknown

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 9	812
2. Value is 9	301
3. Value not equal to 0 or 1or 9	203
4. Relational Field in Error	999
5. Value = 0 and Race/Ethnicity Code = 5 OR 7..... Reset to 9	550
6. Value = 1 and Race/Ethnicity Code is not equal to 5 OR 7. Reset to 9	550

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ELIGIBLE FILE

Data Element Name: FEDERAL-FISCAL-YEAR-QUARTER

Definition: Root Field - Indicates the Federal Fiscal Year and Quarter for the record.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(5)	0.1%	20011

Coding Requirements:

Values conform to the format "CCYYQ", where:

CCYY is the Federal Fiscal Year covered by this Eligibility Record (e. g., "2001" for FFY 2001); and

Q is the Federal Fiscal Quarter covered by this Eligibility Record:

1 Federal Fiscal Quarter 1 (10/01-12/31)
2 Federal Fiscal Quarter 2 (01/01-03/31)
3 Federal Fiscal Quarter 3 (04/01-06/30)
4 Federal Fiscal Quarter 4 (07/01-09/30)

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 9-filled	812
2. Q is < 1 OR Q is > 4	203
3. CCYY is < 1984	203
4. Relational Field in Error	999
5. Value is > than the fiscal quarter specified in END-OF-TIME-PERIOD in Header Record	506
6. Value is < than the fiscal quarter specified by START-OF-TIME-PERIOD in the Header Record AND TYPE-OF-RECORD = {1}; (that is, a current quarter record does not refer to the current quarter)	701
7. Value is = fiscal quarter specified by START-OF-TIME-PERIOD in the Header Record AND TYPE-OF-RECORD = {2 or 3}; (that is, a prior quarter record refers to the current quarter)	701

ELIGIBLE FILE

Data Element Name: HEALTH-INSURANCE

Definition: Monthly Field - A flag indicating whether this enrollee had private health insurance coverage during the month. This includes both coverage purchased by the State or by a third party. Medicare is not considered private health insurance. Enrollment in a Medicaid/Medicare HMO does not constitute health insurance for this data element.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(1)	5.0%	1

Coding Requirements:

Valid Values	Code Definition
0	Not eligible for Medicaid during month
1	Eligible did not have private insurance coverage
2	Eligible had private health insurance coverage purchased by a third party
3	Eligible had private health insurance coverage purchased by the State
4	Both 2 or 3 apply OR either 2 or 3 apply and funding source unknown
9	State had only invalid or missing information

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 9-filled	812
2. Value is 9	301
3. Value < 0 OR Value > 4	203
4. Relational Field in Error	999
5. Value is <> 0 AND DAYS-OF-ELIGIBILITY = +00 AND SCHIP-CODE<>"3"	502
6. Value = 0 AND DAYS-OF-ELIGIBILITY NOT = +00	502
7. Value is > 0 in any month later than the month that included DATE-OF DEATH	504

ELIGIBLE FILE

Data Element Name: HIC-NUMBER

Definition: Root Field- The eligible's Medicare Health Insurance Claim (HIC) Identification Number, if applicable.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(12)	5.0%	123456789A

Coding Requirements:

If eligible is enrolled in Medicare and HIC Number is not available, 9-fill field (counts against error tolerance).

If eligible is NOT enrolled in Medicare, 8-fill field.

Error Condition	Resulting Error Code
1. Value is improperly "Space Filled"	303
2. Value is 9-filled	301
3. Value is 0-filled	304
4. Relational Field in Error	999
5. Value is 8-filled AND DUAL-ELIGIBLE-FLAG = {01,02,03,04,05,06,07,08, OR 09}	537

Data Element Name: INCOME-CODE

Definition: Monthly Field - (OPTIONAL FIELD) A code indicating the family income level associated with the SCHIP program reporting requirements for the month. This code is to be reported for Medicaid eligibles below the SCHIP age limit, Medicaid expansion SCHIP enrollees and non-Medicaid SCHIP eligibles reported by the State. For States not opting to provide this data on ANY eligible records, blank-fill this field.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(2)	5.0%	00

Coding Requirements:

Valid Values	Code Definition
BLANK	State has not opted to include this field for ANY Eligible-file records
00	Individual was not a Medicaid eligible and not eligible for SCHIP for the month
01	Individual's State-defined family income is within level 01 for the month
02	Individual's State-defined family income is within level 02 for the month
03	Individual's State-defined family income is within level 03 for the month
04	Individual's State-defined family income is within level 04 for the month
05	Individual's State-defined family income is within level 05 for the month
06	Individual's State-defined family income is within level 06 for the month
07	Individual's State-defined family income is within level 07 for the month
09	Individual's State-defined family income is UNKNOWN for the month
88	Individual was eligible for Medicaid, but above the age limit for SCHIP enrollment

The income level brackets are State defined, and must be submitted to CMS in the MSIS documentation. The income levels are expressed as a Percentage of the Federal (or State-defined, which may take into account State income disregards) Poverty Levels. Examples of State-defined income codes include: 01- Up to 100 % of FPL; 02 - Between 100 and 150% of FPL; 03 - Between 150 and 175% of FPL; and 04 - Over 175% of FPL. Codes can also be defined to address income levels defined by cost-sharing levels.

Error Condition	Resulting Error Code
1. Value is '09'-filled	301
2. Value not equal to '00, '01', '02', '03', '04', '05', '06', '07' OR '88'	203

ELIGIBLE FILE

Data Element Name: MAINTENANCE-ASSISTANCE-STATUS

Definition: Monthly Field - A code indicating an eligible's maintenance assistance status. See Attachment 3 for a description of MSIS coding categories.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(1)	0.1%	1

Coding Requirements:

Valid Values	Code Definition
0	Individual was not Eligible for Medicaid this month
1	Receiving Cash or Eligible under section 1931 of the Act
2	Medically Needy
3	Poverty Related
4	Other
5	1115 - Demonstration expansion eligibles
9	Status is unknown

Error Condition	Resulting Error Code
1. Value is '9'	301
2. Value not equal to '0', '1,' '2', '3', '4', or '5'	203
3. Relational Field in Error	999
4. Value is <> '0' AND DAYS-OF-ELIGIBILITY = +00	502
5. Value is '0' AND DAYS-OF-ELIGIBILITY NOT = +00	502
6. Value is = '1', '2', '3', '4', or '5' in any month later than the month that included DATE-OF-DEATH	504

Data Element Name: MSIS-CASE-NUMBER

Definition: Root Field - The state-assigned number which uniquely identifies the Medicaid case to which the enrollee belongs on the last day of the current Federal Fiscal Year Quarter. The definition of a case varies. There are single-person cases (mostly aged and blind/disabled) and multi-person cases (mostly TANF) in which each member of the case has the same case number, but a unique MSIS identification number. A warning for longitudinal research efforts: a person's case number may change over time.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(12)	0.1%	1045329867

Coding Requirements:

This field must contain the Medicaid case identification number assigned by the State. The format of the Medicaid case identification number must be supplied to CMS with the State's MSIS application.

Error Condition	Resulting Error Code
1. Duplicate Eligible Record (MSIS-IDENTIFICATION-NUMBER, MSIS-CASE-NUMBER, FEDERAL-FISCAL-YEAR-QUARTER, DATE-OF-BIRTH SOCIAL-SECURITY-NUMBER match)	801
2. Value is improperly "Space Filled"	303
3. Value is 9-filled	301
4. Value is 0-filled	304
5. Value is 8-filled	305

ELIGIBLE FILE

Data Element Name: MSIS-IDENTIFICATION-NUMBER

Definition: Root Field - A unique identification number used to identify a Medicaid Eligible to MSIS (see section 5.1).

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(20)	0.1%	123456789

Coding Requirements:

For SSN States, this field should be space-filled unless a temporary identification number has been assigned. Whenever such a temporary MSIS-ID is in effect, enter that number in this field. When a permanent SSN is assigned carry the temporary number in this field for at least one quarter to enable CMS to establish a link between the SSN and the temporary ID.

For Non-SSN States, this field must contain an identification number assigned by the State. The format of the state MSIS-ID numbers must be supplied to CMS with the state's MSIS application.

Error Condition	Resulting Error Code
1. Duplicate Eligible record (MSIS-IDENTIFICATION-NUMBER, MSIS-CASE-NUMBER, FEDERAL-FISCAL-YEAR-QUARTER, DATE-OF-BIRTH match) Second record is not saved.	801
2. Non-unique Duplicate (DATE-OF-BIRTH does not match; but MSIS-IDENTIFICATION-NUMBER, FEDERAL-FISCAL-YEAR-QUARTER do match - Eligible with oldest DATE-OF-BIRTH saved)	802
3. Value is improperly "Space Filled"	303
4. Value is 9-filled	301
5. Value is 0-filled	304
6. Value is 8-filled	305

ELIGIBLE FILE

Data Element Names: PLAN-ID-1
PLAN-ID-2
PLAN-ID-3
PLAN-ID-4

Definition: Monthly Fields - Fields for specifying up to four managed care plan identification numbers under which the eligible individual is covered during the month.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(12)	5.0%	MED001356

Coding Requirements:

Please fill in the monthly PLAN-ID fields in sequence (e.g., if an individual is enrolled in two managed care plans, only the first and second set of monthly fields should be used; if only enrolled in one plan, code PLAN-ID-1 and 8-fill PLAN-ID-2 through PLAN-ID-4).

Enter the managed care plan identification number assigned by the State.

If individual is not eligible for Medicaid during the month, 0-fill all four fields.

If individual is not enrolled in any managed care plan during the month, 8-fill all four fields.

Error Condition	Resulting Error Code
1. Value is "SPACE FILLED"	303
2. Value is <> "000000000000" AND DAYS-OF-ELIGIBILITY = +00 AND SCHIP CODE<>"3"	502
3. Value is = "000000000000" AND DAYS-OF-ELIGIBILITY NOT = +00	502
4. Value is = "888888888888" AND corresponding PLAN-TYPE > = 01 and < = 08	538
5. Value is < > "888888888888" AND corresponding PLAN-TYPE = 88	538
6. Value is > "000000000000" in any month later than the month that included DATE-OF-DEATH.	504
7. Value appears more than once in monthly array AND VALUE<>"888888888888" OR "SPACE Filled"	532

Data Element Names: PLAN-TYPE-1
PLAN-TYPE-2
PLAN-TYPE-3
PLAN-TYPE-4

Definition: Monthly Fields - Codes for specifying up to four managed care plan types under which the eligible individual is covered during the month.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(2)	5.0%	01

Coding Requirements:

Please fill in the monthly PLAN-TYPE fields in sequence (e.g., if an individual is enrolled in two managed care plans, only the first and second set of monthly fields should be used; if only enrolled in one plan, code PLAN-TYPE-1 and 8-fill PLAN-TYPE-2 through PLAN-TYPE-4).

Values must correspond to associated PLAN-ID-NUMBER.

Valid Values	Code Definition
00	Individual was not eligible for Medicaid this month
01	Eligible is enrolled in a medical or comprehensive managed care plan this month (e.g. HMO)
02	Eligible is enrolled in a dental managed care plan this month
03	Eligible is enrolled in a behavioral managed care plan this month
04	Eligible is enrolled in a prenatal/delivery managed care plan this month
05	Eligible is enrolled in a long-term care managed care plan this month
06	Program for All-Inclusive Care for the Elderly (PACE)
07	Eligible is enrolled in a primary care case management managed care plan this month
08	Eligible is enrolled in an other managed care plan this month
88	Not applicable, individual is eligible for Medicaid, but is NOT enrolled in a managed care plan this month
99	Eligible's managed care plan status is unknown.

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 99	812
2. Value is 9-filled	301
3. Value is not valid	203
4. Relational Field in Error	999
5. Value is <> 00 AND DAYS-OF-ELIGIBILITY= +00 AND SCHIP-CODE <>"3"	502
6. Value = 00 AND DAYS-OF-ELIGIBILITY <> +00	502
7. Value is > 00 in any month later than the month that included DATE-OF-DEATH	504
8. Value is 04 AND SEX-CODE <> "F"	539

9. Value appears more than once in monthly array AND VALUE <>88.....532

ELIGIBLE FILE

Data Element Name: RACE-CODE-1

Definition: Root Field - A code indicating if the eligible has indicated a race of White.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(1)	5.0%	1

Coding Requirements:

Use this code to indicate if the eligible's race demographics includes a race of White. This determination is independent of indications of other races. That is, for RACE-CODE-1 through RACE-CODE-5, any combination of race codes is possible. If there is no available race information for the eligible, code all five RACE-CODE(s) as 0, and the race for the eligible will be deemed to be **unknown**.

Valid Values	Code Definition
0	Non-White or Race Unknown
1	White

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 0	810
2. Value not equal to 0 OR 1 - Reset to 0	203
3. Relational Field in Error	999
4. Value = 0 and Race/Ethnicity Code = 1	550
5. Value = 1 and Race/Ethnicity Code is not equal to 1 or 7 or 8. Reset to 0.	550

ELIGIBLE FILE

Data Element Name: RACE-CODE-2

Definition: Root Field - A code indicating if the eligible has indicated a race of Black or African-American.

Field Description:

COBOL Error PICTURE	Tolerance	Example Value
9(1)	5.0%	1

Coding Requirements:

Use this code to indicate if the eligible's race demographics includes a race of Black or African-American. This determination is independent of indications of other races. That is, for RACE-CODE-1 through RACE-CODE-5, any combination of race codes is possible. If there is no available race information for the eligible, code all five RACE-CODE(s) as 0, and the race for the eligible will be deemed to be **unknown**.

Valid Values	Code Definition
0	Non-Black or African American or Race Unknown
1	Black or African American

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 0	810
2. Value not equal to (0 OR 1) - Reset to 0	203
3. Relational Field in Error	999
4. Value = 0 and Race/Ethnicity Code = 2	550
5. Value = 1 and Race/Ethnicity Code is not equal to 2 or 7 or 8. Reset to 0	550

ELIGIBLE FILE

Data Element Name: RACE-CODE-3

Definition: Root Field - A code indicating if the eligible has indicated a race of American Indian or Alaska Native.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(1)	5.0%	1

Coding Requirements:

Use this code to indicate if the eligible's race demographics includes a race of American Indian or Alaska Native. This determination is independent of indications of other races. That is, for RACE-CODE-1 through RACE-CODE-5, any combination of race codes is possible. If there is no available race information for the eligible, code all five RACE-CODE(s) as 0, and the race for the eligible will be deemed to be **unknown**.

Valid Values	Code Definition
0	Non-American Indian or Alaska Native or Race Unknown
1	American Indian or Alaska Native

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 0	810
2. Value not equal to 0 OR 1 - Reset to 0	203
3. Relational Field in Error	999
4. Value = 0 and Race/Ethnicity Code = 3	550
5. Value = 1 and Race/Ethnicity Code is not equal to 3 or 7 or 8. Reset to 0	550

ELIGIBLE FILE

Data Element Name: RACE-CODE-4

Definition: Root Field - A code indicating if the eligible has indicated a race of Asian.

Field Description:

COBOL Error PICTURE	Tolerance	Example Value
9(1)	5.0%	1

Coding Requirements:

Use this code to indicate if the eligible's race demographics includes a race of Asian. This determination is independent of indications of other races. That is, for RACE-CODE-1 through RACE-CODE-5, any combination of race codes is possible. If there is no available race information for the eligible, code all five RACE-CODE(s) as 0, and the race for the eligible will be deemed to be **unknown**.

Valid Values	Code Definition
0	Non-Asian or Race Unknown
1	Asian

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 0	810
2. Value not equal to 0 OR 1 - Reset to 0	203
3. Relational Field in Error	999
4. Value = 0 and Race/Ethnicity Code = 4	550
5. Value = 1 and Race/Ethnicity Code is not equal to 4 or 7 or 8. Reset to 0	550

ELIGIBLE FILE

Data Element Name: RACE-CODE-5

Definition: Root Field - A code indicating if the eligible has indicated a race of Native Hawaiian or other Pacific Islander.

Field Description:

COBOL Error PICTURE	Tolerance	Example Value
9(1)	5.0%	1

Coding Requirements:

Use this code to indicate if the eligible's race demographics includes a race of Native Hawaiian or other Pacific Islander. This determination is independent of indications of other races. That is, for RACE-CODE-1 through RACE-CODE-5, any combination of race codes is possible. If there is no available race information for the eligible, code all five RACE-CODE(s) as 0, and the race for the eligible will be deemed to be **unknown**.

Valid Values	Code Definition
0	Non-Native Hawaiian or Other Pacific Islander or Race Unknown
1	Native Hawaiian or Other Pacific Islander

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 0	810
2. Value not equal to 0 OR 1 - Reset to 0	203
3. Relational Field in Error	999
4. Value = 0 and Race/Ethnicity Code = 6	550
5. Value = 1 and Race/Ethnicity Code is not equal to 6 or 7 or 8. Reset to 0	550

ELIGIBLE FILE

Data Element Name: RACE-ETHNICITY-CODE

Definition: Root Field - A code indicating the eligible's race/ethnicity.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(1)	2.0%	5

Coding Requirements:

Use the appropriate race/ethnicity code that best describes the eligible's race/ethnicity grouping. If only one race is known and no ethnicity is indicated, select one of the codes from 1-4 or 6. If only ethnicity is indicated and race is not, code 5 should be used. If ethnicity is indicated and one or more races are known, use code 7. If more than one race is known and ethnicity is not indicated, select code 8. Finally, if neither race nor ethnicity is known, code 9 should be used.

Valid Values	Code Definition
1	White
2	Black or African American
3	American Indian or Alaska Native
4	Asian
5	Hispanic or Latino (No race information available)
6	Native Hawaiian or Other Pacific Islander
7	Hispanic or Latino and one or more races
8	More than one race (Hispanic or Latino not indicated)
9	Unknown

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 9-filled	810
2. Value is 9	301
3. Value < 1. Reset to 9	203

ELIGIBLE FILE

Data Element Name: RESTRICTED-BENEFITS-FLAG

Definition: Monthly Field - A flag that indicates the scope of Medicaid benefits to which an eligible is entitled during each month.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(1)	5.0 %	2

Coding Requirements:

Valid Values	Code Definition
0	Individual is not eligible for Medicaid during the month.
1	Individual is eligible for Medicaid and entitled to the full scope of Medicaid benefits.
2	Individual is eligible for Medicaid but only entitled to restricted benefits based on alien status.
3	Individual is eligible for Medicaid but only entitled to restricted benefits based on Medicare dual-eligibility status (e.g., QMB, SLMB, QDWI, QI).
4	Individual is eligible for Medicaid but only entitled to restricted benefits for pregnancy-related services.
5	Individual is eligible for Medicaid but, for reasons other than alien, dual-eligibility or pregnancy-related status, is only entitled to restricted benefits (e.g., restricted benefits based upon substance abuse, medically needy or other criteria).
6	Individual is eligible for Medicaid but only entitled to restricted benefits for family planning services.
7	**Individual is eligible for Medicaid and entitled to Medicaid benefits under an alternative package of benchmark-equivalent coverage**.
9	Individual's benefit restrictions are unknown.

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 9	812
2. Value is 9	301
3. Value is < 0 OR Value is > 7	203
4. Relational Field in Error	999
5. Value is <> 0 AND DAYS-OF-ELIGIBILITY = +00 AND SCHIP-CODE<>"3"	502
6. Value is 0 AND DAYS-OF-ELIGIBILITY NOT = +00	502
7. Value is > 0 in any month later than the month that included DATE-OF-DEATH.	504
8. Value = 3 AND DUAL-ELIGIBLE-CODE = 00,02,04 OR 08	537
9. Value = 4 AND SEX-CODE <> "F"	539

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ELIGIBLE FILE

Data Element Name: SCHIP-CODE

Definition: Monthly Field - A code indicating the individual's inclusion in the SCHIP program for the month.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(1)	5.0%	2

Coding Requirements:

Valid Values	Code Definition
0	Individual was not a Medicaid eligible and not eligible for SCHIP for the month
1	Individual was Medicaid eligible, but was not included in either Medicaid expansion SCHIP OR a separate title XXI SCHIP program for the month
2	Individual was included in the Medicaid expansion SCHIP program and subject to enhanced Federal matching for the month
3	Individual was not Medicaid eligible, but was included in a non-Medicaid expansion title XXI SCHIP program for the month. Inclusion of MSIS eligibility records for these non-Medicaid SCHIP individuals is optional.
9	SCHIP status unknown

Error Condition	Resulting Error Code
1. Value is '9'-filled	301
2. Value not equal to '0', '1', '2', or '3'	203
3. Relational Field in Error	999
4. Value = '0' OR '3' AND DAYS-OF-ELIGIBILITY <> +00	502
5. Value = '1' OR '2' AND DAYS-OF-ELIGIBILITY = +00	502
6. Value = '2' OR '3' AND DATE-OF-BIRTH implies eligible was NOT under 19 on the last day of the month	997

ELIGIBLE FILE

Data Element Name: SEX-CODE

Definition: Root Field - The eligible's gender.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(1)	2.0%	F

Coding Requirements:

Valid Values	Code Definition
F	Female
M	Male
U	Unknown

Error Condition	Resulting Error Code
1. Value is Numeric - Reset to "U"	812
2. Value is "U"	301
3. Value is not "F", "M", "U"	203

ELIGIBLE FILE

Data Element Name: SOCIAL-SECURITY-NUMBER

Definition: Root Field - The eligible's social security number.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(9)	0.1%	253981873

Coding Requirements:

For SSN States:

Value must = eligible's valid Social Security Number and SSN-INDICATOR = 1. If the SSN is not available and a temporary identification number has been assigned in the MSIS-IDENTIFICATION-NUMBER field, this field must = 888888888.

For NON-SSN States:

Value should = eligible's SSN or 999999999 if the SSN is unknown.

See Section 5.1 for some additional examples in context.

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 8-filled	811
2. Value is 999999999	301
3. Value=888888888 AND SSN-INDICATOR in the Header Record =1 AND MSIS-IDENTIFICATION-NUMBER is equal to spaces	305

ELIGIBLE FILE

Data Element Name: TANF-CASH-FLAG

Definition: Monthly Field - A flag that indicates whether the eligible received Temporary Assistance for Needy Families (TANF) benefits during the month.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(1)	2.0%	1

Coding Requirements:

Valid Values	Code Definition
0	Individual was not eligible for Medicaid at any time during the month.
1	Individual did not receive TANF benefits during the month
2	Individual did receive TANF benefits during the month.(States should only use this value if they can accurately separate eligibles receiving TANF benefits from other 1931 eligibles reported into MAS 1)
9	Individual's TANF status is unknown

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 9	812
2. Value is 9-filled	301
3. Value is < 0 or > 2	203
4. Relational Field in Error	999
5. Value <> 0 AND DAYS-OF-ELIGIBILITY = +00 AND SCHIP-CODE<>"3"	502
6. Value = 0 AND DAYS-OF-ELIGIBILITY <> +00	502
7. Value is > 0 in any month later than the month that included DATE-OF-DEATH	504

ELIGIBLE FILE

Data Element Name: TYPE-OF-RECORD

Definition: Root Field - A code indicating whether the eligibility information contained in this record refers to the current fiscal quarter (the quarter specified in the Header Record) or to a previous quarter. A previous quarter could pertain to either retroactive eligibility or to a record that corrects eligibility information submitted in an earlier quarter.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(1)	2.0%	1

Coding Requirements:

Valid Values	Code Definition
1	For all ELIGIBLE File records that contain eligibility information pertaining to the current federal fiscal quarter, that is, to the reporting quarter specified in the Header Record.
2	For all ELIGIBLE File records that contain eligibility data pertaining to a retroactive quarter of eligibility, that is, to a quarter earlier than the reporting quarter specified in the Header Record. Although records with TYPE-OF-RECORD = 2 refer to prior quarters of eligibility, they must contain only information being reported for the first time.
3	For all ELIGIBLE File records that contain eligibility data that corrects or updates previously reported information pertaining to a quarter earlier than the reporting quarter specified in the Tape Label Internal Dataset Name. These records correct information in all prior quarter records, regardless of whether they were originally submitted with TYPE-OF-RECORD = 1 or 2.
9	If TYPE-OF-RECORD is unknown.

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 9-filled	812
2. Value = 9	301
3. Value < 1 OR Value > 3	203

ELIGIBLE FILE

Data Element Names: WAIVER-ID-1
WAIVER-ID-2
WAIVER-ID-3

Definition: Monthly Fields - Fields for specifying up to three waiver programs under which the eligible individual is covered during the month. These Ids must be assigned by the State, using alpha or numeric codes, to uniquely identify each specific waiver program(s) under which the individual is covered. The categories of waiver programs include 1915(b), 1915(c), combined (b)/(c) programs, and 1115 demonstrations. Individuals are to be associated with a specific waiver only if they are enrolled in a waiver program.

In order to support more detailed analysis of the waiver data, States must submit a hard-copy baseline crosswalk showing the MSIS WAIVER-ID number, and the associated approved full waiver ID number and name. Updates to this crosswalk must be submitted when waivers are added or ID numbers are changed.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(2)	5.0%	C1

Coding Requirements:

Please fill in the monthly WAIVER-ID fields in sequence (e.g., if an individual is enrolled in two waivers, only the first and second set of monthly fields should be used—8 fill the WAIVER-ID-3 field. If only enrolled in one waiver, code WAIVER-ID-1 and 8-fill WAIVER-ID-2 and WAIVER-ID-3).

Enter the coded WAIVER-ID number assigned by the State, and reported in the hard-copy crosswalk documentation.

If individual is not eligible for Medicaid during the month, 0-fill all three fields.

If individual is not enrolled in waiver during the month, 8-fill all three fields.

Error Condition	Resulting Error Code
1. Value is ”SPACE FILLED”	303
2. Relational Field in Error	999
3. Value is (<> “00" AND <> “88") AND DAYS-OF-ELIGIBILITY = +00 AND SCHIP CODE<>”3"	502
4. Value is = “00" AND DAYS-OF-ELIGIBILITY NOT = +00	502
5. Value is (<> “00" AND <> “88") AND corresponding WAIVER-TYPE = 0 or 8	538
6. Value is = “88" or “00” AND corresponding WAIVER-TYPE = 1 THROUGH 7 or 9 or F or A	538
7. Value is > “00" in any month later than the month that included DATE-OF-DEATH.	504
8. Value appears more than once in monthly array AND VALUE (<> “00" AND <> “88" and <> “SPACE Filled”)	

ELIGIBLE FILE

Data Element Names: WAIVER-TYPE-1
WAIVER-TYPE-2
WAIVER-TYPE-3

Definition: Monthly Fields - Codes for specifying up to three waiver types under which the eligible individual is covered during the month.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(1)	5.0%	3

Coding Requirements:

Please fill in the monthly WAIVER-TYPE fields in sequence (e.g., if an individual is enrolled in two waivers, only the first and second set of monthly fields should be used; if only enrolled in one waiver, code WAIVER-TYPE-1 and 8-fill WAIVER-TYPE-2 through WAIVER-TYPE-3).

Values must correspond to associated WAIVER-ID-NUMBER.

Valid Values	Code Definition
0	Individual was not eligible for Medicaid this month
1	The associated Waiver-ID-Number is for an 1115 waiver this month. May also be called a research, experimental, demonstration or pilot waiver or refer to consumer-directed care or expanded eligibility. May cover entire State or just a geographic entity or specific population.
2	The associated Waiver-ID-Number is for a 1915(b) waiver this month. May also be called managed care, freedom-of-choice, statewideness, selective contracting, comparability, or program waiver.
3	The associated Waiver-ID-Number is for a 1915(c) waiver this month. May also be called 2176, Home and Community Based Care, HCBS, HCB, and will often mention specific populations such as MR/DD, aged, disabled/physically disabled, aged/disabled, AIDS/ARC, mental health, TBI/head injury, special care children/technology dependent children.
4	The associated Waiver-ID-Number is a combined 1915(b)(c) waiver this month. Includes both managed care and alternatives to institutional long term care such as: case management; homemaker/home health aid; personal care services; adult day health; habilitation; respite.
5	The associated Waiver-ID-Number is for a HIFA (Health Insurance and Flexibility and Accountability) waiver this month. May also be called demonstration waiver or refer to the eligibility expansion, and will be a new waiver on or after August 2001.
6	The associated Waiver-ID-Number is for Pharmacy waiver coverage this month. Includes waivers under 1115 demonstration authority which are primarily intended to increase coverage or expand eligibility for pharmacy benefits.
7	The associated Waiver-ID-Number is for another type of waiver.
8	Not applicable, individual is eligible for Medicaid, but is NOT enrolled in a waiver this month.
9	The associated Waiver-ID-Number is for an unknown type of waiver.
A	The associated Waiver-ID-Number is for a disaster-related waiver that allows for coverage related to a hurricane or other disaster this month.
F	The associated Waiver-ID-Number is for a Family Planning-ONLY waiver this month. In these waivers, the beneficiary's Medicaid-covered benefits are restricted to Family Planning Services.

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ELIGIBLE FILE

Data Element Names: WAIVER-TYPE-1 (cont.)
WAIVER-TYPE-2
WAIVER-TYPE-3

Error Condition	Resulting Error Code
1. Value is 9-filled	301
2. Value is not valid	203
3. Relational Field in Error	999
4. Value is <> 0 AND DAYS-OF-ELIGIBILITY= +00 AND SCHIP-CODE <>"3"	502
5. Value = 0 AND DAYS-OF-ELIGIBILITY <> +00	502

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ELIGIBLE FILE

Data Element Name: ZIP-CODE

Definition: Root Field - Zip code of eligible's place of residence.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(5)	5.0%	21365

Coding Requirements:

Value must be a valid U. S. Postal Service ZIP Code for the State.

Value = 99999 if ZIP code is unknown.

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 9-filled	812
2. Value is 99999	301
3. Value is not a valid ZIP Code for the State specified by STATE-ABBREVIATION in the Header Record	507
4. Relational Field in Error	999
5. Value is not a valid ZIP-CODE for COUNTY-CODE specified	531

6. MSIS CLAIM FILES

MSIS utilizes four claims files: Inpatient Claims (CLAIMIP), Long Term Care Claims (CLAIMLT), Other Claims (CLAIMOT), and Prescription Drug Claims (CLAIMRX). Each Claim file tape submitted to CMS:

- must begin with the Standard Header Record (See Section 4.3);
- must contain one record for every claim of the appropriate type paid, or encounters processed, during the reporting quarter; and
- must conform to one of the four standard claims file record formats and data element lists, although many data elements are common to all four claims files.

Claim files must include:

- one record for each line item that is separately adjudicated;
- all fully adjudicated current quarter claims that have completed the State's processing cycle, for which the State has determined that it has liability to reimburse the provider;
- all adjustments to prior quarter claims adjudicated in the reporting quarter;
- adjudicated claims which passed all the States' eligibility and coverage edits, but which resulted in a zero liability because of payments by responsible third parties;
- claim records representing capitated payments or fees paid to capitated plans;
- encounter claims (TYPE-OF-CLAIM=3), to the extent that they are routinely received by the State;
- Medicare/Medicaid Crossover claims, which are identified by the presence of valid values in the MEDICARE-DEDUCTIBLE-PAYMENT and MEDICARE-COINSURANCE-PAYMENT fields.

Do not include any claim that does not relate to covered Medicaid services (e.g., claims for services to non-Medicaid SCHIP individuals) , or that has been returned to the provider because of insufficient information.

All claims records are edited by MSIS's validation program for completeness and validity. Edits are applied to adjustment claim records, and count against each field's error tolerance, except where noted in the error condition specifications for each field.

6.1 Unique Personal Identifiers

Claims file records are associated with eligibles by means of the MSIS Personal Identification Number (MSIS-ID)(or SSN, for SSN States), discussed in section 5.1. The four claims files utilize the same MSIS-ID or MSIS-IDENTIFICATION-NUMBER (or SSN, for SSN States) as the ELIGIBLE File.

6.2 Claims File Record Types

Claims files contain several types of valid records: current fee-for-service claims (TYPE-OF-CLAIM=1) for medical services, capitated payments (TYPE-OF-CLAIM=2), and encounter claims (TYPE-OF-CLAIM=3). Encounter claims simulate claims that would have been generated for HMO/HIO, PHP and PCCM patients if they were billed on a fee-for-service basis. Additionally some States use “service-tracking” claims (TYPE-OF-CLAIM=4) for special purposes, such as tracking individual services covered in a lump sum billing. The claim type can always be distinguished by the value of the TYPE-OF-CLAIM field. Adjustment claims are identified and categorized by the ADJUSTMENT-INDICATOR field. TYPE-OF-CLAIM 5 is used to identify supplemental payment (above capitation fee or above negotiated rate) (e.g., FQHC additional reimbursement)

Note that the ADJUSTMENT-INDICATOR field identifies whether adjustment records involve negative or positive adjustments to prior claims values. Where the adjustment involves reduced payment or quantity amounts (e.g., voids or credits), the reduced fields must include negative values corresponding to the adjustment. For example, for a void of a prior claim with a MEDICAID-AMOUNT-PAID of 100, the subsequent void adjustment would include a MEDICAID-AMOUNT-PAID of -100. Negating amounts for these adjustments is required for all value and amount fields. The formats for fields where this can occur are all established as signed numeric formats.

6.3 Sorting Rules

The claims files must be sorted in standard EBCDIC (ascending) collating sequence, using MSIS-IDENTIFICATION-NUMBER as the sort key. Improperly sorted files will be returned.

6.4 Claims Files Contents

MSIS recognizes that Medicaid claims do not always contain the same information. These differences are accommodated through the use of four distinct claims files. The four claims files have similar logical structures. The differences among the four files lie in the kinds of services they report and in some of the detailed information required by each group of services.

All charges reported in MSIS claims files are recorded in whole dollars.

NOTE: Since claims are summarized based on date of payment, service category and other coding changes in effect as of the date of adjudication must be used even if the service date is for a prior year.

6.4.1 CLAIMIP File

CLAIMIP file records identify Title XIX claims for inpatient hospital services.

Note: For the purposes of the CLAIMIP file, any service that is billed as inpatient care is considered an acute care inpatient hospital service, and is included in the file. This file also includes records for services billed by Religious Non-Medical institutions. Inpatient psychiatric services provided in a separately administered psychiatric wing or psychiatric hospital are not considered acute and are not part of the CLAIMIP file. The latter are included in the Long Term Care Claims File (CLAIMLT).

6.4.2 CLAIMLT File

CLAIMLT file records identify Title XIX claims for long term care services received in an institution. The phrase "long term care" includes services received in:

- Nursing Facilities (NFs);
- Intermediate Care Facilities for the Mentally Retarded (ICF-MRs);
- Psychiatric Hospitals; and
- Independent (free-standing) psychiatric wings of acute care hospitals.

6.4.3 CLAIMOT File

CLAIMOT file records cover all Medicaid claims that are not included in either the CLAIMIP file, the CLAIMLT file, or the CLAIMRX file. CLAIMOT file records include:

- Provider claims for all non-institutional Medicaid services;
- Provider claims for all services received in hospitals, NFs, or ICF/MRs that are not billed as part of a long term care or inpatient claim, such as claims for physician visits, services of private duty nurses, encounters,. etc;

- Capitated payments; and

- Claims for medical and non-medical services received under an approved Title XIX waiver.

CLAIMOT records may contain bills for multiple units of service, for example, several physician visits related to the same illness. However, a single line item or claim record may refer to only one procedure code. Thus, lab and X-ray claims related to a sequence of office visits must be recorded as separate line items with each having its own CLAIMOT record.

6.4.4 CLAIMRX File

CLAIMRX file records identify Title XIX claims for prescription drugs (including durable medical equipment and supplies provided by a pharmacist under a prescription). Injectibles and other drugs dispensed as a bundled service are reported for the provider administering the service (e.g. physician-administered inoculations are reported on the CLAIMOT file as physician service).

6.5 CLAIMS Files - Physical and Logical Data Record Layouts

The tables in sections 6.5.1 - 6.5.4 summarize the fields in the four claims file records in the order in which they physically occur in their respective records. The record layouts list the field name, and provide COBOL picture summaries, error tolerances, and record position indicators for each field.

The COBOL PICTURE clauses obey ANSI standard rules. These rules are summarized in Section 3.3. The field start and end positions indicate the exact position of the field within the record.

The error tolerance for each field demarcates the maximum allowable percentage of records submitted that may have missing, unknown, or invalid code combinations. Error rates in excess of the error tolerance for **any** field will cause the entire file to be rejected. Moreover, a file will be rejected if, within the first 500 records of a claim file, the current quarter claims (TYPE-OF-CLAIM = 1) have a DATE-OF-PAYMENT that is not consistent with the reporting quarter. No detailed error messages will be produced if this condition occurs.

The tables in sections 6.5.5 - 6.5.8 summarize the fields in the four claims file records in the order in which fields are processed by the validation program.

6.5.1 CLAIMIP Physical Record Layout:

CLAIMIP RECORD SUMMARY

FIELD NAME	COBOL PICTURE	- POSITION - START	END	DEFAULT ERROR TOLERANCE
MSIS-IDENTIFICATION-NUMBER	X(20)	01	20	0.1%
ADJUSTMENT-INDICATOR	9(1)	21	21	2.0%
TYPE-OF-SERVICE	9(2)	22	23	0.1%
TYPE-OF-CLAIM	9(1)	24	24	2.0%
DATE-OF-PAYMENT-ADJUDICATION	9(8)	25	32	2.0%
MEDICAID-AMOUNT-PAID	S9(8)	33	40	0.1%
BEGINNING-DATE-OF-SERVICE	9(8)	41	48	2.0%
ENDING-DATE-OF-SERVICE	9(8)	49	56	2.0%
PROVIDER-ID-NUMBER-BILLING	X(12)	57	68	5.0%
AMOUNT-CHARGED	S9(8)	69	76	5.0%
OTHER-THIRD-PARTY-PAYMENT	S9(6)	77	82	2.0%
PROGRAM-TYPE	9(1)	83	83	2.0%
PLAN-ID-NUMBER	X(12)	84	95	2.0%
MEDICAID-COVERED-INPATIENT-DAYS	S9(5)	96	100	2.0%
MEDICARE-DEDUCTIBLE-PAYMENT	S9(5)	101	105	2.0%
MEDICARE-COINSURANCE-PAYMENT	S9(5)	106	110	2.0%
DIAGNOSIS-CODE-PRINCIPAL	X(6)	111	116	5.0%
DIAGNOSIS-CODE-2	X(6)	117	122	5.0%
DIAGNOSIS-CODE-3	X(6)	123	128	5.0%
DIAGNOSIS-CODE-4	X(6)	129	134	5.0%
DIAGNOSIS-CODE-5	X(6)	135	140	5.0%
DIAGNOSIS-CODE-6	X(6)	141	146	5.0%
DIAGNOSIS-CODE-7	X(6)	147	152	5.0%
DIAGNOSIS-CODE-8	X(6)	153	158	5.0%
DIAGNOSIS-CODE-9	X(6)	159	164	5.0%
PROC-CODE-PRINCIPAL	X(7)	165	171	5.0%
PROC-CODE-FLAG-PRINCIPAL	9(2)	172	173	5.0%
PROC-CODE-MOD-PRINCIPAL	X(2)	174	175	5.0%
PROC-CODE-2	X(7)	176	182	5.0%
PROC-CODE-FLAG-2	9(2)	183	184	5.0%
PROC-CODE-MOD-2	X(2)	185	186	5.0%
PROC-CODE-3	X(7)	187	193	5.0%
PROC-CODE-FLAG-3	9(2)	194	195	5.0%
PROC-CODE-MOD-3	X(2)	196	197	5.0%
PROC-CODE-4	X(7)	198	204	5.0%
PROC-CODE-FLAG-4	9(2)	205	206	5.0%
PROC-CODE-MOD-4	X(2)	207	208	5.0%
PROC-CODE-5	X(7)	209	215	5.0%
PROC-CODE-FLAG-5	9(2)	216	217	5.0%
PROC-CODE-MOD-5	X(2)	218	219	5.0%
PROC-CODE-6	X(7)	220	226	5.0%
PROC-CODE-FLAG-6	9(2)	227	228	5.0%
PROC-CODE-MOD-6	X(2)	229	230	5.0%
ADMISSION-DATE	9(8)	231	238	5.0%
PATIENT-STATUS	9(2)	239	240	5.0%
DIAGNOSIS-RELATED-GROUP(DRG)	9(4)	241	244	100.0%
DIAGNOSIS-RELATED-GROUP-INDICATOR	X(4)	245	248	100.0%

6.5.1 CLAIMIP Physical Record Layout (continued):

CLAIMIP RECORD SUMMARY - continued

FIELD NAME	COBOL PICTURE	- POSITION - START	END	DEFAULT ERROR TOLERANCE
PROC-DATE-PRINCIPAL	9(8)	249	256	5.0%
UB-REV-CODE-1	9(4)	257	260	5.0%
UB-REV-UNITS-1	S9(7)	261	267	5.0%
UB-REV-CHARGE-1	S9(8)	268	275	5.0%
UB-REV-CODE-2	9(4)	276	279	5.0%
UB-REV-UNITS-2	S9(7)	280	286	5.0%
UB-REV-CHARGE-2	S9(8)	287	294	5.0%
UB-REV-CODE-3	9(4)	295	298	5.0%
UB-REV-UNITS-3	S9(7)	299	305	5.0%
UB-REV-CHARGE-3	S9(8)	306	313	5.0%
UB-REV-CODE-4	9(4)	314	317	5.0%
UB-REV-UNITS-4	S9(7)	318	324	5.0%
UB-REV-CHARGE-4	S9(8)	325	332	5.0%
UB-REV-CODE-5	9(4)	333	336	5.0%
UB-REV-UNITS-5	S9(7)	337	343	5.0%
UB-REV-CHARGE-5	S9(8)	344	351	5.0%
UB-REV-CODE-6	9(4)	352	355	5.0%
UB-REV-UNITS-6	S9(7)	356	362	5.0%
UB-REV-CHARGE-6	S9(8)	363	370	5.0%
UB-REV-CODE-7	9(4)	371	374	5.0%
UB-REV-UNITS-7	S9(7)	375	381	5.0%
UB-REV-CHARGE-7	S9(8)	382	389	5.0%
UB-REV-CODE-8	9(4)	390	393	5.0%
UB-REV-UNITS-8	S9(7)	394	400	5.0%
UB-REV-CHARGE-8	S9(8)	401	408	5.0%
UB-REV-CODE-9	9(4)	409	412	5.0%
UB-REV-UNITS-9	S9(7)	413	419	5.0%
UB-REV-CHARGE-9	S9(8)	420	427	5.0%
UB-REV-CODE-10	9(4)	428	431	5.0%
UB-REV-UNITS-10	S9(7)	432	438	5.0%
UB-REV-CHARGE-10	S9(8)	439	446	5.0%
UB-REV-CODE-11	9(4)	447	450	5.0%
UB-REV-UNITS-11	S9(7)	451	457	5.0%
UB-REV-CHARGE-11	S9(8)	458	465	5.0%
UB-REV-CODE-12	9(4)	466	469	5.0%
UB-REV-UNITS-12	S9(7)	470	476	5.0%
UB-REV-CHARGE-12	S9(8)	477	484	5.0%
UB-REV-CODE-13	9(4)	485	488	5.0%
UB-REV-UNITS-13	S9(7)	489	495	5.0%
UB-REV-CHARGE-13	S9(8)	496	503	5.0%
UB-REV-CODE-14	9(4)	504	507	5.0%
UB-REV-UNITS-14	S9(7)	508	514	5.0%
UB-REV-CHARGE-14	S9(8)	515	522	5.0%
UB-REV-CODE-15	9(4)	523	526	5.0%
UB-REV-UNITS-15	S9(7)	527	533	5.0%
UB-REV-CHARGE-15	S9(8)	534	541	5.0%

6.5.1 CLAIMIP Physical Record Layout (continued):

CLAIMIP RECORD SUMMARY - continued

FIELD NAME	COBOL PICTURE	- POSITION - START	END	DEFAULT ERROR TOLERANCE
UB-REV-CODE-16	9(4)	542	545	5.0%
UB-REV-UNITS-16	S9(7)	546	552	5.0%
UB-REV-CHARGE-16	S9(8)	553	560	5.0%
UB-REV-CODE-17	9(4)	561	564	5.0%
UB-REV-UNITS-17	S9(7)	565	571	5.0%
UB-REV-CHARGE-17	S9(8)	572	579	5.0%
UB-REV-CODE-18	9(4)	580	583	5.0%
UB-REV-UNITS-18	S9(7)	584	590	5.0%
UB-REV-CHARGE-18	S9(8)	591	598	5.0%
UB-REV-CODE-19	9(4)	599	602	5.0%
UB-REV-UNITS-19	S9(7)	603	609	5.0%
UB-REV-CHARGE-19	S9(8)	610	617	5.0%
UB-REV-CODE-20	9(4)	618	621	5.0%
UB-REV-UNITS-20	S9(7)	622	628	5.0%
UB-REV-CHARGE-20	S9(8)	629	636	5.0%
UB-REV-CODE-21	9(4)	637	640	5.0%
UB-REV-UNITS-21	S9(7)	641	647	5.0%
UB-REV-CHARGE-21	S9(8)	648	655	5.0%
UB-REV-CODE-22	9(4)	656	659	5.0%
UB-REV-UNITS-22	S9(7)	660	666	5.0%
UB-REV-CHARGE-22	S9(8)	667	674	5.0%
UB-REV-CODE-23	9(4)	675	678	5.0%
UB-REV-UNITS-23	S9(7)	679	685	5.0%
UB-REV-CHARGE-23	S9(8)	686	693	5.0%
FILLER	X(32)	694	725	

6.5.2 CLAIMLT Physical Record Layout:

CLAIMLT RECORD SUMMARY

FIELD NAME	COBOL PICTURE	- POSITION - START	END	DEFAULT ERROR TOLERANCE
MSIS-IDENTIFICATION-NUMBER	X(20)	01	20	0.1%
ADJUSTMENT-INDICATOR	9(1)	21	21	2.0%
TYPE-OF-SERVICE	9(2)	22	23	0.1%
TYPE-OF-CLAIM	9(1)	24	24	2.0%
DATE-OF-PAYMENT-ADJUDICATION	9(8)	25	32	2.0%
MEDICAID-AMOUNT-PAID	S9(8)	33	40	0.1%
BEGINNING-DATE-OF-SERVICE	9(8)	41	48	2.0%
ENDING-DATE-OF-SERVICE	9(8)	49	56	2.0%
PROVIDER-ID-NUMBER-BILLING	X(12)	57	68	5.0%
AMOUNT-CHARGED	S9(8)	69	76	5.0%
OTHER-THIRD-PARTY-PAYMENT	S9(6)	77	82	2.0%
PROGRAM-TYPE	9(1)	83	83	2.0%
PLAN-ID-NUMBER	X(12)	84	95	2.0%
MEDICAID-COVERED-INPATIENT-DAYS	S9(5)	96	100	2.0%
MEDICARE-DEDUCTIBLE-PAYMENT	S9(5)	101	105	2.0%
MEDICARE-COINSURANCE-PAYMENT	S9(5)	106	110	2.0%
DIAGNOSIS-CODE-1	X(6)	111	116	5.0%
DIAGNOSIS-CODE-2	X(6)	117	122	5.0%
DIAGNOSIS-CODE-3	X(6)	123	128	5.0%
DIAGNOSIS-CODE-4	X(6)	129	134	5.0%
DIAGNOSIS-CODE-5	X(6)	135	140	5.0%
ADMISSION-DATE	9(8)	141	148	5.0%
PATIENT-STATUS	9(2)	149	150	5.0%
ICF-MR-DAYS	S9(5)	151	155	2.0%
LEAVE-DAYS	S9(5)	156	160	5.0%
NURSING-FACILITY-DAYS	S9(5)	161	165	2.0%
PATIENT-LIABILITY	S9(6)	166	171	2.0%
FILLER	X(29)	172	200	

6.5.3 CLAIMOT Physical Record Layout

CLAIMOT RECORD SUMMARY

FIELD NAME	COBOL PICTURE	- POSITION - START	END	DEFAULT ERROR TOLERANCE
MSIS-IDENTIFICATION-NUMBER	X(20)	1	20	0.1%
ADJUSTMENT-INDICATOR	9(1)	21	21	2.0%
TYPE-OF-SERVICE	9(2)	22	23	0.1%
TYPE-OF-CLAIM	9(1)	24	24	2.0%
DATE-OF-PAYMENT-ADJUDICATION	9(8)	25	32	2.0%
MEDICAID-AMOUNT-PAID	S9(8)	33	40	0.1%
BEGINNING-DATE-OF-SERVICE	9(8)	41	48	2.0%
ENDING-DATE-OF-SERVICE	9(8)	49	56	2.0%
PROVIDER-ID-NUMBER-BILLING	X(12)	57	68	5.0%
AMOUNT-CHARGED	S9(8)	69	76	5.0%
OTHER-THIRD-PARTY-PAYMENT	S9(6)	77	82	2.0%
PROGRAM-TYPE	9(1)	83	83	2.0%
PLAN-ID-NUMBER	X(12)	84	95	2.0%
QUANTITY-OF-SERVICE	S9(5)	96	100	2.0%
MEDICARE-DEDUCTIBLE-PAYMENT	S9(5)	101	105	2.0%
MEDICARE-COINSURANCE-PAYMENT	S9(5)	106	110	2.0%
DIAGNOSIS-CODE-1	X(6)	111	116	5.0%
DIAGNOSIS-CODE-2	X(6)	117	122	5.0%
PLACE-OF-SERVICE	9(2)	123	124	5.0%
SPECIALTY-CODE	X(4)	125	128	100.0%
SERVICE-CODE	X(7)	129	135	5.0%
SERVICE-CODE-FLAG	9(2)	136	137	5.0%
SERVICE-CODE-MOD	X(2)	138	139	5.0%
UB-92-REVENUE-CODE	9(4)	140	143	100.0%
PROVIDER-ID-NUMBER-SERVICING	X(12)	144	155	5.0%
FILLER	X(20)	156	175	

6.5.4 CLAIMRX Physical Record Layout

CLAIMRX RECORD SUMMARY

FIELD NAME	COBOL PICTURE	- POSITION - START	END	DEFAULT ERROR TOLERANCE
MSIS-IDENTIFICATION-NUMBER	X(20)	01	20	0.1%
ADJUSTMENT-INDICATOR	9(1)	21	21	2.0%
TYPE-OF-SERVICE	9(2)	22	23	0.1%
TYPE-OF-CLAIM	9(1)	24	24	2.0%
DATE-OF-PAYMENT-ADJUDICATION	9(8)	25	32	2.0%
MEDICAID-AMOUNT-PAID	S9(8)	33	40	0.1%
DATE-PRESCRIBED	9(8)	41	48	2.0%
FILLER	9(8)	49	56	
PROVIDER-ID-NUMBER-BILLING	X(12)	57	68	5.0%
AMOUNT-CHARGED	S9(8)	69	76	5.0%
OTHER-THIRD-PARTY-PAYMENT	S9(6)	77	82	2.0%
PROGRAM-TYPE	9(1)	83	83	2.0%
PLAN-ID-NUMBER	X(12)	84	95	2.0%
QUANTITY-OF-SERVICE	S9(5)	96	100	2.0%
DAYS-SUPPLY	9(3)	101	103	5.0%
NATIONAL-DRUG-CODE	X(12)	104	115	5.0%
PRESCRIPTION-FILL-DATE	9(8)	116	123	2.0%
NEW-REFILL-INDICATOR	9(2)	124	125	2.0%
PRESCRIBING-PHYSICIAN-ID-NUMBER	X(12)	126	137	5.0%
FILLER	X(38)	138	175	

6.5.5 CLAIMIP Logical Record Layout:

MSIS-ID-NUMBER
TYPE-OF-CLAIM
ADJUSTMENT-INDICATOR
TYPE-OF-SERVICE
PROGRAM-TYPE
BEGINNING-DATE-OF-SERVICE
ENDING-DATE-OF-SERVICE
ADMISSION-DATE
DIAGNOSIS-CODE-PRINCIPAL
DIAGNOSIS-CODE-2
DIAGNOSIS-CODE-3
DIAGNOSIS-CODE-4
DIAGNOSIS-CODE-5
DIAGNOSIS-CODE-6
DIAGNOSIS-CODE-7
DIAGNOSIS-CODE-8
DIAGNOSIS-CODE-9
MEDICAID-COVERED-INPATIENT-DAYS
PROC-CODE-FLAG-PRINCIPAL
PROC-CODE-PRINCIPAL
PROC-CODE-MOD-PRINCIPAL
PROC-DATE-PRINCIPAL
PROC-CODE-FLAG-2
PROC-CODE-2
PROC-CODE-MOD-2
PROC-CODE-FLAG-3
PROC-CODE-3
PROC-CODE-MOD-3
PROC-CODE-FLAG-4
PROC-CODE-4
PROC-CODE-MOD-4
PROC-CODE-FLAG-5
PROC-CODE-5
PROC-CODE-MOD-5
PROC-CODE-FLAG-6
PROC-CODE-6
PROC-CODE-MOD-6
PATIENT-STATUS
AMOUNT-CHARGED
UB-REV-CODE-1
UB-REV-UNITS-1
UB-REV-CHARGE-1
UB-REV-CODE-2
UB-REV-UNITS-2
UB-REV-CHARGE-2
Occurrences 3 through 22
UB-REV-CODE-23
UB-REV-UNITS-23
UB-REV-CHARGE-23
MEDICARE-DEDUCTIBLE-PAYMENT
MEDICARE-COINSURANCE-PAYMENT
OTHER-THIRD-PARTY-PAYMENT
MEDICAID-AMOUNT-PAID
DATE-OF-PAYMENT-ADJUDICATION
PROVIDER-ID-NUMBER-BILLING
PLAN-ID-NUMBER
DIAGNOSIS-RELATED-GROUP-INDICATOR
DIAGNOSIS-RELATED-GROUP(DRG)

(Continue top of next column)

6.5.6 CLAIMLT Logical Record Layout:

MSIS-ID-NUMBER
TYPE-OF-CLAIM
ADJUSTMENT-INDICATOR
TYPE-OF-SERVICE
PROGRAM-TYPE
BEGINNING-DATE-OF-SERVICE
ENDING-DATE-OF-SERVICE
ADMISSION-DATE
DIAGNOSIS-CODE-1
DIAGNOSIS-CODE-2
DIAGNOSIS-CODE-3
DIAGNOSIS-CODE-4
DIAGNOSIS-CODE-5
PATIENT-STATUS
NURSING-FACILITY-DAYS
ICF-MR-DAYS
LEAVE-DAYS
MEDICAID-COVERED-INPATIENT-DAYS
AMOUNT-CHARGED
MEDICARE-DEDUCTIBLE-PAYMENT
MEDICARE-COINSURANCE-PAYMENT
OTHER-THIRD-PARTY-PAYMENT
MEDICAID-AMOUNT-PAID
PATIENT-LIABILITY
DATE-OF-PAYMENT-ADJUDICATION
PROVIDER-ID-NUMBER-BILLING
PLAN-ID-NUMBER

6.5.7 CLAIMOT Logical Record Layout:

MSIS-ID-NUMBER
TYPE-OF-CLAIM
ADJUSTMENT-INDICATOR
TYPE-OF-SERVICE
PROGRAM-TYPE
SPECIALITY-CODE
PLACE-OF-SERVICE
BEGINNING-DATE-OF-SERVICE
ENDING-DATE-OF-SERVICE
DIAGNOSIS-CODE-1
DIAGNOSIS-CODE-2
SERVICE-CODE-FLAG
SERVICE-CODE
SERVICE-CODE-MOD
UB92-REVENUE-CODE
QUANTITY-OF-SERVICE
AMOUNT-CHARGED
MEDICARE-DEDUCTIBLE-PAYMENT
MEDICARE-COINSURANCE-PAYMENT
OTHER-THIRD-PARTY-PAYMENT
MEDICAID-AMOUNT-PAID
DATE-OF-PAYMENT-ADJUDICATION
PROVIDER-ID-NUMBER-BILLING
PROVIDER-ID-NUMBER-SERVICING
PLAN-ID-NUMBER

6.5.8 CLAIMRX Logical Record Layout:

MSIS-ID-NUMBER
TYPE-OF-CLAIM
ADJUSTMENT-INDICATOR
TYPE-OF-SERVICE
PROGRAM-TYPE
DATE-PRESCRIBED
QUANTITY-OF-SERVICE
DAYS-SUPPLY
AMOUNT-CHARGED
OTHER-THIRD-PARTY-PAYMENT
MEDICAID-AMOUNT-PAID
DATE-OF-PAYMENT-ADJUDICATION
PROVIDER-ID-NUMBER-BILLING
PRESCRIBING-PHYSICIAN-ID-NUMBER
PLAN-ID-NUMBER
NATIONAL-DRUG-CODE(NDC)
PRESCRIPTION-FILL-DATE
NEW-REFILL-INDICATOR

6.6 Claims Files - Data Field/Element Specifications

The following Data Dictionary describes in detail the specifications for each data element (field) in the MSIS Claim tape records (excluding the Standard Header Record). Data elements are listed in alphabetical order to facilitate locating information about a specific field. Each data element is explained, including the content specifications and edit criteria applied to the data element by the MSIS Validation process. The edit criteria are presented in the order in which edit checks occur. Examples are also provided which illustrate properly entered data elements.

CLAIMS FILES

Data Element Name: ADJUSTMENT-INDICATOR

Definition: CLAIMIP, CLAIMLT, CLAIMOT, CLAIMRX- Code indicating type of adjustment record claim/encounter represents.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(1)	2.0%	2

Coding Requirements:

Valid Values	Code Definition
0	Original Claim/Encounter
1	Void of a prior submission
2	Re-submittal
3	Credit Adjustment (negative supplemental)
4	Debit Adjustment (positive supplemental)
5	Gross Adjustment. Adjustment represents adjustment at an aggregate level (e.g., provider level adjustment rather than an adjustment at the claim/encounter level).
9	Unknown

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 9	812
2. Value = 9	301
3. Value is not included in the list of valid codes - Reset to 9	201
4. Relational Field in Error	999
5. Value = 5 AND TYPE-OF-CLAIM <>4 - Reset to 9	509
6. Value <> 5 AND TYPE-OF-CLAIM = 4 - Reset to 9	509
7. Value = 5 AND first byte of MSIS-IDENTIFICATION-NUMBER <> “&” - Reset to 9	522
8. Value <> 5 AND first byte of MSIS-IDENTIFICATION-NUMBER = “&”- Reset to 9	522

CLAIMS FILES

Data Element Name: ADMISSION-DATE

Definition: CLAIMIP, CLAIMLT - The date on which the recipient was admitted to a hospital or long term care facility.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(8)	5.0%	19980531

Coding Requirements:

Value must be a valid date in CCYYMMDD format.

If admission date is not known, fill with 99999999

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 0	810

THE FOLLOWING EDITS WILL NOT COUNT AGAINST THE ERROR TOLERANCE FOR ADJUSTMENT RECORDS (ADJUSTMENT INDICATOR=1, 2, 3, 4, OR 5)

2. Value = 99999999	301
3. Value is not a valid date	102
4. Value CC <19 OR >20. Value is not a valid date. Reset to 000000.	102
5. Relational Field in Error	999
6. Value > BEGINNING-DATE-OF-SERVICE	511

CLAIMS FILES

Data Element Name: AMOUNT-CHARGED

Definition: CLAIMIP, CLAIMLT, CLAIMOT, CLAIMRX - The total charge for this claim as submitted by the provider.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
S9(8)	5.0%	+00000950

Coding Requirements:

If the amount is missing or invalid, fill with +99999999.

If TYPE-OF-CLAIM = 3 (encounter record) this field should either be "00000000" filled or contain the amount paid by the plan to the provider. If TYPE-OF-SERVICE =20, 21, OR 22, this field should be "00000000" filled.

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 0	810
2. Value = +99999999 - Reset to 0	301
3. Relational Field in Error	999
4. Value = +00000000 AND (TYPE-OF-SERVICE <> {20, 21, 22} AND TYPE OF CLAIM<>3 AND ADJUSTMENT INDICATOR<>0)	.304
5. Value <> +00000000 AND TYPE-OF-CLAIM = {4 Gross Adjustment}	509
6. Value < +00000000 AND ADJUSTMENT-INDICATOR = {0, 2, 4}	607
7. Value > +00000000 AND ADJUSTMENT-INDICATOR = {1,3}	607

CLAIMS FILES

Data Element Name: BEGINNING-DATE-OF-SERVICE

Definition: CLAIMIP, CLAIMLT, CLAIMOT - For services received during a single encounter with a provider, the date the service covered by this claim was received. For services involving multiple encounters on different days, or periods of care extending over two or more days, the date on which the service covered by this claim began. For capitation premium payments, the date on which the period of coverage related to this payment began.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(8)	2.0%	19980531

Coding Requirements:

Value must be a valid date in CCYYMMDD format.

If date is not known, fill with 99999999

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 0	810
2. Value = 99999999 - Reset to 0	301
3. Value is not a valid date - Reset to 0	102
4. Relational Field in Error	999
5. Value > END-OF-TIME-PERIOD in the Header Record AND TYPE-OF-SERVICE <> {20, 21, 22}	605
6. Value > ENDING-DATE-OF-SERVICE	517

Data Element Name: DATE-OF-PAYMENT-ADJUDICATION

Definition: CLAIMIP, CLAIMLT, CLAIMOT, CLAIMRX - The date on which the payment status of the claim was finally adjudicated by the State.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(8)	2.0%	19980531

Coding Requirements:

Value must be a valid date in CCYYMMDD format.

If date is not known, fill with 99999999

For Encounter Records (TYPE-OF-CLAIM=3); use date the encounter was processed.

For Adjustment Records (ADJUSTMENT-INDICATOR<> 0), use date of final adjudication when possible.

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 0	810
2. Value = 99999999 - Reset to 0	301
3. Value is not a valid date - Reset to 0	102
4. Relational Field in Error	999
5. Value < START-OF-TIME-PERIOD in the Header Record	514
6. Value > END-OF-TIME-PERIOD in the Header Record	506

Data Element Name: DATE-PRESCRIBED

Definition: CLAIMRX - Date the drug, device or supply was prescribed by the physician or other practitioner. This should not be confused with the DATE-FILLED which represents the date the prescription was actually filled by the provider.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(8)	2.0%	19980531

Coding Requirements:

Value must be a valid date in CCYYMMDD format.

If date is not known, fill with 99999999

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 0	810
2. Value = 99999999 - Reset to 0	301
3. Value is not a valid date - Reset to 0	102
4. Relational Field in Error	999
5. Value > PRESCRIPTION-FILL-DATE	535

Data Element Name: DAYS-SUPPLY

Definition: CLAIMRX - Number of days supply dispensed.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(3)	5.0%	31

Coding Requirements:

Values should be 1-365.

If Value is unknown, 9-fill.

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 0	810

THE FOLLOWING EDITS WILL NOT COUNT AGAINST THE ERROR TOLERANCE FOR ADJUSTMENT RECORDS (ADJUSTMENT INDICATOR=1, 2, 3, 4, OR 5)

2. Value = 999 - Reset to 0	301
3. Value = 0 or Value > 365	203
4. Value < 0 AND ADJUSTMENT-INDICATOR = {0, 2, 4}	607

CLAIMS FILES

Data Element Name: DIAGNOSIS-CODE-PRINCIPAL

Definition: CLAIMIP - The ICD-9-CM code for the principal diagnosis for this claim. Principal diagnosis is the condition established after study to be chiefly responsible for the admission. Even though another diagnosis may be more severe than the principal diagnosis, the principal diagnosis, as defined above, is entered.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(6)	5.0%	21050

Coding Requirements:

Code full valid ICD-9-CM codes, without a decimal point. For example: 210.5 is coded as "2105 ". Include all five digits where applicable.

Enter invalid codes exactly as they appear in the State system. Do not "8" or "9-fill".

"Probable", "suspected", "likely", "questionable", "possible", or "still to be ruled out" diagnoses are acceptable.

Note: Sixth character reserved for implementation of ICD-10-CM codes.

Error Condition — Resulting Error Code

THE FOLLOWING EDITS WILL NOT COUNT AGAINST THE ERROR TOLERANCE FOR ADJUSTMENT RECORDS (ADJUSTMENT INDICATOR=1, 2, 3, 4, OR 5)

1. Relational Field in Error 999
2. First character of Value is not {"0" through "9", or alpha character} 101
3. Second or third character of Value is not {"0" through "9"} 101
4. Fourth or fifth character of Value is not {" " or "0" through "9"} 101
5. Fourth character of Value = " " AND fifth character of Value <> " " 101
6. Sixth character of Value <> " " 101
7. Value = "999999" 301
8. Value= " " 303
9. Value ="888888" 305

CLAIMS FILES

Data Element Name: DIAGNOSIS-CODE-1 through DIAGNOSIS-CODE-9

Definition: DIAGNOSIS-CODE-1: CLAIMLT, CLAIMOT - The ICD-9-CM code for the first diagnosis for this claim (For CLAIMIP, DIAGNOSIS-CODE-PRINCIPAL is used in place of DIAGNOSIS-CODE-1).

DIAGNOSIS-CODE-2: CLAIMIP, CLAIMLT, CLAIMOT - Second ICD-9-CM code found on the claim.

DIAGNOSIS-CODE-3 through DIAGNOSIS-CODE-5 : CLAIMIP, CLAIMLT - The third through fifth ICD-9-CM codes that appear on the claim.

DIAGNOSIS-CODE-6 through DIAGNOSIS-CODE-9 : CLAIMIP- The sixth through ninth ICD-9CM codes that appear on the claim.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(6)	5.0%	21050

Coding Requirements:

Code valid ICD-9-CM codes (up to nine occurrences, depending on file type) without a decimal point. For example: 210.5 is coded as "2105 ".

If more than nine diagnosis codes appear on the claim, enter the codes for the first nine that appear. If less than nine diagnosis codes are used, blank fill the unused fields.

Enter invalid codes exactly as they appear in the State system. Do not “8" or "9-fill".

CLAIMIP: “Probable”, “suspected”, “likely”, “questionable”, “possible”, or “still to be ruled out” diagnoses are acceptable.

CLAIMOT: Code Specific ICD-9-CM code. There are many types of claims that aren’t expected to have diagnosis codes, such as transportation, DME, lab, etc. Do not add vague and unspecified diagnosis codes to those claims. The error tolerence for this field will be adjusted on a State-specific basis to accommodate the absence of diagnosis codes.

CLAIMLT: Provide diagnosis coding as submitted on bill.

Note: Sixth character reserved for implementation of ICD-10-CM codes.

Error Condition Resulting Error Code

THE FOLLOWING EDITS WILL NOT COUNT AGAINST THE ERROR TOLERANCE FOR ADJUSTMENT RECORDS (ADJUSTMENT INDICATOR=1, 2, 3, 4, OR 5)

1. Value = “999999".....301
2. Value= “888888".....305
3. Value <> “blank” AND first character of Value is not {"0" through "9", or alpha character}.....101
4. Value <> “blank” AND second or third character of Value is not {"0" through "9"}.....101

Data Element Name: DIAGNOSIS-CODE-1 through DIAGNOSIS-CODE-9 (continued)

Error Condition	Resulting Error Code
5. Value <> “blank” AND fourth or fifth character of Value is not " " or "0" through "9"}	101
6. Value <> “blank” AND fourth character of Value = " " AND fifth character of Value <> " "	101
7. Value <> “blank” AND sixth character of Value <> “ ”	101
8. Relational Field in Error.	999
9. Value Diagosis-Code 1= “blank”.	303
10. Value <> “blank” AND preceding DIAGNOSIS-CODE value(s) = “blank”.	542
11. Value appears in preceding field	542

Data Element Name: DIAGNOSIS-RELATED-GROUP (DRG)

Definition: CLAIMIP - Code representing the Diagnosis Related Group that is applicable for the inpatient services being rendered.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(4)	100%	370

Coding Requirements:

Enter DRG used by the State.

If DRGs are not used, 8-fill the field.

If Value is unknown, 9-fill the field.

Error Condition	Resulting Error Code
1. Value Not-Numeric - Reset to 0	810

THE FOLLOWING EDITS WILL NOT COUNT AGAINST THE ERROR TOLERANCE FOR ADJUSTMENT RECORDS (ADJUSTMENT INDICATOR=1, 2, 3, 4, OR 5)

2. Value = 8888 AND DIAGNOSIS-RELATED-GROUP-INDICATOR <> “8888"	540
3. Value = 9999 AND DIAGNOSIS-RELATED-GROUP-INDICATOR <> “9999"	540
4. Value <> 8888 AND Value DIAGNOSIS-RELATED-GROUP-INDICATOR = “8888"	306
5. Value <> 9999 AND DIAGNOSIS-RELATED-GROUP-INDICATOR = “9999"	540

Data Element Name: DIAGNOSIS-RELATED-GROUP-INDICATOR

Definition: CLAIMIP - An indicator identifying the grouping algorithm used to assign DIAGNOSIS-RELATED-GROUP (DRG) values.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(4)	100%	HG15

Coding Requirements:

Values are generated by combining two types of information:

Position 1-2, State/Group generating DRG:
If state specific system, fill with two digit US postal code representation for state.
If CMS Grouper, fill with “HG”.
If any other system, fill with “XX”.

Position 3-4, fill with the number that represents the DRG version used (01-98). For example, “HG15" would represent CMS Grouper version 15. If version is unknown, fill with “99".

If no DRG system is used, fill the field with “8888".

If Value is unknown, fill the field with “9999".

Error Condition — Resulting Error Code

THE FOLLOWING EDITS WILL NOT COUNT AGAINST THE ERROR TOLERANCE FOR ADJUSTMENT RECORDS (ADJUSTMENT INDICATOR=1, 2, 3, 4, OR 5)

1. Value = “9999".....301

2. First and second characters of Value <> {“A” - “Z”} AND Value is NOT 8-Filled.....101

3. Third and fourth characters of Value <> {“01" - “98"} AND first and second.....101
Value = {“HG”} AND Value is NOT 8-Filled

Data Element Name: ENDING-DATE-OF-SERVICE

Definition: CLAIMIP, CLAIMLT, CLAIMOT - For services received during a single encounter with a provider, the date the service covered by this claim was received. For services involving multiple encounters on different days, or periods of care extending over two or more days, the date on which the service covered by this claim ended. For capitation premium payments, the date on which the period of coverage related to this payment ends/ended.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(8)	2.0%	19980531

Coding Requirements:

Value must be a valid date in CCYYMMDD format.

If date is not known, fill with 99999999

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to all 0's	810
2. Value = 99999999 - Reset to all 0's	301
3. Value is not a valid date - Reset to all 0's	102
4. Relational Field in Error	999
5. Value > END-OF-TIME-PERIOD in the Header Record AND TYPE-OF-SERVICE <> {20, 21, 22}	605
6. Value < BEGINNING-DATE-OF-SERVICE	511

Data Element Name: ICF-MR-DAYS

Definition: CLAIMLT - The number of days of intermediate care for the mentally retarded should be included in this claim that were paid for, in whole or in part, by Medicaid.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
S9(5)	2.0%	+14

Coding Requirements:

ICF-MR-DAYS include every day of intermediate care facility services for the mentally retarded that is at least partially paid for by the State, even if private or third party funds are used for some portion of the payment.

If value exceeds +99998 days, code as +99998. (e.g., code 100023 as +99998)

ICF-MR-DAYS is applicable only for TYPE-OF-SERVICE = 05.

For all claims for psychiatric services or nursing facility care services (TYPE-OF-SERVICE = 02, 04, or 07), fill with +88888.

If value is not known or invalid, fill with +99999.

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 0 OR Value = -88888	810
2. Value = +99999 - Reset to 0	301
3. Relational Field in Error	999
4. Value <> +88888 AND TYPE-OF-SERVICE = {02, 04, or 07}	306
5. Value = +88888 AND TYPE-OF-SERVICE = {05}	305
6. Value > +00000 AND NURSING-FACILITY-DAYS > +0	508
7. Value > (ENDING-DATE-OF-SERVICE - BEGINNING-DATE OF-SERVICE) + 1	603
8. Value < +00000 AND ADJUSTMENT-INDICATOR = {0, 2, 4}	607
9. Value > +00000 AND ADJUSTMENT-INDICATOR = {1,3}	607

Note: During CMS's "Valids File" processing, if value is 8-filled, reset to 0.

Data Element Name: LEAVE-DAYS

Definition: CLAIMLT - The number of days, during the period covered by Medicaid, on which the patient did not reside in the long term care facility.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
S9(5)	5.0%	+999

Coding Requirements:

If value exceeds +99998, code as +99998 (e.g., code 100023 as +99998).

LEAVE-DAYS is applicable only for TYPE-OF-SERVICE = 05 or 07.

When TYPE-OF-SERVICE = 02 or 04 fill with +88888.

If invalid fill with +99999.

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 0 OR Value = -88888	810
2. Value = +99999 - Reset to 0	301
3. Relational Field in Error	999
4. Value <> +88888 AND TYPE-OF-SERVICE = {02 or 04}	306
5. Value = +88888 AND TYPE-OF-SERVICE = {05 or 07}	305
6. Value > 0 AND > NURSING-FACILITY-DAYS AND TYPE-OF-SERVICE = 07	508
7. Value > 0 AND > ICF-MR-DAYS AND TYPE-OF-SERVICE = 05	608
8. Value < +00000 AND ADJUSTMENT-INDICATOR = {0, 2, 4}	607
9. Value > +00000 AND ADJUSTMENT-INDICATOR = {1,3}	607

Note: During CMS's "Valids File" processing, if value is 8-filled, reset to 0.

Data Element Name: MEDICAID-AMOUNT-PAID

Definition: CLAIMIP, CLAIMLT, CLAIMOT, CLAIMRX - The amount paid by Medicaid on this claim or adjustment.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
S9(8)	0.1%	+00000950

Coding Requirements:

If invalid or unknown, fill with +99999999.

TYPE-OF-CLAIM = 3 (encounter): If MEDICAID had no liability for the bill, 0-fill. Amount Paid should reflect the actual amount paid by Medicaid. It is not intended to reflect fee-for-service equivalents. If the claim contains the amount paid to a provider by a plan, please put that payment to the AMOUNT CHARGED field.

For claims where Medicaid payment is only available at the header level, report the entire payment amont on the MSIS record corresponding to the line item with the highest charge. Zero fill Medicaid Amount Paid on all other MSIS records created from the original claim.

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 0	810
2. Value = +99999999 - Reset to 0	301
3. Relational Field in Error	999
4. Value < +00000000 AND ADJUSTMENT-INDICATOR = {0, 2 or 4}	607
5. Value > +00000000 AND ADJUSTMENT-INDICATOR = {1,3}	607

Data Element Name: MEDICAID-COVERED-INPATIENT-DAYS

Definition: CLAIMIP - The number of inpatient days covered by Medicaid on this claim. For states that combine delivery/birth services on a single claim, include covered days for both the mother and the neonate in this field.

CLAIMLT - The number of inpatient psychiatric days covered by Medicaid on this claim.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
S9(5)	2.0%	+30

Coding Requirements:

This field is applicable when:

- A CLAIMIP record includes at least one accommodation revenue code = (values 100-219) in UB-REV-CODE-(1-23) fields.
- A CLAIMLT record has TYPE-OF-SERVICE = 02 or 04 (inpatient mental health/psychiatric services).

When this field is not applicable, fill with +88888.

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 0 OR Value = -88888	810
2. Value = +99999 - Reset to 0	301
3. Relational Field in Error	999
4. Value <> +88888 AND TYPE-OF-SERVICE = {05 or 07}	306
5. Value =+88888 AND TYPE-OF-SERVICE = {02 or 04}	305
6. Value > (ENDING-DATE-OF-SERVICE - BEGINNING-DATE-OF-SERVICE + 1 (in days))X2	603
7. Value < +00000 AND ADJUSTMENT-INDICATOR = {0, 2, 4}	607
8. Value > +00000 AND ADJUSTMENT-INDICATOR = {1,3}	607

Note: During CMS's "Valids File" processing, if value is 8-filled, reset to 0.

Data Element Name: MEDICARE-COINSURANCE-PAYMENT

Definition: CLAIMIP, CLAIMLT, CLAIMOT - The amount paid by Medicaid, on this claim, toward the recipient's Medicare coinsurance.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
S9(5)	2.0%	+99998

Coding Requirements:

This field is relevant only for Crossover (Medicare is third party payee) claims. Crossover claims with coinsurance can only occur when TYPE-OF-SERVICE = (01, 02, 04, 07, 08, 10 through 12, 15, 19, 24 through 26, 30, 31, 33 through 39)

If claim is not a Crossover claim, fill with +88888.

If the Medicare coinsurance amount can be identified separately from Medicare deductible payments, code that amount in this field.

If Medicare coinsurance and deductible payments cannot be separated, fill this field with +99998 and code the combined payment amount in MEDICARE-DEDUCTIBLE-PAYMENT.

For Crossover claims with no coinsurance payment, fill with +00000.

For Crossover claims with missing or invalid coinsurance amounts, fill with +99999.

For TYPE-OF-CLAIM = 3 (encounter record) fill with +88888.

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 0 OR Value = -88888	810
2. Value = +99999 - Reset to 0	301
3. Relational Field in Error	999
4. Value <> +88888 AND (MEDICARE-DEDUCTIBLE-PAYMENT = +88888 OR TYPE-OF=SERVICE = 13 OR TYPE-OF-CLAIM = 3)	306
5. Value = +99998 AND MEDICARE-DEDUCTIBLE-AMOUNT = (+0, +999998)	515
6. Value > AMOUNT-CHARGED	606
7. Value < +00000 AND ADJUSTMENT-INDICATOR = {0, 2, 4}	607
8. Value > +00000 AND ADJUSTMENT-INDICATOR = {1,3}	607

Note: During CMS's "Valids File" processing, if value is 8-filled or Value = 99998, reset to 0.

Data Element Name: MEDICARE-DEDUCTIBLE-PAYMENT

Definition: CLAIMIP, CLAIMLT, CLAIMOT - The amount paid by Medicaid, on this claim, toward the recipient's Medicare deductible.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
S9(5)	2.0%	+00200

Coding Requirements:

This field is relevant only for Crossover (when Medicare is the third party payee) claims. Crossover claims with deductibles can only occur when TYPE-OF-SERVICE = {01, 02, 04, 08, 10 through 13, 15, 19, 24 through 26, 30, 31, 33 through 39).

If claim is not a Crossover claim, or if a type of claim 3 (encounter claim) fill with +88888.

If the Medicare deductible amount can be identified separately from Medicare coinsurance payments, code that amount in this field.

If the Medicare coinsurance and deductible payments cannot be separated, fill this field with the combined payment amount and code +99998 in MEDICARE-COINSURANCE-PAYMENT.

For Crossover claims with no Medicare deductible payment, fill this field with +00000.

For Crossover claims with missing or invalid deductible amounts, fill this field with +99999.

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to all 0's OR Value = -88888	810
2. Value = +99999 - Reset to all 0's	301
3. Relational Field in Error	999
4. Value <> +88888 AND VALUE<> +00000 AND TYPE-OF=SERVICE = {05 or 07}	306
5. Value > AMOUNT-CHARGED	510
6. Value < +00000 AND ADJUSTMENT -INDICATOR = {0, 2, or 4}	607
7. Value > +00000 AND ADJUSTMENT-INDICATOR = {1,3}	607

Note: During CMS's "Valids File" processing, if value is 8-filled, reset to 0.

CLAIMS FILES

Data Element Name: MSIS-IDENTIFICATION-NUMBER

Definition: CLAIMIP, CLAIMLT, CLAIMOT, CLAIMRX - A unique identification number used to identify a Medicaid Eligible to MSIS (see section 5.1).

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(20)	0.1%	123456789

Coding Requirements:

For SSN States, this field must contain the Eligible's Social Security Number. If the SSN is unknown and a temporary number is assigned, this field will contain that number.

For non-SSN States, this field must contain an identification number assigned by the State. The format of the State ID numbers must be supplied to CMS with the state's MSIS application.

For lump sum adjustments, this field must begin with an '&'.

Error Condition	Resulting Error Code
1. Value is "Space Filled"	303
2. Value = all 9's	301
3. Value = all 0's	304
4. Value is 8-filled	305
5. Duplicate Claim Record - 100% match of all fields AND TYPE-OF-SERVICE<>09,11,13, OR 25	803

CLAIMS FILES

Data Element Name: NATIONAL-DRUG-CODE

Definition: CLAIMRX - A code indicating the drug, device or medical supply covered by this claim, in National Drug Code (NDC) format.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(12)	5.0%	00039001460

Coding Requirements:

This field is applicable only for TYPE-OF-SERVICE = 16 or 19.

Drug code formats must be supplied by State in advance of submitting any file data. States must inform CMS of the NDC segments used and their size (e.g., {5,4,2} or {5,4} as defined in the National Drug Code Directory).

If the Drug Code is less than 12 characters in length, the value must be left justified and padded with spaces.

If Durable Medical Equipment or supply is prescribed by a physician and provided by a pharmacy then HCPCS or state specific codes can be put in the NDC field.

Error Condition	Resulting Error Code

THE FOLLOWING EDITS WILL NOT COUNT AGAINST THE ERROR TOLERANCE FOR ADJUSTMENT RECORDS (ADJUSTMENT INDICATOR=1, 2, 3, 4, OR 5)

1. Value = 9-filled 301

2. Value = 0-filled 304

3. Value is “Space Filled” 303

4. Value is invalid AND TYPE-OF-SERVICE=16 203
   Position 1-5 must be Numeric
   Position 6-9 must be Alpha Numeric,
   Position 10-11 must be Alpha Numeric or blank,
   Position 12 must be blank

Data Element Name: NEW-REFILL- INDICATOR

Definition: CLAIMRX - Indicator showing whether the prescription being filled was a new prescription or a refill. If it is a refill, the indicator will indicate the number of refills.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(2)	2.0%	3

Coding Requirements:

00	=	New Prescription
01-98	=	Number of Refill
99	=	Unknown

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 9- filled.	812
2. Value = 99 AND NATIONAL-DRUG-CODE <> “999999999999"	536

THE FOLLOWING EDITS WILL NOT COUNT AGAINST THE ERROR TOLERANCE FOR ADJUSTMENT RECORDS (ADJUSTMENT INDICATOR=1, 2, 3, 4, OR 5)

3. Value = 99	301

Data Element Name: NURSING-FACILITY-DAYS

Definition: CLAIMLT - The number of days of nursing care included in this claim that were paid for, in whole or in part, by Medicaid. Includes days during which nursing facility received partial payment for holding a bed during patient leave days.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
S9(5)	2.0%	+14

Coding Requirements:

NURSING-FACILITY-DAYS include every day of nursing care services that is at least partially paid for by the State, even if private or third party funds are used for some portion of the payment.

If value exceeds +99998 days, code as +99998.

NURSING-FACILITY-DAYS is applicable only for TYPE-OF-SERVICE = 07.

For all claims for psychiatric services or intermediate care services for mentally retarded (TYPE-OF-SERVICE = 02, 04, or 05), fill with +88888.

If value is not known or invalid, fill with +99999.

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 0 OR Value = -88888	810
2. Value =+99999 - Reset to 0	301
3. Relational Field in Error	999
4. Value <> +88888 AND TYPE-OF-SERVICE = {02, 04, or 05}	306
5. Value =+88888 AND TYPE-OF-SERVICE = {07}	305
6. Value > (ENDING-DATE-OF-SERVICE - BEGINNING-DATE-OF-SERVICE + 1)	603
7. Value < +00000 AND ADJUSTMENT-INDICATOR = {0, 2, 4}	607
8. Value > +00000 AND ADJUSTMENT-INDICATOR = {1,3}	607

Note: During CMS's "Valids File" processing, if value is 8-filled, reset to 0.

Data Element Name: OTHER-THIRD-PARTY-PAYMENT

Definition: CLAIMIP, CLAIMLT, CLAIMOT, CLAIMRX - The total amount paid by all sources other than Medicaid, Medicare, and the recipient's personal funds.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
S9(6)	2.0%	+200

Coding Requirements:

If amount is missing or invalid, fill with +999999.

If TYPE-OF-CLAIM = 3 (encounter record), enter the actual amount paid. If there was no paid amount, fill with +000000.

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 0	810
2. Value = +999999 - Reset to 0	301
3. Relational Field in Error	999
4. Value > (AMOUNT-CHARGED-MEDICARE -COINSURANCE-PAYMENT + MEDICARE-DEDUCTIBLE-PAYMENT)	704
5. Value < +000000 AND ADJUSTMENT-INDICATOR = {0, 2 or 4}	607
6. Value > +000000 AND ADJUSTMENT-INDICATOR = {1,3}	607

Data Element Name: PATIENT-LIABILITY

Definition: CLAIMLT - The total amount paid by the patient for services where they are required to use their personal funds to cover part of their care before Medicaid funds can be utilized.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
S9(6)	2.0%	+200

Coding Requirements:

If amount is missing or invalid, fill with +999999.

If TYPE-OF-CLAIM = 3 (encounter record) and no funds were used, fill with +000000.

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 0	810
2. Value = +999999 - Reset to 0	301
3. Relational Field in Error	999
4. Value > AMOUNT-CHARGED-MEDICAID MINUS (MEDICARE COINSURANCE-PAYMENT + MEDICARE-DEDUCTIBLE-PAYMENT)	704
5. Value < +000000 AND ADJUSTMENT-INDICATOR = {0, 2, 4}	607
6. Value > +000000 AND ADJUSTMENT-INDICATOR = {1,3}	607

CLAIMS FILE

Data Element Name: PATIENT-STATUS (previously DISCHARGE -STATUS)

Definition: CLAIMIP, CLAIMLT - A code indicating the Patients status as of the ENDING-DATE-OF-SERVICE. Values used are from UB-92.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(2)	5.0%	05

Coding Requirements:

Valid Values	Code Definition
01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to another short-term general hospital
03	Discharged/transferred to NF
04	Discharged/transferred to an ICF
05	Discharged/transferred to another type of institution (including distinct parts) or referred for outpatient services to another institution
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advise or discontinued care
08	Discharged/transferred to home under care of a home IV drug therapy provider
09*	Admitted as an inpatient to this hospital
20	Expired
30	Still a patient
40	Expired at home
41	Expired in a medical facility such as a hospital, NF or freestanding hospice
42	Expired - place unknown
43	Discharged/transferred to a Federal hospital (effective 10/1/03)
50	Discharged home with Hospice care
51	Discharged to a medical facility with Hospice care
61	Discharged to a hospital-based Medicare approved swing bed
62	Discharged/transferred to another rehab facility/rehab unit of a hospital
63	Discharged/transferred to a long term care hospital
65	Discharged/transferred to a psych hospital/psych unit of a hospital (effective 4/1/04)
66	**Discharged to Critical Access Hospital**
71	Discharged/transferred to another institution for outpatient services (deleted as of 10/1/03)
72	Discharged/transferred to this institution for outpatient services (deleted as of 10/1/03)
99	Unknown

* In situations where a patient is admitted before midnight of the third day following the day of an outpatient service, the outpatient services are considered inpatient. Therefore, code 09 would apply only to services that begin longer than 3 days earlier, such as observation following outpatient surgery, which results in admission.

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 9-filled	812

THE FOLLOWING EDITS WILL NOT COUNT AGAINST THE ERROR TOLERANCE FOR ADJUSTMENT RECORDS (ADJUSTMENT INDICATOR=1, 2, 3, 4, OR 5)

2. Value = 99	301
3. Value < 01 OR Value > 72	203
4, Value = {10-19, 21-29, 31-39, 44-49, 52-60, 64, 67-70, 73-98}	201

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CLAIMS FILES

Data Element Name: PLACE-OF-SERVICE

Definition: CLAIMOT - A code indicating where the service was performed. CMS 1500 values are used for this data element.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(2)	5.0%	11

Coding Requirements:

Code	Definition
00-02	Unassigned
03	School
04	Homeless Shelter
05	Indian Health Service Free Standing Facility
06	Indian Health Service Provider-based Facility
07	Tribal 638 Free-standing Facility
08	Tribal 638 Provider-based Facility
09-10	Unassigned
11	Office
12	Home
13	**Assisted Living Facility**
14	**Group Home**
15	Mobile Unit
16-19	Unassigned
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgery Center
25	Birthing Center
26	Military Treatment Facility
27-30	Unassigned
31	Skilled Nursing Facility, (obsolete)
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
35-40	Unassigned
41	Ambulance (Land)
42	Ambulance (Air or Water)
43-48	Unassigned
49	**Independent Clinic**
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility

Data Element Name: PLACE-OF-SERVICE (continued)

Code	Definition
56	Psychiatric Residential Treatment Center
57	**Non-Residential Substance Abuse Treatment Facility**
58-59	Unassigned
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
63-64	Unassigned
65	End Stage Renal Disease Treatment Facility
66-70	Unassigned
71	State or Local Public Health Clinic
72	Rural Health Clinic
73-80	Unassigned
81	Independent Laboratory
82-87	Unassigned
88	Not Applicable
89-98	Unassigned
99	Other Unlisted Facility

Note: Value = 99 will be counted as error.

If there are new valid CMS 1500 PLACE- OF- SERVICE codes that are not listed in this dictionary, these codes may be used and will not trigger an error.

If TYPE-OF-SERVICE = {20, 21, 22} (capitated payment) fill with 88.

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 9-filled	812

THE FOLLOWING EDITS WILL NOT COUNT AGAINST THE ERROR TOLERANCE FOR ADJUSTMENT RECORDS (ADJUSTMENT INDICATOR=1, 2, 3, 4, OR 5)

2.	Value = 99	301
3.	Value Not one of the listed valid codes (including unassigned Values = {00-02, 09-10, 16-19, 27-30, 35-40, **43-48, 58-59**, 63-64, 66-70, 73-80, 82-87, 89-98})	203
4.	Relational Field in Error	999
5.	Value = 88 AND TYPE-OF-SERVICE <> {20, 21, 22}	305
6.	Value <> 88 AND TYPE-OF-SERVICE = {20, 21, 22}	306

Data Element Name: PLAN-ID-NUMBER

Definition: CLAIMIP, CLAIMLT, CLAIMOT, CLAIMRX- A unique number which represents the health plan under which the non-fee-for-service encounter was provided.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(12)	2.0%	53289

Coding Requirements:

When available, use the National Provider Identification Number. Until such time as this number is implemented, use the number as it is carried in the State's system. If possible, this number should match the Provider ID number used on Premium Payments. (TYPE-OF-SERVICE=20, 21, 22)

If TYPE-OF-CLAIM <> 3 (Encounter Record) AND TYPE-OF-SERVICE <> {20, 21, 22}, 8-fill.

If Value is unknown, 9-fill.

Error Condition	Resulting Error Code
1. Value is "Space Filled"	303
2. Value = all 9's	301
3. Value = all 0's	304
4. Relational Field in Error	999
5. Value = all 8's AND TYPE-OF-CLAIM = 3	509
6. Value = all 8's AND TYPE OF SERVICE = {20, 21, 22}	521
7. TYPE-OF-SERVICE = {20,21,} AND Value <> PROVIDER-IDENTIFICATION-NUMBER- BILLING	529

CLAIMS FILES

Data Element Name: PRESCRIBING-PHYSICIAN-ID-NUMBER

Definition: CLAIMRX - A unique identification number assigned to a provider by the which identifies the physician or other provider prescribing the drug, device or supply. For physicians, this must be the individual's ID number, not a group identification number.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(12)	5.0%	01CA79300

Coding Requirements:

Valid formats must be supplied by the State in advance of submitting file data.

If Value is invalid, record it exactly as it appears in the State system. Do not 9-fill.

If Value is unknown, fill with "999999999999".

If the prescribing physician provider ID is not available, but the physician's Drug Enforcement Agency (DEA) ID is on the State file, then the State should use the DEA ID for this data element.

Error Condition — Resulting Error Code

THE FOLLOWING EDITS WILL NOT COUNT AGAINST THE ERROR TOLERANCE FOR ADJUSTMENT RECORDS (ADJUSTMENT INDICATOR=1, 2, 3, 4, OR 5)

1. Value = "999999999999"..... 301
2. Value is "Space Filled"..... 303
3. Relational Field in Error..... 999
4. Value = PROVIDER-IDENTIFICATION-BILLING..... 524

Data Element Name: PRESCRIPTION-FILL-DATE

Definition: CLAIMRX- Date the drug, device or supply was dispensed by the provider

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(8)	2.0%	19980531

Coding Requirements:

Value must be a valid date in CCYYMMDD format.

If date is not known, fill with 99999999

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 0	810
2. Value = 99999999 - Reset to 0	301
3. Value is not a valid date - Reset to 0	102
4. Relational Field in Error	999
5. Value > END-OF-TIME-PERIOD in the Header Record	506

CLAIMS FILES

Data Element Name: PROC-CODE-PRINCIPAL

Definition: CLAIMIP - A code used by the State to identify the principal procedure performed during the hospital stay referenced by this claim. A principal procedure is performed for definitive treatment rather than for diagnostic or exploratory purposes. It is closely related to either the principal diagnosis or to complications that arise during other treatments.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(7)	5.0%	123456

Coding Requirements:

If no principal procedure was performed, fill with "8888888".

Value must be a valid code. If PROC-CODE-FLAG-PRINCIPAL = {10 through 87} valid codes must be supplied by the State.

For national coding systems, code should conform to the nationally recognized formats:

CPT (PROC-CODE-FLAG-PRINCIPAL=01): Positions 1-5 should be numeric and position 6-7 must be blank.

ICD-9-CM (PROC-CODE-FLAG-PRINCIPAL=02): Positions 1-2 must be numeric, positions 3-4 must be numeric or blank, positions 5-7 must be blank.

HCPCS (PROC-CODE-FLAG-PRINCIPAL=06): Position 1 must be an alpha character (“A”-“Z”) and position 6-7 must be blank.. Value can include both National and Local (Regional) codes. For National codes (position 1=“A”-“V”) positions 2-5 must be numeric; for Local (Regional) codes, positions 2-5 must be alphanumeric (e.g., “X1234" or “WW234").

For other schemes which are not nationally recognized, states should supply CMS with lists of valid values and any formats which should apply.

If value is unknown, fill with "9999999".

Data Element Name: PROC-CODE-PRINCIPAL (continued)

Error Condition	Resulting Error Code
THE FOLLOWING EDITS WILL NOT COUNT AGAINST THE ERROR TOLERANCE FOR ADJUSTMENT RECORDS (ADJUSTMENT INDICATOR=1, 2, 3, 4, OR 5)	
1. Value = "9999999"	301
2. Value = “0000000"	304
3. Value is “Space Filled”	303
4. Relational Field In Error	999
5. Value <> "8888888" AND PROC-CODE-FLAG-PRINCIPAL = 88	306
6. Value = "8888888" AND PROC-CODE-FLAG-PRINCIPAL <> 88	305
7. Value is invalid as related to PROC-CODE-FLAG-PRINCIPAL=01 (CPT-4)	203
8. Value is invalid as related to PROC-CODE-FLAG-PRINCIPAL=02 (ICD-9)	203
9. Value is invalid as related to PROC-CODE-FLAG-PRINCIPAL=06 (HCPCS)	203

CLAIMS FILES

Data Element Name: PROC-CODE-2 through PROC-CODE-6

Definition: CLAIMIP - A series of up to five codes used by the State to identify the procedures performed in addition to the principal procedure during the hospital stay referenced by this claim.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(7)	5.0%	123456

Coding Requirements:

Enter as many procedures as are reported after the principal procedure up to five additional codes. Remaining fields should be 8-filled (e.g., if claim contains two additional procedures, they would be reported in PROC-CODE-2 and PROC-CODE-3. Remaining fields PROC-CODE-4 through PROC-CODE-6 would all be 8-filled.)

Value must be a valid code. If corresponding PROC-CODE-FLAG = {10 through 87} valid codes must be supplied by the State.

For national coding systems, code should conform to the nationally recognized formats:

CPT (corresponding PROC-CODE-FLAG = 01): Positions 1-5 should be numeric and position 6-7 must be blank.

ICD-9-CM (corresponding PROC-CODE-FLAG = 02): Positions 1-2 must be numeric, positions 3-4 must be numeric or blank, positions 5-7 must be blank.

HCPCS (corresponding PROC-CODE-FLAG = 06): Position 1 must be an alpha character (“A”-“Z”) and position 6-7 must be blank.. Value can include both National and Local (Regional) codes. For National codes (position 1=“A”-“V”) positions 2-5 must be numeric; for Local (Regional) codes, positions 2-5 must be alphanumeric (e.g., “X1234" or “WW234").

For other schemes which are not nationally recognized, states should supply CMS with lists of valid values and any formats which should apply.

If value is unknown, fill with “999999".

Data Element Name: PROC-CODE-2 through PROC-CODE-6 (continued)

Error Condition	Resulting Error Code
THE FOLLOWING EDITS WILL NOT COUNT AGAINST THE ERROR TOLERANCE FOR ADJUSTMENT RECORDS (ADJUSTMENT INDICATOR=1, 2, 3, 4, OR 5)	
1. Value is = "9999999"	301
2. Value = “0000000"	304
3. Value is “Space Filled”	303
4. Relational Field in Error	999
5. Value is <> "8888888" AND corresponding PROC-CODE-FLAG = 88	306
6. Value is = "8888888" AND corresponding PROC-CODE-FLAG <> 88	305
7. Value is invalid as related to corresponding PROC-CODE-FLAG= 01 (CPT-4)	203
8. Value is invalid as related to corresponding PROC-CODE-FLAG = 02 (ICD-9-CM).	203
9. Value is invalid as related to corresponding PROC-CODE-FLAG = 06 (HCPCS)	203

Data Element Name: PROC-CODE-FLAG-PRINCIPAL

Definition: CLAIMIP - A flag that identifies the coding system used for the PROC-CODE-PRINCIPAL.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(2)	5.0%	01

Coding Requirements:

Valid Values	Code Definition
01	CPT-4
02	ICD-9-CM
03	CRVS 74 (Obsolete)
04	CRVS 69 (Obsolete)
05	CRVS 64 (Obsolete)
06	HCPCS (Both National and Regional HCPCS)
07	ICD-10-CM (Not yet implemented. For future use)
10 - 87	Other Systems
88	Not Applicable
99	Unknown

If no principal procedure was performed, fill with 88.

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 99	812

THE FOLLOWING EDITS WILL NOT COUNT AGAINST THE ERROR TOLERANCE FOR ADJUSTMENT RECORDS (ADJUSTMENT INDICATOR=1, 2, 3, 4, OR 5)

2. Value = 99	301
3. Value is not in the list of valid codes, above	201
4. Relational Field in Error	999
5. Value <> 88 AND MEDICAID-COVERED-INPATIENT-DAYS= +00000	520
6. Value = 07 AND Coding Scheme has not yet been implemented (BEGINNING-DATE-OF-SERVICE < implementation date: current estimate = year 2000)	511

CLAIMS FILES

Data Element Name: PROC-CODE-FLAG-2 through PROC-CODE-FLAG-6

Definition: CLAIMIP - A series of flags that identifies the coding system used for the associated procedure codes (PROC-CODE-2 through PROC-CODE-6)

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(2)	5.0%	01

Coding Requirements:

Valid Values	Code Definition
01	CPT-4
02	ICD-9-CM
03	CRVS 74 (Obsolete)
04	CRVS 69 (Obsolete)
05	CRVS 64 (Obsolete)
06	HCPCS (Both National and Regional HCPCS)
07	ICD-10 CM (Not yet been implemented. For future use)
10 - 87	Other Systems
88	Not Applicable
99	Unknown

If no Second Procedure was performed, fill with 88.

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 99	812

THE FOLLOWING EDITS WILL NOT COUNT AGAINST THE ERROR TOLERANCE FOR ADJUSTMENT RECORDS (ADJUSTMENT INDICATOR=1, 2, 3, 4, OR 5)

2. Value is = 99	301
3. Value is not in the list of valid codes, above	201
4. Relational Field in Error	999
5. Value <> 88 AND MEDICAID-COVERED-DAYS = +00000	520
6. Value in PROC-CODE-FLAG-2 <> 88 AND PROC-CODE-FLAG-PRINCIPAL = “88"	306
7. Array range should not contain imbedded 88 coded fields (e.g., one field has value 88, all remaining fields should also contain = 88).	306
8. Value= 07 AND Coding Scheme has not yet been implemented (BEGINNING-DATE-OF-SERVICE < implementation date: current estimate = year 2000)	511

Data Element Name: PROC-CODE-MOD-PRINCIPAL

Definition: CLAIMIP - The procedure code modifier used with the Principal Procedure Code. For example, some States use modifiers to indicate assistance in surgery or anesthesia services.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(2)	5.0%	" "

Coding Requirements:

A list of valid codes must be supplied by the State prior to submission of any file data.

If no Principal Procedure was performed, fill with "88".

If a modifier is not applicable, fill with " ".

Error Condition	Resulting Error Code

THE FOLLOWING EDITS WILL NOT COUNT AGAINST THE ERROR TOLERANCE FOR ADJUSTMENT RECORDS (ADJUSTMENT INDICATOR=1, 2, 3, 4, OR 5)

1. Relational Field in Error 999
2. Value = “88" AND PROC-CODE-PRINCIPAL <> “8888888" 305
3. Value <> “88" AND PROC-CODE-PRINCIPAL = “8888888" 306

CLAIMS FILES

Data Element Name: PROC-CODE-MOD-2 through PROC-CODE-MOD-6

Definition: CLAIMIP - A series of procedure code modifiers used with the corresponding Procedure Codes. For example, some States use modifiers to indicate assistance in surgery or anesthesia services.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(2)	5.0%	" "

Coding Requirements:

A list of valid codes must be supplied by the State prior to submission of any file data.

If no corresponding procedure (PROC-CODE-2 through PROC-CODE-6) was performed, fill modifier with "88".

If a modifier is not applicable, fill with " ".

Error Condition	Resulting Error Code

THE FOLLOWING EDITS WILL NOT COUNT AGAINST THE ERROR TOLERANCE FOR ADJUSTMENT RECORDS (ADJUSTMENT INDICATOR=1, 2, 3, 4, OR 5)

1. Relational Field in Error 999
2. Value = “88" AND corresponding PROC-CODE <> “8888888" 305
3. Value <> “88" AND corresponding PROC-CODE = “8888888" 306

CLAIMS FILES

Data Element Name: PROC-DATE-PRINCIPAL

Definition: CLAIMIP - The date on which the principal procedure was performed.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(8)	5.0%	19980531

Coding Requirements:

Value must be a valid date in CCYYMMDD format.

If date is not known, fill with 99999999

If PROC-CODE-PRINCIPAL = “88888888", fill with 88888888

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to all 0's	810
THE FOLLOWING EDITS WILL NOT COUNT AGAINST THE ERROR TOLERANCE FOR ADJUSTMENT RECORDS (ADJUSTMENT INDICATOR=1, 2, 3, 4, OR 5)	
2. Value = 99999999 - Reset to all 0's	301
3. Relational Field in Error	999
4. Value <> 88888888 AND PROC-CODE-PRINCIPAL = "88888888"	306
5. Value = 88888888 AND PROC-CODE-PRINCIPAL <> "88888888"	305
6. Value is not a valid date	102
7. Value < BEGINNING-DATE-OF-SERVICE	511
8. Value > ENDING-DATE-OF-SERVICE	517

Data Element Name: PROGRAM-TYPE

Definition: CLAIMIP, CLAIMLT, CLAIMOT, CLAIMRX- Code indicating special Medicaid program under which the service was provided. Refer to Attachment 5 for information on the various program types.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(1)	2.0%	0

Coding Requirements:

Valid Values	Code Definition
0	No Special Program
1	EPSDT
2	Family Planning
3	Rural Health Clinic
4	Federally Qualified Health Centers (FQHC)
5	Indian Health Services
6	Home and Community Based Care for Disabled Elderly and Individuals Age 65 and Older
7	Home and Community Based Care Waiver Services
9	Unknown

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 9	812
2. Value = 9	301
3. Relational Field in Error	999
4. Value > 7	201

CLAIMS FILES

Data Element Name: PROVIDER-ID-NUMBER-BILLING

Definition: CLAIMIP, CLAIMLT, CLAIMOT, CLAIMRX - A unique identification number assigned by the state to a provider or capitation plan. This should represent the entity billing for the service. For encounter records (TYPE-OF-CLAIM = 3), this represents the entity billing (or reporting) to the managed care plan (See PLAN-ID-NUMBER for reporting capitation plan-ID). Capitation PLAN-ID should be used in this field only for premium payments (TYPE-OF-SERVICE = 20, 21, 22)

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(12)	5.0%	01CA79300

Coding Requirements:

Valid formats must be supplied by the State in advance of submitting file data.

If Value is invalid, record it exactly as it appears in the State system. Do not 9-fill.

If Value is unknown, fill with "999999999999".

Note: Once a national provider ID numbering system is in place, the national number should be used as opposed to the State's ID number

Error Condition	Resulting Error Code
1. Value = "999999999999"	301
2. Value is "Space Filled"	303
3. Value is 0-filled	304

Data Element Name: PROVIDER-ID-NUMBER-SERVICING

Definition: CLAIMOT - A unique number to identify the provider who treated the recipient (as opposed to the provider "billing" for the service, see PROVIDER-ID-NUMBER-BILLING)

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(12)	5.0%	01CA79300

Coding Requirements:

Valid formats must be supplied by the State in advance of submitting file data.

If Value is invalid, record it exactly as it appears in the State system. Do not 9-fill.

If "Servicing" provider and the "Billing" provider are the same then use the same number in both fields. For institutional billing providers (TYPE-OF-SERVICE = 11, 12) and other providers operating as a group, the numbers should be different.

8-fill field for premium payments (TYPE-OF-SERVICE = 20, 21, 22)

If Value is unknown, fill with "999999999999".

Error Condition — Resulting Error Code

THE FOLLOWING EDITS WILL NOT COUNT AGAINST THE ERROR TOLERANCE FOR ADJUSTMENT RECORDS (ADJUSTMENT INDICATOR=1, 2, 3, 4, OR 5)

1. Value = "999999999999"..... 301
2. Value is "Space Filled"..... 303
3. Value is 0-filled..... 304
4. Relational Field in Error..... 999
5. Value = "888888888888" AND TYPE-OF-SERVICE <> {20, 21, 22}..... 305
6. Value <> "888888888888" AND TYPE-OF-SERVICE = {20, 21, 22}..... 306
7. Value = PROVIDER-ID-NUMBER-BILLING AND TYPE-OF-SERVICE = {11,12}..... 529

Data Element Name: QUANTITY-OF-SERVICE

Definition: CLAIMOT, CLAIMRX - The number of units of service received by the recipient as shown on the claim record.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
S9(5)	2.0%	+00004

Coding Requirements:

This field is only applicable when the service being billed can be quantified in discrete units, e.g., a number of visits or the number of units of a prescription/refill that were filled. For prescriptions/refills, use the Medicaid Drug Rebate definition of a unit, which is the smallest unit by which the drug is normally measured; e.g. tablet, capsule, milliliter, etc. For drugs not identifiable or dispensed by a normal unit, e.g. powder-filled vials, use 1 as the number of units.

NOTE==> One prescription for 100 250-milligram tablets results in QUANTITY-OF-SERVICE=100.
Prior to fiscal year 1998, one prescription for 100 tablets resulted in QUANTITY-OF-SERVICE=1.

This field is not applicable for institutional services, dental services, laboratory and x-ray services, premium payments, or miscellaneous services (includes claims with TYPES-OF-SERVICE 09, 15, ~~17~~, 19, 20, 21, 22). Fill with +88888 for these types of services.

If invalid or missing, fill with +99999.

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 0 OR Value = -88888	810
2. Value = +99999 - Reset to 0	301
3. Relational Field in Error	999
4. Value <> +88888 AND TYPE-OF-SERVICE = {09, 15, 19, 20, 21, 22}	306
5. Value = +88888 AND (TYPE-OF-SERVICE = {08, 10 through 14, 16, or 18} AND TYPE-OF-CLAIM = {1 or 2})	305
6. Value < +00000 AND ADJUSTMENT-INDICATOR = {0, 2, 4}	607
7. Value > +00000 AND ADJUSTMENT-INDICATOR = {1,3}	607

Note: During CMS's "Valids File" processing, if value is 8-filled, reset to 0.

CLAIMS FILES

Data Element Name: SERVICE-CODE

Definition: CLAIMOT - The code used by the State to indicate the service provided during the period covered by this claim.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(7)	5.0%	A23456

Coding Requirements:

Field should contain a code for each service or other administrative cost (e.g.,premium payments, EPSDT group screens) where the State has a national or local code to identify it. For situations where no code exists (e.g., end year cost settlements), fill with "8888888".

For outpatient claims on which multiple line items are not separately adjudicated, crossover claims, and TYPE-OF-SERVICE = {20, 21, 22}, fill with "8888888".

For national coding systems, code should conform to the nationally recognized formats:

CPT (SERVICE-CODE-FLAG = 01): Positions 1-5 should be numeric and position 6-7 must be blank.

ICD-9-CM (SERVICE-CODE-FLAG = 02): Positions 1-2 must be numeric, positions 3-4 must be numeric or blank, positions 5-7 must be blank.

HCPCS (SERVICE-CODE-FLAG = 06): Position 1 must be an alpha character ("A"-"Z") and position 6-7 must be blank. Value can include both National and Local (Regional) codes. For National codes . (Position 1="A"-"V") positions 2-5 must be numeric; for Local (Regional) codes, positions 2-5 must be alphanumeric (e.g., "X1234" or "WW234").

For other schemes which are not nationally recognized, states should supply CMS with lists of valid values and any formats which should apply.

If Value is unknown, fill with "9999999".

Error Condition	Resulting Error Code
1. Value = "9999999"	301
2. Value = "0000000"	304
3. Value is "Space Filled"	303
4. Relational Field in Error	999
5. Value <> "8888888" AND SERVICE-CODE-FLAG = 88	306

DATA ELEMENT NAME: SERVICE CODE (CONTINUED)

Error Condition Code		Resulting Error
6.	Value = "8888888" AND SERVICE-CODE-FLAG <> 88	305
7.	Value is invalid as related to SERVICE-CODE-FLAG = 01 (CPT 4)	203
8.	Value is invalid as related to SERVICE-CODE-FLAG= 02 (ICD-9)	203
9.	Value is invalid as related to SERVICE-CODE-FLAG= 06 (HCPCS)	203
10.	SERVICE-CODE-FLAG = (10 through 87) AND state specific Values have not been supplied.	998

CLAIMS FILES

Data Element Name: SERVICE-CODE-FLAG

Definition: CLAIMOT - A flag that identifies the coding system used for SERVICE-CODE.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(2)	5.0%	01

Coding Requirements:

Valid Values	Code Definition
01	CPT-4
02	ICD-9-CM
03	CRVS 74 (Obsolete)
04	CRVS 69 (Obsolete)
05	CRVS 64 (Obsolete)
06	HCPCS (Both National and Regional HCPCS)
07	ICD-10- CM (Not yet implemented. For future use)
10 - 87	Other Systems
88	Not Applicable
99	Unknown

This field is not applicable if:

- multiple line items on outpatient claims are not separately adjudicated
- claim is a crossover claim and the state does not collect service level detail.
- TYPE-OF-SERVICE = {20, 21, 22} and the state does not use service codes to identify premium payments.

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 99	812
THE FOLLOWING EDITS WILL NOT COUNT AGAINST THE ERROR TOLERANCE FOR ADJUSTMENT RECORDS (ADJUSTMENT INDICATOR=1, 2, 3, 4, OR 5)	
2. Value = 99	301
3. Relational Field in Error	999
4. Value = 88 AND (TYPE-OF-SERVICE <> {11,20, 21, 22} OR MEDICARE-COINSURANCE-AMOUNT + MEDICARE-DEDUCTIBLE-AMOUNT = 0) AND (UB-92-REVENUE CODE = 8888 OR 9999)	305
5. Value is not in the list of valid codes above	201
6. Value = 07 AND Coding Scheme has not yet been implemented (BEGINNING-DATE-OF-SERVICE < implementation date: current estimate = year 2000).	511

CLAIMS FILES

Data Element Name: SERVICE-CODE-MOD

Definition: CLAIMOT - A service code modifier can be used to enhance the Service Code.
(e.g., anesthesia or surgical assistance services billed separately from actual procedure)

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(2)	5.0%	" "

Coding Requirements:

If modifiers other than standard HCPCS or CPT values are used, the State must supply a list of valid codes and their definitions prior to submission of any data files.

If SERVICE-CODE = “8888888", fill with “88".

If a modifier is not applicable, fill with " ".

Error Condition	Resulting Error Code
1. Relational Field in Error	999
2. Value <> “88" AND SERVICE-CODE= “8888888"	306

Data Element Name: SPECIALTY-CODE

Definition: CLAIMOT - Code which describes the area of specialty for the individual providing the service. Applies only to Physicians, Osteopaths, Dentists and other Licensed Practitioners.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(4)	100%	1234

Coding Requirements:

There is currently no standard coding for this field. Therefore, States are instructed to carry the specialty code using the coding system in place at the State level.

"Blank" fill if no specialty code is available.

Values must be one of the valid codes submitted by the State (States must submit lists of valid State Specific Specialty Codes to CMS in advance of transmitting MSIS files, and must update those lists whenever changes occur.)

Error Condition	Resulting Error Code
None	

CLAIMS FILES

Data Element Name: TYPE-OF-CLAIM

Definition: CLAIMIP, CLAIMLT, CLAIMOT, CLAIMRX - A code indicating what kind of payment is covered in this claims.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(1)	2.0%	1

Coding Requirements:

Valid Values	Code Definition
1	A Current Fee-For-Service Claim for medical services
2	Capitated Payment
3	Encounter (a.k.a. "Dummy") record that simulates a bill for a service rendered to a patient covered under some form of Capitation Plan. This includes billing records submitted by providers to non-State entities (e.g., MCOs, health plans) for which the State has no financial liability since the at-risk entity has already received a capitated payment from the State.
4	A "Service Tracking Claim" (a.k.a. "Gross Adjustment") that documents services received by an individual patient, when the State accepts a lump sum bill from a provider that covered similar services delivered to more than one patient, such as group screening for EPSDT.
5	Supplemental Payment (above capitation fee or above negotiated rate) (e.g., FQHC additional reimbursement)
9	Unknown (Counts against error tolerance)

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 9	812
2. Value = 9	301
3. Value is not included in the list of valid codes	201
4. Value = 4 AND first byte of MSIS-IDENTIFICATION-NUMBER <> "&"	522
5. Value<>4 AND first byte of MSIS-IDENTIFICATION-NUMBER = "&"	522

CLAIMS FILES

Data Element Name: TYPE-OF-SERVICE

Definition: CLAIMIP, CLAIMLT, CLAIMOT, CLAIMRX - A code indicating the type of service being billed. Refer to Attachment 4 for information on the various types of service.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(2)	0.1%	05

Coding Requirements:

Valid Values	Code Definition
01	Inpatient Hospital
02	Mental Hospital Services for the Aged
04	Inpatient Psychiatric Facility Services for Individuals Age 21 Years and Under
05	ICF Services for the Mentally Retarded
07	NF'S - All Other
08	Physicians
09	Dental
10	Other Practitioners
11	Outpatient Hospital
12	Clinic
13	Home Health
15	Lab and X-Ray
16	Prescribed Drugs
19	Other Services
20	Capitated Payment s to HMO, HIO or **PACE Plan**
21	Capitated Payments to Prepaid Health Plans (PHPs)
22	Capitated Payments for Primary Care Case Management (PCCM)
24	Sterilizations
25	Abortions
26	Transportation Services
30	Personal Care Services
31	Targeted Case Management
33	Rehabilitation Services
34	PT, OT, Speech, Hearing Language
35	Hospice Benefits
36	Nurse Midwife Services
37	Nurse Practitioner Services
38	Private Duty Nursing
39	Religious Non-Medical Health Care Institutions
99+	Invalid or unknown codes-included in error tolerance

NOTE: The following codes are invalid: 03, 06, 14, 17, 18, 23, 27, 28, 29, 32,40.

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CLAIMS FILES

Data Element Name: TYPE-OF-SERVICE (continued)

Valid Values for Each File Type

CLAIMIP Files may contain TYPE-OF-SERVICE Values:	01, 24, 25, or 39
CLAIMLT Files may contain TYPE-OF-SERVICE Values:	02, 04, 05 or 07
CLAIMOT Files may contain TYPE-OF-SERVICE Values:	08 THROUGH 13, 15, 19 THROUGH 22, 24 THROUGH 26, 30, 31, 33 THROUGH 38
CLAIMRX Files may contain TYPE-OF-SERVICE Value	16 or 19

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 99	812
2. Value = 99	301
3. Value < 01 OR Value > 39 OR = {03, 06, 14, 17, 18, 23, 27, 28, 29, 32}	201
4. Value <> {01, 24, 25 or 39} AND FILE-NAME = "CLAIMIP"	516
5. Value <> {02, 04, 05 or 07} AND FILE-NAME = "CLAIMLT"	516
6. Value <> {08 through 13 OR 15 OR 19 through 22 OR 24 through 26 OR 30 OR 31 OR 33 through 38} AND FILE-NAME = "CLAIMOT"	516
7. Value <> {16 OR 19} AND FILE-NAME = "CLAIMRX"	516
8. Relational Field in Error AND FILE-NAME = "CLAIMOT"	999
9. Value = {20, 21, 22} AND TYPE-OF-CLAIM <> {2 OR 5}	518

Note: All claims for inpatient psychiatric care provided in a separately administered psychiatric wing or psychiatric hospital are included in the CLAIMLT file.

CLAIMS FILES

Data Element Name: UB-92-REVENUE-CODE

Definition: CLAIMOT - UB-92 revenue code reported on the UB-92 line item that is represented on this claim/encounter record.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(4)	100%	305

Coding Requirements:

Only valid codes as defined by the "National Uniform Billing Committee" should be used.

This field is only applicable to those providers using the UB-92 billing form for claim submission, TYPE-OF-SERVICE=11 (and others as relevant within the State).

For those TYPE-OF-SERVICE values where the information is not applicable, 8-fill.

If Value is missing, 9-fill

NOTE: For States that collect both SERVICE-CODE and UB-92-REVENUE-CODE, both codes should be used. This field is seen as a supplement to the SERVICE-CODE field and not a replacement.

Error Condition	Resulting Error Code

THE FOLLOWING EDITS WILL NOT COUNT AGAINST THE ERROR TOLERANCE FOR ADJUSTMENT RECORDS (ADJUSTMENT INDICATOR=1, 2, 3, 4, OR 5)

1. Value = 9999 301
2. Value = 0000 304
3. Relational Field in Error 999
4. Value is Non-Numeric – RESET TO 0000 810
5. Value = 8888 AND TYPE-OF-SERVICE = 11 521
6. Value = SERVICE-CODE 530

Data Element Name: UB-REV-CHARGE-1 through UB-REV-CHARGE-23

Definition: CLAIMIP - The total charge for the related UB-92 Revenue Code (UB-REV-CODE-1 through UB-REV-CODE-23) for the billing period. Total charges include both covered and non covered charges (as defined by UB-92 Billing Manual, form locator 47)

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
S9(8)	5.0%	+450

Coding Requirements:

If the amount is missing or invalid, fill with +99999999

Enter charge for each UB-92 Revenue Code listed on the claim (up to 23 occurrences). If more than 23 codes are used, enter the charges for the first 23 which appear. If less than 23 are present, fill the fields which are not applicable to the claim with +88888888.

The sum of charges (UB-REV-CHARGE-1 through UB-REV-CHARGE-23) must be less than or equal to AMOUNT-CHARGED.

If TYPE-OF-CLAIM = 3 (encounter record) enter the charge amount if available. If not available, fill with +00000000.

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 0	810

THE FOLLOWING EDITS WILL NOT COUNT AGAINST THE ERROR TOLERANCE FOR ADJUSTMENT RECORDS (ADJUSTMENT INDICATOR=1, 2, 3, 4, OR 5)

2. Value = +99999999 -Reset to 0	301
3. Relational Field In Error	999
4. Value <> +88888888 AND corresponding UB-REV-CODE Value = 8888	306
5. Value = +88888888 AND corresponding UB-REV-CODE Value < > 8888	305
6. Value < 0 AND ADJUSTMENT-INDICATOR = {0, 2, 4}	607
7. Sum of (UB-REV-CHARGE-1 through UB-REV-CHARGE-23) >AMOUNT-CHARGED+23	510

Note: During CMS's "Valids" File processing, if value is 8-filled, reset to 0.

CLAIMS FILE

Data Element Name: UB REV-CODE-1 through UB-REV-CODE-23

Definition: CLAIMIP - "A code which identifies a specific accommodation, ancillary service or billing calculation" (as defined by UB-92 Billing Manual, form locator 42)

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(4)	5.0%	202

Coding Requirements:

Only valid codes as defined by the "National Uniform Billing Committee" should be used.

Enter all UB-92 Revenue Codes listed on the claim (up to 23 occurrences). If more than 23 codes are used, enter the first 23 which appear. When less than 23 codes are present, 8-fill fields which are not applicable to the claim (e.g., if claim contains 10 revenue line items, enter codes in fields 1-10 and 8-fill fields 11-23).

Value must be a valid code.

If Value invalid, record it exactly as it appears in the State system. Do not 9-fill.

If Value is unknown, fill with 9999.

Error Condition	Resulting Error Code
1. Value is Non-Numeric (reset applicable field to 0)	810

THE FOLLOWING EDITS WILL NOT COUNT AGAINST THE ERROR TOLERANCE FOR ADJUSTMENT RECORDS (ADJUSTMENT INDICATOR=1, 2, 3, 4, OR 5)

2. Value = 0000	304
3. Value = 9999	301
4. Relational Field In Error	999
5. Array range should not contain imbedded 8-filled fields (e.g., once an 8-filled field appears, remaining fields should also be 8-filled)	306
6. No accommodation revenue code (100-219) exists within array of values, AND MEDICAID-COVERED-INPATIENT-DAYS not {0, +88888}	520

Note: During CMS's "Valids" File processing, if value is 8-filled, reset to 0.

Data Element Name: UB-REV-UNITS-1 through UB-REV-UNITS-23

Definition: CLAIMIP - Units associated with UB-92 Revenue Code fields (UB-REV-CODE-1 through UB-REV-CODE-23). "A quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood , or renal dialysis treatments, etc." (as defined by UB-92 Billing Manual, form locator 46).

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
S9(7)	5.0%	+0000007

Coding Requirements:

Enter units for each UB-92 Revenue Code listed on the claim (up to 23 occurrences). If more than 23 codes are used, enter the units for the first 23 which appear. When less than 23 are present, 8-fill fields which are not applicable to the claim (e.g., if claim contains 10 revenue line items, enter codes in fields 1-10 and 8-fill fields 11-23).

If Value is unknown, fill with +9999999.

Error Condition — Resulting Error Code

1. Value in one or more fields is Non-Numeric (reset applicable field to 0).....810

THE FOLLOWING EDITS WILL NOT COUNT AGAINST THE ERROR TOLERANCE FOR ADJUSTMENT RECORDS (ADJUSTMENT INDICATOR=1, 2, 3, 4, OR 5)

2. Value in one or more field = +9999999 (reset field to 0).....301

3. Relational Field In Error.....999

4. Value = +8888888 AND corresponding UB92-REV-CODE (1-23) <> 8888.....305

5. Value <> +8888888 AND corresponding UB92-REV-CODE-(1-23) = 8888.....306

6. Value < 0 AND ADJUSTMENT-INDICATOR = {0, 2, 4}.....607

Note: During CMS's "Valids File" processing, if value is 8-filled, reset to 0.

APPENDIX A. ERROR MESSAGE LIST

The following is a list of the actual error messages that will appear on the Validation Report.

ERROR CODE	ERROR MESSAGE
000	Field has passed all edits
101	Value is not in required format
102	Value is not a valid date
201	Value is not included in the valid code list
202	Value is not one of the allowable file names
203	Value out of range
301	Value is "9-filled"
303	Value is "Space-filled"
304	Value is "0-filled" (invalid default setting)
305	Value is illegally "8-filled"
306	Value is not "8-filled" and field is not applicable.
307	Value is not “0-filled” and field is not applicable
401	Value is inconsistent with the fiscal quarter specified in the Tape Label Internal Dataset Name
402	Value is different from file name contained in the Tape Label Internal Dataset Name
421	Value is not the date immediately following END-OF- TIME-PERIOD in the corresponding Header Record submitted for the previous reporting quarter
501	Relational edit with DATE-FILE-CREATED failed
502	Relational edit with DAYS-OF-ELIGIBILITY failed
503	Relational edit with MAINTENANCE-ASSISTANCE-STATUS failed
504	Relational edit with DATE-OF-DEATH failed
505	Relational edit with DATE-OF-BIRTH failed
506	Relational edit with END-OF-TIME-PERIOD in Header Record failed
507	Relational edit with STATE-ABBREVIATION failed
508	Relational edit with NURSING-FACILITY-DAYS failed
509	Relational edit with TYPE-OF-CLAIM failed
510	Relational edit with AMOUNT-CHARGED failed
511	Relational edit with BEGINNING-DATE-OF-SERVICE failed
512	Relational edit with ADMISSION-DATE failed
513	Relational edit with DATE-OF-PAYMENT-ADJUDICATION failed
514	Relational edit with START-OF-TIME-PERIOD in Header Record failed
515	Relational edit with MEDICARE-DEDUCTIBLE-AMOUNT failed
516	Relational edit with FILE-NAME failed
517	Relational edit with ENDING-DATE-OF-SERVICE failed
518	Relational edit with TYPE-OF-COVERAGE failed
519	Relational edit with SOCIAL-SECURITY-NUMBER failed
520	Relational edit with MEDICAID-COVERED-INPATIENT-DAYS failed
521	Relational edit with TYPE-OF-SERVICE failed
522	Relational edit with MSIS-IDENTIFICATION-NUMBER failed
523	Not used
524	Relational edit with PROVIDER-IDENTIFICATION-NUMBER-BILLING failed
525	Not used
526	Not used
527	Not used
528	Not used

APPENDIX A. ERROR MESSAGE LIST (continued)

ERROR CODE	ERROR MESSAGE
529	Relational edit with TYPE-OF-SERVICE AND PROVIDER-IDENTIFICATION-NUMBER-BILLING
530	Relational edit with SERVICE-CODE failed
531	Relational edit with COUNTY-CODE failed
532	Relational edit among eligibility data element monthly array failed
533	Relational edit with BASIS-OF-ELIGIBILITY failed
534	Relational edit with TANF-FLAG failed
535	Relational edit with PRESCRIPTION-FILL-DATE failed
536	Relational edit with NATIONAL-DRUG-CODE
537	Relational edit with DUAL-ELIGIBLE-FLAG failed
538	Relational edit with corresponding monthly PLAN-TYPE or WAIVER-TYPE field failed
539	Relational edit with SEX-CODE failed
540	Relational edit with DIAGNOSIS-RELATED-GROUP-INDICATOR failed
541	Relational edit with DIAGNOSIS-PRINCIPAL failed
542	Relational edit with PRECEDING DIAGNOSIS failed
550	Relational edit with RACE-ETHNICITY-CODE and ETHNICITY-CODE or RACE-CODE failed
601	Relational edit with FEDERAL-FISCAL-YEAR and FEDERAL-FISCAL-QUARTER failed
602	Relational edit with MSIS-IDENTIFICATION-NUMBER and SSN-INDICATOR failed
603	Relational edit with BEGINNING-DATE-OF-SERVICE and ENDING-DATE-OF-SERVICE failed
604	Relational edit with ACCOMMODATION-CHARGES and AMOUNT-CHARGED failed
605	Relational edit with END-OF-TIME-PERIOD and TYPE-OF-SERVICE failed
606	Relational edit with MEDICARE-DEDUCTIBLE-AMOUNT and AMOUNT-CHARGED failed
607	Relational edit with ADJUSTMENT-INDICATOR failed
608	Relational edit with ICF/MR Days failed
701	Relational edit with FEDERAL-FISCAL-YEAR, FEDERAL-FISCAL-QUARTER, and TYPE-OF-RECORD failed
702	Relational edit with DATE-OF-BIRTH, MAINTENANCE-ASSISTANCE-STATUS, and DAYS-OF-ELIGIBILITY failed
703	Relational edit with MSIS-IDENTIFICATION-NUMBER, TEMPORARY-IDENTIFICATION-NUMBER, and SSN-INDICATOR failed
704	Relational edit with AMOUNT-CHARGED, MEDICARE-COINSURANCE-PAYMENT, and MEDICARE-DEDUCTIBLE-PAYMENT failed
801	Duplicate Eligible Record (Exact match on: ID, FFY, QTR, SEX, DOB)
802	Non-Unique Duplicate Eligible Record (Exact match on: ID, FFY, QTR, SEX and/or DOB do not match)
803	Duplicate Claim Record - 100% match on all fields
810	Non-Numeric Value Provided - Reset to 0
811	Non-Numeric Value Provided - Reset to 8-filled
812	Non-Numeric Value Provided - Reset to 9-filled
813	Non-Numeric Value Provided - Reset to 41(obsolete)
814	Non-Numeric Value Provided in Header Record
996	**INFORMATIONAL** - Value = 1 and DATE-OF-BIRTH implies Recipient was not over 64 on the first day of the month
997	**INFORMATIONAL** - Value not consistent with eligible's age
998	**INFORMATIONAL** - State specific values not available
999	**INFORMATIONAL** - Relational edit not performed because the related field was already flagged in error
CQC	**CURRENT QUARTER CHECK** - File appears to be for the wrong quarter. More than 50% of the Current Quarter records contained within the first 500 records of the file are outside of the reporting quarter

MEDICAID STATISTICAL INFORMATION SYSTEM

(MSIS)

Tape Specifications and Data Dictionary Attachments

ATTACHMENT 1 - MSIS Foreign Tape Login Transmittal

MSIS FOREIGN TAPE LOGIN   Page __ of __

Please ESTABLISH the following tape(s) in the CMS Data Center
FOREIGN TAPE LIBRARY:

USER ID	VOLSER	DATASET NAME	(File Type)	REEL # of N	SLOT #
MW00 _________	MW00._________.YR_________	.QTR__.	____________	___ of ___	_______
MW00 _________	MW00._________.YR_________	.QTR__.	____________	___ of ___	_______
MW00 _________	MW00._________.YR_________	.QTR__.	____________	___ of ___	_______
MW00 _________	MW00._________.YR_________	.QTR__.	____________	___ of ___	_______
MW00 _________	MW00._________.YR_________	.QTR__.	____________	___ of ___	_______
MW00 _________	MW00._________.YR_________	.QTR__.	____________	___ of ___	_______
MW00 _________	MW00._________.YR_________	.QTR__.	____________	___ of ___	_______
MW00 _________	MW00._________.YR_________	.QTR__.	____________	___ of ___	_______
MW00 _________	MW00._________.YR_________	.QTR__.	____________	___ of ___	_______
MW00 _________	MW00._________.YR_________	.QTR__.	____________	___ of ___	_______
MW00 _________	MW00._________.YR_________	.QTR__.	____________	___ of ___	_______
MW00 _________	MW00._________.YR_________	.QTR__.	____________	___ of ___	_______

STATE ________________________________

Shipper __________________________ Date ___/___/_____

Tape Handler ______________________ Date ___/___/_____

MSIS _________________________ Date ___/___/_____
(signatures)

RECORD COUNTS

EL _____________

IP _____________

LT _____________

OT _____________

RX ______________

If you have a problem please contact Kathy Ranshous at (410) 786-0958.
Please mail all MSIS tape files to the following address:

Centers for Medicare and Medicaid Services
CMS Data Center
Attn: Foreign Tape Library
7500 Security Boulevard
Baltimore, MD 21244-1850

November 2004

MEDICAID STATISTICAL INFORMATION SYSTEM
(MSIS)

Tape Specifications and Data Dictionary Attachments

ATTACHMENT 2 - MSIS Validation Report Format

VALIDATION REPORT

A validation report is generated at the conclusion of the data validation process. This report provides a file specific analysis of the State's data.

Report Page 1

Report Identification	-	Descriptive information about the report, including: state, date, file type, reporting period, and number of validation attempts.
Validation Status	-	The outcome of the data validation process. This indicates whether or not the validation process reached completion or encountered a fatal error. The remainder of the report is meaningful only if the complete file could be successfully validated.
Error Tolerance Analysis	-	A statistical summary of the file's records in error.
Variable Error Analysis	-	This section displays every data element contained in the file type. For each field, the report shows: error tolerance (allowable), number of records in error, and error percentage achieved.
Error Frequency Analysis	-	Counts of records grouped by the frequency of errors generated by individual records.
Verdict (File Status)	-	The final ACCEPTED/REJECTED status of the file.

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Report Identification	-	Descriptive information about the report, including: state, date, file type, reporting period, and number of validation attempts.
Edit Specifications	-	Specific error codes with explanations for each field found in error. A count of records failing each edit is included.
Filler	-	filler

MEDICAID STATISTICAL INFORMATION SYSTEM

(MSIS)

Tape Specifications and Data Dictionary Attachments

ATTACHMENT 3 - Comprehensive Eligibility Crosswalk

MAS/BOE - INDIVIDUALS RECEIVING CASH ASSISTANCE OR ELIGIBLE UNDER SECTION 1931 OF THE ACT-AGED
MSIS Coding (MAS-1, BOE-1)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Aged individuals receiving SSI, eligible spouses or persons receiving SSI pending a final determination of disposal of resources exceeding SSI dollar limits; and persons considered to be receiving SSI under §1619(b) of the Act.	42 CFR 435.120, §1619(b) of the Act, §1902(a)(10)(A)(I)(II) of the Act, PL 99-643, §2.
2	Aged individuals who meet more restrictive requirements than SSI and who are either receiving or not receiving SSI; or who qualify under §1619 of the Act.	42 CFR 435.121, §1619(b)(3) of the Act, §1902(f) of the Act, PL 99-643, §7.
3	Aged individuals receiving mandatory State supplements.	42 CFR 435.130.
4	Aged individuals who receive a State supplementary payment (but not SSI) based on need.	42 CFR 435.230, §1902(a)(10)(A)(ii) of the Act.

MAS/BOE - INDIVIDUALS RECEIVING CASH ASSISTANCE OR ELIGIBLE UNDER SECTION 1931 OF THE ACT - BLIND/DISABLED
MSIS Coding (MAS-1, BOE-2)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Blind and/or disabled individuals receiving SSI, eligible spouses or persons receiving SSI pending a final determination of blindness, disability, and/or disposal of resources exceeding SSI dollar limits; and persons considered to be receiving SSI under §1619(b) of the Act.	42 CFR 435.120, §1619(b) of the Act, §1902(a)(10)(A)(I)(II) of the Act, PL 99-643, §2.
2	Blind and/or disabled individuals who meet more restrictive requirements than SSI and who are either receiving or not receiving SSI; or who qualify under §1619.	42 CFR 435.121, §1619(b)(3) of the Act, §1902(f) of the Act, PL 99-643, §7.
3	Blind and/or disabled individuals receiving mandatory State supplements.	42 CFR 435.130.
4	Blind and/or disabled individuals who receive a State supplementary payment (but not SSI) based upon need.	42 CFR 435.230, §1902(a)(10)(A)(ii)of the Act.

MAS/BOE - INDIVIDUALS RECEIVING CASH ASSISTANCE OR ELIGIBLE UNDER SECTION 1931 OF THE ACT - CHILDREN
MSIS Coding (MAS-1, BOE-4)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Low Income Families with Children qualified under §1931 of the Act.	42 CFR 435.110, §1902(a)(10)(A)(I)(I) of the Act, §1931 of the Act.
2	Children age 18 who are regularly attending a secondary school or the equivalent of vocational or technical training.	42 CFR 435.110, §1902(a)(10)(A)(I)(I).

MAS/BOE - INDIVIDUALS RECEIVING CASH ASSISTANCE OR ELIGIBLE UNDER SECTION 1931 OF THE

ACT - ADULTS
MSIS Coding (MAS-1, BOE-5)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Adults deemed essential for well-being of a recipient [see 45 CFR 233.20(a)(2)(vi)] qualified for Medicaid under §1931 of the Act.	42 CFR 435.110, §1902(a)(10)(A)(I)(I)of the Act, §1931 of the Act.
2	• Pregnant women who have no other eligible children. • Other adults in "adult only" units.	42 CFR 435.110, §1902(a)(10)(A)(I)(I)of the Act.

MAS/BOE - INDIVIDUALS RECEIVING CASH ASSISTANCE OR ELIGIBLE UNDER SECTION 1931 -U CHILDREN
MSIS Coding (MAS-1, BOE-6) - (OPTIONAL)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Unemployed Parent Program - Cash assistance benefits to low income individuals in two parent families where the principle wage earner is employed fewer than 100 hours a month.	42 CFR 435.110, §1902(a)(10)(A)(I)(I) of the Act, §1931 of the Act.
2	Children age 18 who are regularly attending a secondary school or the equivalent of vocational or technical training.	42 CFR 435.110, §1902(a)(10)(A)(I)(I) of the Act.

MAS/BOE - INDIVIDUALS RECEIVING CASH ASSISTANCE OR ELIGIBLE UNDER SECTION 1931 - U ADULTS
MSIS Coding (MAS-1, BOE-7) - (OPTIONAL)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Adults deemed essential for well-being of a recipient (see 45 CFR 233.20(a)(2)(vi)) qualified under §1931 of the Act (Low Income Families with Children).	42 CFR 435.110, §1902(a)(10)(A)(I)(I) of the Act, §1931 of the Act.
2	• Pregnant women who have no other eligible children. • Other Adults in "adult only" units.	42 CFR 435.110, §1902(a)(10)(A)(I)(I) of the Act.

MAS/BOE - MEDICALLY NEEDY - AGED
MSIS Coding (MAS-2, BOE-1)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Aged individuals who would be ineligible if not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212, and the same rules apply to medically needy individuals.	42 CFR 435.326.
2	Aged	42 CFR 435.320, 42 CFR 435.330.

MAS/BOE - MEDICALLY NEEDY - BLIND/DISABLED
MSIS Coding (MAS-2, BOE-2)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Blind and/or disabled individuals who would be ineligible if not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.	42 CFR 435.326.
2	Blind/Disabled	42 CFR 435.322,

ITEM	DESCRIPTION	CFR/PL CITATIONS
		42 CFR 435.324, 42 CFR 435.330.
3	Blind and/or disabled individuals who meet all Medicaid requirements except current blindness and/or disability criteria, and have been continuously eligible since 12/73 under the State's requirements.	42 CFR 435.340.

MAS/BOE - MEDICALLY NEEDY - CHILDREN

MSIS Coding (MAS-2, BOE-4)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Individuals under age 18 who, but for income and resources, would be eligible.	§1902(a)(10)(C)(ii)(I) of the Act, PL 97-248, §137.
2	Infants under the age of 1 and who were born after 9/30/84 to and living in the household of medically needy women.	§1902(e)(4) of the Act, PL 98-369, §2362.
3	Other financially eligible individuals under age 18-21, as specified by the State.	42 CFR 435.308.
4	Children who would be ineligible if not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.	42 CFR 435.326.

MAS/BOE - MEDICALLY NEEDY - ADULTS

MSIS Coding (MAS-2, BOE-5)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Pregnant women.	42 CFR 435.301.
2	Caretaker relatives who, but for income and resources, would be eligible.	42 CFR 435.310.
3	Adults who would be ineligible if not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.	42 CFR 435.326.

MAS/BOE - POVERTY RELATED ELIGIBLES - AGED

MSIS Coding (MAS-3, BOE-1)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Qualified Medicare Beneficiaries (QMBs) who are entitled to Medicare Part A, whose income does not exceed 100% of the Federal poverty level, and whose resources do not exceed twice the SSI standard.	§§1902(a)(10)(E)(I) and 1905(p)(1) of the Act, PL 100-203, §4118(p)(8), PL 100-360, §301(a) & (e), PL 100-485, §608(d)(14), PL 100-647, §8434.
2	Specified Low-Income Medicare Beneficiaries (SLMBs) who meet all of the eligibility requirements for QMB status, except for the income in excess of the QMB income limit, but not exceeding 120% of the Federal poverty level.	§4501(b) of OBRA 90, as amended in §1902(a)(10)(E) of the Act.
3	Qualifying individuals having higher income than allowed for QMBs or SLMBs.	§1902(a)(10)(E)(iv) of the Act.

4	Aged individual not described in S 1902(a)(10)(A)(1) of the Act, with income below the poverty level and resources within state limits, who are entitled to full Medicaid benefits.	§1902(a)(10)(A)(ii)(X), 1902(m)(1) of the Act, PL 99-509, §§9402 (a) and (b).

MAS/BOE - POVERTY RELATED ELIGIBLES - BLIND/DISABLED

MSIS Coding (MAS-3, BOE-2)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Qualified Medicare Beneficiaries (QMBs) who are entitled to Medicare Part A, whose income does not exceed 100% of the Federal poverty level, and whose resources do not exceed twice the SSI standard.	§§1902(a)(10)(E)(I) and 1905(p)(1) of the Act, PL 100-203, §4118(p)(8), PL 100-360, §301(a) & (e), PL 100-485, §608(d)(14), PL 100-647, §8434.
2	Specified Low-Income Medicare Beneficiaries (SLMBs) who meet all of the eligibility requirements for QMB status, except for the income in excess of the QMB income limit, but not exceeding 120% of the Federal poverty level.	§4501(b) of OBRA 90 as amended in §1902(a)(10)(E)(I) of the Act.
3	Qualifying individuals having higher income than allowed for QMBs or SLMBs.	§1902(a)(10)(E)(iv) of the Act.
4	Qualified Disabled Working Individuals (QDWIs) who are entitled to Medicare Part A.	§§1902(a)(10)(E)(ii) and 1905(s) of the Act.
5	Disabled individuals not described in §1902(a)(10)(A)(1) of the Act, with income below the poverty level and resources within state limits, which are entitled to full Medicaid benefits.	§§1902(a)(10)(A)(ii)(X), 1902(m)(1) and (3) of the Act, P.L. 99-509, §§9402 (a) and (b).

MAS/BOE - POVERTY RELATED ELIGIBLES - CHILDREN

MSIS Coding (MAS-3, BOE-4)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Infants and children up to age 6 with income at or below 133% of the Federal Poverty Level (FPL).	§§1902(a)(10)(A)(I)(IV) & (VI), 1902(l)(1)(A), (B), & (C) of the Act, PL 100-360, §302(a)(1), PL 100-485, §608(d)(15).
2	Children under age 19 (born after 9/30/83) whose income is at or below 100% of the Federal poverty level within the State's resource requirements.	§1902(a)(10)(A)(I) (VII) of the Act.
3	Infants under age 1 whose family income is below 185% of the poverty level and who are within any optional State resource requirements.	§§1902(a)(10)(A)(ii) (IX) and 1902(l)(1)(D) of the Act, PL 99-509, §§9401(a) & (b), PL 100-203, §4101.
4	Children made eligible under the more liberal income and resource requirements as authorized under §1902(r)(2) of the Act when used to disregard income on a poverty-level-related basis.	§1902(r)(2) of the Act.
5	Children made eligible by a Title XXI Medicaid expansion under the State Child Health Insurance Program (SCHIP)	P.L. 105-100.

MAS/BOE - POVERTY RELATED ELIGIBLES - ADULTS
MSIS Coding (MAS-3, BOE-5)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Pregnant women with incomes at or below 133% of the Federal Poverty Level.	§1902(a)(10)(A)(I), (IV) and (VI); §1902(l)(1)(A), (B), & (C) of the Act, PL 100-360, §302(a)(1), PL 100-485, §608(d)(15).
2	Women who are eligible until 60 days after their pregnancy, and whose incomes are below 185% of the FPL and have resources within any optional State resource requirements.	§§1902(a)(10)(A)(ii)(IX) and 1902(l)(1)(D) of the Act, PL 99-509, §§9401(a) & (b), PL 100-203, §4101.
3	Caretaker relatives and pregnant women made eligible under more liberal income and resource requirements of §1902(r)(2) of the Act when used to disregard income on a poverty-level related basis.	§1902(r)(2) of the Act.
4	Adults made eligible by a Title XXI Medicaid expansion under the State Child Health Insurance Program (SCHIP).	Title XXI of the Social Security Act.

MAS/BOE - POVERTY RELATED ELIGIBLES - ADULTS
MSIS Coding (MAS-3, BOE-A)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Women under age 65 who are found to have breast or cervical cancer, or have precancerous conditions.	§1902(a)(10)(a)(ii)(XVIII), P.L. 106-354.

MAS/BOE - OTHER ELIGIBLES - AGED
MSIS Coding (MAS-4, BOE-1)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Aged individuals who meet more restrictive requirements than SSI and who are either receiving or not receiving SSI; or who qualify under §1619 of the Act.	42 CFR 435.121, §1619(b)(3) of the Act, §1902(f) of the Act, PL 99-643, §7.
2	Aged individuals who are ineligible for optional State supplements or SSI due to requirements that do not apply under title XIX.	42 CFR 435.122.
3	Aged essential spouses considered continuously eligible since 12/73; and some spouses who share hospital or nursing facility rooms for 6 months or more.	42 CFR 435.131.
4	Institutionalized aged individuals who have been continuously eligible since 12/73 as inpatients or residents of Title XIX facilities.	42 CFR 435.132.
5	Aged individuals who would be SSI/SSP eligible except for the 8/72 increase in OASDI benefits.	42 CFR 435.134.
6	Aged individuals who would be eligible for SSI but for title II cost-of-living adjustment(s).	42 CFR 435.135.
7	Aged aliens who are not lawful, permanent residents or who do not have PRUCOL status, but who are otherwise qualified, and who require emergency care.	PL 99-509, §9406.
8	Aged individuals who would be eligible for AFDC, SSI, or an optional State supplement if not in a medical institution.	42.CFR 435.211, §1902(a)(10)(A)(ii) and §1905(a) of the Act.
9	Aged individuals who meet income and resource	42 CFR 435.210,

ITEM	DESCRIPTION	CFR/PL CITATIONS
	requirements for AFDC, SSI, or an optional State supplement.	§1902(a)(10)(A)(ii) and §1905 of the Act.
10	Aged individuals who have become ineligible and who are enrolled in a qualified HMO or "§1903(m)(2)(G) entity" that has a risk contract.	42 CFR 435.212 §1902(e)(2), PL 99-272, §9517, PL 100-203, §4113(d).
11	Aged individuals who, solely because of coverage under a home and community based waiver, are not in a medical institution, but who would be eligible if they were.	42 CFR 435.217, §1902(a)(10)(A)(ii), (VI); 50 PL 100-13.
12	Aged individuals who elect to receive hospice care who would be eligible if in a medical institution.	§1902(a)(10)(A)(ii), (VII) of the Act, PL 99-272, §9505.
13	Aged individuals in institutions who are eligible under a special income level specified in Supplement 1 to Attachment 2.6-A of the State's title XIX Plan.	42 CFR 435.236, §1902(a)(10)(A)(ii) of the Act.

MAS/BOE - OTHER ELIGIBLES - BLIND/DISABLED

MSIS Coding (MAS-4, BOE-2)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Blind and/or disabled individuals who meet more restrictive requirements than SSI, including both those receiving and not receiving SSI payments	42 CFR 435.121, §1619(b)(3) of the Act, §1902(f) of the Act, PL 99-643, §7.
2	Blind and/or disabled individuals who are ineligible for optional State supplements or SSI due to requirements that do not apply under title XIX.	42 CFR 435.122.
3	Blind and/or disabled essential spouses considered continuously eligible since 12/73; and some spouses who share hospital or nursing facility rooms for 6 months or more.	42 CFR 435.131.
4	Institutionalized blind and/or disabled individuals who have been continuously eligible since 12/73 as inpatients or residents of Title XIX facilities.	42 CFR 435.132.
5	Blind and/or disabled individuals who would be SSI/SSP, eligible except for the 8/72 increase in OASDI benefits.	42 CFR 435.134.
6	Blind and/or disabled individuals who would be eligible for SSI but for title II cost-of-living adjustment(s).	42 CFR 435.135, §503 PL 94-566.
7	Blind and/or disabled aliens who are not lawful, permanent residents or who do not have PRUCOL status, but who are otherwise qualified, and who require emergency care.	PL 99-509, §9406.
8	Blind and/or disabled individuals who meet all Medicaid requirements except current blindness, or disability criteria, who have been continuously eligible since 12/73 under the State's 12/73 requirements.	42 CFR 435.133.
9	Blind and/or disabled individuals, age 18 or older, who became blind or disabled before age 22 and who lost SSI or State supplementary payments eligibility because of an increase in their OASDI (childhood disability) benefits.	§1634(c) of the Act; PL 99-643, §6.
10	Blind and/or disabled individuals who would be eligible	42 CFR 435.211,

ITEM	DESCRIPTION	CFR/PL CITATIONS
	for AFDC, SSI, or an optional State supplement if not in a medical institution.	§§1902(a)(10)(A)(ii) and 1905(a) of the Act.
11	Qualified severely impaired blind or disabled individuals under age 65, who, except for earnings, are eligible for SSI.	§§1902(a)(10)(A)(I)(II) and 1905(q) of the Act, PL 99-509, §9404 and §1619(b)(8) of the Act, PL 99-643, §7
12	Blind and/or disabled individuals who meet income and resource requirements for AFDC, SSI, or an optional State supplement.	42 CFR 435.210, §§1902(a)(10)(A)(ii) and 1905 of the Act.
13	Working disabled individuals who buy-in to Medicaid	§1902(a)(10)(A)(ii)(XIII).
14	Blind and/or disabled individuals who have become ineligible who are enrolled in a qualified HMO or "§1903(m)(2)(G) entity" that has a risk contract.	42 CFR 435.212 §1902(e)(2) of the Act; PL 99-272, §9517; PL 100-203, §4113(d).
15	Blind and/or disabled individuals who, solely because of coverage under a home and community based waiver, are not in a medical institution and who would be eligible if they were.	42 CFR 435.217, §1902(a)(10)(A)(ii)(VI) of the Act, 50 PL 100-13.
16	Blind and/or disabled individuals who elect to receive hospice care, and who would be eligible if in a medical institution.	§1902(a)(10)(A)(ii)(VII), PL 99-272, §9505
17	Blind and/or disabled individuals in institutions who are eligible under a special income level specified in Supplement 1 to Attachment 2.6-A of the State's title XIX Plan.	42 CFR 435.231. §1902(a)(10)(A)(ii) of the Act.
18	Blind and/or disabled widows and widowers who have lost SSI/SSP benefits but are considered eligible for Medicaid until they become entitled to Medicare Part A.	§1634 of the Act, PL 101-508, §5103.
19	Certain Disabled children, 18 or under, who live at home, but who, if in a medical institution, would be eligible for SSI or a State supplemental payment.	42 CFR 435.225; §1902(e)(3) of the Act.
20	Continuation of Medicaid eligibility for disabled children who lose SSI benefits because of changes in the definition of disability.	§1902(a)(10)(A)(ii) of the Act; P.L. 15-32, §491.
21	Disabled individuals with medically improved disabilities made eligible under the Ticket to Work and Work Incentives Improvement Act (TWWIIA) of 1999.	§1902(a)(10)(A)(ii)(XV) of the Act.

MAS/BOE - OTHER ELIGIBLES - CHILDREN

MSIS Coding (MAS-4, BOE-4)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Children of families receiving up to 12 months of extended Medicaid benefits (for those eligible after 4/1/90).	§1925 of the Act, PL 100-485, §303.
2	"Qualified children" under age 19 born after 9/30/83 or at an earlier date at State option, who meet the State's AFDC income and resource requirements.	§§1902(a)(10)(A)(I)(III) and 1905(n) of the Act, PL 98-369, §2361, PL 99-272, §9511, PL 100-203, §4101.
3	Children of individuals who are ineligible for AFDC-related Medicaid because of requirements that do not apply under title XIX.	42 CFR 435.113.

ITEM	DESCRIPTION	CFR/PL CITATIONS
4	Children of individuals who would be eligible for Medicaid under §1931 of the Act (Low income families with children) except for the 7/1/72 (PL 92-325) OASDI increase and were entitled to OASDI and received cash assistance in 8/72.	42 CFR 435.114.
5	Children whose mothers were eligible for Medicaid at the time of childbirth, and are deemed eligible for one year from birth as long as the mother remained eligible, or would have if pregnant, and the child remains in the same household as the mother.	42 CFR 435.117, §1902(e)(4) of the Act, PL 98-369, §2362.
6	Children of aliens who are not lawful, permanent residents or who do not have PRUCOL status, but who are otherwise qualified, and who require emergency care.	PL 99-509, §9406.
7	Children who meet income and resource requirements for AFDC, SSI, or an optional State supplement	42 CFR 435.210, §1902(a)(10)(A)(ii) and §1905 of the Act.
8	Children who would be eligible for AFDC, SSI, or an optional State supplement if not in a medical institution.	42 CFR 435.211, §1902(a)(10)(A)(ii) and §1905(a) of the Act.
9	Children who have become ineligible who are enrolled in a qualified HMO or "§1903(m)(2)(G) entity" that has a risk contract.	42 CFR 435.212, §1902(e)(2) of the Act, PL 99-272, §9517, PL 100-203, §4113(d).
10	Children of individuals who elect to receive hospice care, and who would be eligible if in a medical institution.	§1902(a)(10)(A)(ii)(VII), PL 99-272, §9505.
11	Children who would be eligible for AFDC if work-related child care costs were paid from earnings rather than received as a State service.	42 CFR 435.220.
12	Children of individuals who would be eligible for AFDC if the State used the broadest allowable AFDC criteria.	42 CFR 435.223, §§1902(a)(10)(A)(ii) and 1905(a) of the Act.
13	Children who solely because of coverage under a home and community based waiver, are not in a medical institution, but who would be eligible if they were.	42 CFR 435.217, §1902(a)(10)(A)(ii)(VI) of the Act.
14	Children not described in §1902(a)(10)(A)(I) of the Act, "Ribikoff Kids", who meet AFDC income and resource requirements, and are under a State-established age (18-21).	§§1902(a)(10)(A)(ii) and 1905(a)(I) of the Act, PL 97-248, §137.

MAS/BOE - OTHER ELIGIBLES - ADULTS

MSIS Coding (MAS-4, BOE-5)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Families receiving up to 12 months of extended Medicaid benefits (if eligible on or after 4/1/90).	§1925 of the Act, PL 100-485, §303.
2	Qualified pregnant women whose pregnancies have been medically verified and who meet the State's AFDC income and resource requirements.	§§1902(a)(10)(A)(I)(III) and 1905(n) of the Act, PL 98-369, §2361, PL 99-272, §9511, PL 100-203 §4101.

ITEM	DESCRIPTION	CFR/PL CITATIONS
3	Adults who are ineligible for AFDC-related Medicaid because of requirements that do not apply under title XIX.	42 CFR 435.113.
4	Adults who would be eligible for Medicaid under §1931 of the Act (Low income families with children) except for the 7/1/72 (PL 92-325) OASDI increase; and were entitled to OASDI and received cash assistance in 8/72.	42 CFR 435.114.
5	Women who were eligible while pregnant, and are eligible for family planning and pregnancy related services until the end of the month in which the 60th day occurs after the pregnancy	§1902(e)(5) of the Act, PL 98-369, PL 100-203, §4101, PL 100-360, §302(e).
6	Adult aliens who are not lawful, permanent residents or who do not have PRUCOL status, but who are otherwise qualified, and who require emergency care.	PL 99-509, §9406.
7	Adults who meet the income and resource requirements for AFDC, SSI, or an optional State Supplement.	42 CFR 435.210, §§1902(a)(10)(A)(ii) and 1905 of the Act.
8	Adults who would be eligible for AFDC, SSI, or an optional State Supplement if not in a medical institution.	42 CFR 435.211, §§1902(a)(10)(A)(ii) and 1905(a) of the Act.
9	Adults who have become ineligible who are enrolled in a qualified HMO or "§1903(m)(2)(G) entity" that has a risk contract.	42 CFR 435.212, §1902(e)(2)(A) of the Act, PL 99-272, §9517, PL 100-203, §4113(d).
10	Adults who solely because of coverage under a home and community based waiver, are not in a medical institution, but who would be eligible if they were.	42 CFR 435.217, §1902(a)(10)(A)(ii)(VI) of the Act.
11	Adults who elect to receive hospice care, and who would be eligible if in a medical institution.	§1902(a)(10)(A)(ii), (VII); PL 99-272, §9505.
12	Adults who would be eligible for AFDC if work-related child care costs were paid from earnings rather than received as a State service.	42 CFR 435.220.
13	Pregnant women who have been granted presumptive eligibility.	§§1902(a)(47) and 1920 of the Act, PL 99-509, §9407.
14	Adults who would be eligible for AFDC if the State used the broadest allowable AFDC criteria.	42 CFR 435.223, §§1902(a)(10)(A)(ii) and 1905(a) of the Act.

MAS/BOE - OTHER ELIGIBLES - FOSTER CARE CHILDREN

MSIS Coding (MAS-4, BOE-8)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Children for whom the State makes adoption assistance or foster care maintenance payments under Title IV-E.	42 CFR 435.145, §1902(a)(10)(A)(i)(I) of the Act.
2	Children with special needs covered by State foster care payments or under a State adoption assistance agreement which does not involve Title IV-E.	§1902(a)(10)(A)(ii) (VIII) of the Act, PL 99-272, §9529.

ITEM	DESCRIPTION	CFR/PL CITATIONS
3	Children leave foster care due to age.	Foster Care Independence Act of 1999.

MAS/BOE - SECTION 1115 DEMONSTRATION MEDICAID EXPANSION

MSIS Coding (MAS-5, BOE-1)

ITEM	DESCRIPTION	CFR/PL CITATION
1	Aged individuals made eligible under the authority of a §1115 waiver due to poverty-level related eligibility expansions.	§1115(a)(1), (a)(2) & (b)(1) of the Act, §1902(a)(10), and §1903(m) of the Act.

MAS/BOE - SECTION 1115 DEMONSTRATION MEDICAID EXPANSION

MSIS Coding (MAS-5, BOE-2)

ITEM	DESCRIPTION	CFR/PL CITATION
1	Blind and/or disabled individuals made eligible under the authority of a §1115 waiver due to poverty-level-related eligibility	§1115(a)(1), (a)(2) & (b)(1) of the Act, §1902(a)(10), and §1903(m) of the Act.

MAS/BOE - SECTION 1115 DEMONSTRATION MEDICAID EXPANSION

MSIS Coding (MAS-5, BOE-4)

ITEM	DESCRIPTION	CFR/PL CITATION
1	Children made eligible under the authority of a §1115 waiver due to poverty-level-related eligibility expansions.	§1115(a)(1), (a)(2) & (b)(1) of the Act, §1902(a)(10), and §1903(m) of the Act.

MAS/BOE - SECTION 1115 DEMONSTRATION MEDICAID EXPANSION

MSIS Coding (MAS-5, BOE-5)

ITEM	DESCRIPTION	CFR/PL CITATION
1	Caretaker relatives, pregnant women and/or adults without dependent children made eligible under the authority of at §1115 waiver due to poverty-level-related eligibility expansions.	§1115(a)(1) and (a)(2) of the Act, §1902(a)(10), §1903(m).

MEDICAID STATISTICAL INFORMATION SYSTEM

(MSIS)

Tape Specifications and Data Dictionary Attachments

ATTACHMENT 4 - Types of Service Reference

DEFINITIONS OF TYPES OF SERVICE

The following definitions are adaptations of those given in the Code of Federal Regulations. These definitions, although abbreviated, are intended to facilitate the classification of medical care and services for reporting purposes. They do not modify any requirements of the Act or supersede in any way the definitions included in the Code of Federal Regulations (CFR).

Effective FY 1999, services provided under Family Planning, EPSDT, Rural Health Clinics, FQHC's, and Home-and-Community-Based Waiver programs will be coded according to the types of services listed below. Specific programs with which these services are associated will be identified using the program type coding as defined in Appendix C.1.

NOTE: For hard-copy 2082 submissions only, continue to report program types listed in Appendix C.1 as types of services.

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1. Unduplicated Total.--Report the unduplicated total of recipients by maintenance assistance status (MAS) and by basis of eligibility (BOE). A recipient receiving more than one type of service is reported only once in the unduplicated total.

2. Inpatient Hospital Services (MSIS Code=01)(See 42 CFR 440.10).--These are services that are:

   - o Ordinarily furnished in a hospital for the care and treatment of inpatients;
   - o Furnished under the direction of a physician or dentist (except in the case of nurse-midwife services per 42 CFR 440.165); and
   - o Furnished in an institution that:
     - Is maintained primarily for the care and treatment of patients with disorders other than mental diseases;
     - Is licensed or formally approved as a hospital by an officially designated authority for State standard setting;
     - Meets the requirements for participation in Medicare (except in the case of medical supervision of nurse-midwife services per 42 CFR 440.165); and
     - Has in effect a utilization review plan applicable to all Medicaid patients that meets the requirements in 42 CFR 482.30 unless a waiver has been granted by the Secretary of Health and Human Services.

   Inpatient hospital services do not include nursing facility services furnished by a hospital with swing-bed approval. However, include services provided in a psychiatric wing of a general hospital if the psychiatric wing is not administratively separated from the general hospital.

3. Mental Health Facility Services (See 42 CFR 440.140, 440.160, and 435.1009).--An institution for mental diseases is a hospital, nursing facility, or other institution that is primarily engaged in providing diagnosis, treatment or care of individuals with mental diseases, including medical care, nursing care, and related services. Report totals for services defined under 3a and 3b.

3a. Inpatient Psychiatric Facility Services for Individuals Age 21 and Under (MSIS Code=04)(See 42 CFR 440.160 and 441.150(ff)). --These are services that:

- o Are provided under the direction of a physician;
- o Are provided in a psychiatric facility or inpatient program accredited by the Joint Commission on the Accreditation of Hospitals; and,
- o Meet the requirements set forth in 42 CFR Part 441, Subpart D (inpatient psychiatric services for individuals age 21 and under in psychiatric facilities or programs).

3b. Other Mental Health Facility Services (Individuals Age 65 or Older) (MSIS Code=02)(See 42 CFR 440.140(a) and Part 441, Subpart C).--These are services provided under the direction of a physician for the care and treatment of recipients in an institution for mental diseases that meets the requirements specified in 42 CFR 440.140(a).

4. Nursing Facilities (NF) Services(MSIS Code=07) (See 42 CFR 440.40 and 440.155).--These are services provided in an institution (or a distinct part of an institution) which:

- o Is primarily engaged in providing to residents:
  - Skilled nursing care and related services for residents who require medical or nursing care;
  - Rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or
  - On a regular basis, health-related care and services to individuals who, because of their mental or physical condition, require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental diseases; and;
- o Meet the requirements for a nursing facility described in subsections 1919(b), (c), and (d) of the Act regarding:
  - Requirements relating to provision of services;
  - Requirements relating to residents' rights; and
  - Requirements relating to administration and other matters.

NOTE: ICF Services - All Other.--This is combined with nursing facility services.

5. ICF Services for the Mentally Retarded(MSIS Code=05) (See 42 CFR 440.150 and Part 483 of Subpart I).--These are services provided in an institution for mentally retarded persons or persons with related conditions if the:

- o Primary purpose of the institution is to provide health or rehabilitative services to such individuals;
- o Institution meets the requirements in 42 CFR 442, Subpart C (certification of ICF/MR); and
- o The mentally retarded recipients for whom payment is requested are receiving active treatment as defined in 42 CFR 483.440(a).

Physicians' Services (MSIS Code=08)(See 42 CFR 440.50).--Whether furnished in a physician's office, a recipient's home, a hospital, a NF, or elsewhere, these are services provided:

- o Within the scope of practice of medicine or osteopathy as defined by State law; and
- o By, or under, the personal supervision of an individual licensed under State law to practice medicine or osteopathy, or dental medicine or dental surgery if State law allows such services to be provided by either a physician or dentist.

7. Outpatient Hospital Services (MSIS Code=11) (See 42 CFR 440.20).--These are preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished:

- o To outpatients;
- o Except in the case of nurse-midwife services (see 42 CFR 440.165), under the direction of a physician or dentist; and
- o By an institution that:
  - Is licensed or formally approved as a hospital by an officially designated authority for State standard setting; and
  - Except in the case of medical supervision of nurse midwife services (see 42 CFR 440.165), meets the requirements for participation in Medicare as a hospital.

8. Prescribed Drugs (MSIS Code=16) (See 42 CFR 440.120(a)).--These are simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease or for health maintenance that are:

- o Prescribed by a physician or other licensed practitioner within the scope of professional practice as defined and limited by Federal and State law;
- o Dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and
- o Dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.

9. Dental Services (MSIS Code=09)(See 42 CFR 440.100 and 42 CFR 440.120 (b)).--These are diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his or her profession, including treatment of:

- o The teeth and associated structures of the oral cavity; and
- o Disease, injury, or an impairment that may affect the oral or general health of the recipient.

A dentist is an individual licensed to practice dentistry or dental surgery. Dental services include dental screening and dental clinic services.

NOTE: Include services related to providing and fitting dentures as dental services. Dentures mean artificial structures made by, or under the direction of, a dentist to replace a full or partial set of teeth.

Dental services do not include services provided as part of inpatient hospital, outpatient hospital, non-dental clinic, or laboratory services and billed by the hospital, non-dental clinic, or laboratory or services which meet the requirements of 42 CFR 440.50(b) (i.e., are provided by a dentist but may be provided by either a dentist or physician under State law).

10. Other Licensed Practitioners' Services (MSIS Code=10)(See 42 CFR 440.60).--These are medical or remedial care or services, other than physician services or services of a dentist, provided by licensed practitioners within the scope of practice as defined under State law. The category "Other Licensed Practitioners' Services" is different than the "Other Care" category. Examples of other practitioners (if covered under State law) are:

    - o Chiropractors;
    - o Podiatrists;
    - o Psychologists; and
    - o Optometrists.

    Other Licensed Practitioners' Services include hearing aids and eyeglasses only if they are billed directly by the professional practitioner. If billed by a physician, they are reported as Physicians' Services. Otherwise, report them under Other Care.

    Other Licensed Practitioners' Services do not include prosthetic devices billed by physicians, laboratory or X-ray services provided by other practitioners, or services of other practitioners that are included in inpatient or outpatient hospital bills. These services are counted under the related type of service as appropriate. Devices billed by providers not included under the listed types of service are counted under Other Care.

    Report Other Licensed Practitioners' Services that are billed by a hospital as inpatient or outpatient services, as appropriate.

    Speech therapists, audiologists, opticians, physical therapists, and occupational therapists are not included within Other Licensed Practitioners' Services.

    Chiropractors' services include only services that are provided by a chiropractor (who is licensed by the State) and consist of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by the State to perform.

11. Clinic Services (MSIS Code=12) (See 42 CFR 440.90).--

    Clinic services include preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that are provided:

    - o To outpatients;
    - o By a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients including services furnished outside the clinic by clinic personnel to individuals without a fixed home or mailing address. For reporting purposes, consider a group of physicians who share, only for mutual convenience, space, services of support staff, etc., as physicians, rather than a clinic, even though they practice under the name of the clinic; and
    - o Except in the case of nurse-midwife services (see 42 CFR 440.165), are furnished by, or under, the direction of a physician.

    NOTE: Place dental clinic services under dental services. Report any services not included above under other care. A clinic staff may include practitioners with different specialities.

12. Laboratory and X-Ray Services(MSIS Code=15) (See 42 CFR 440.30).--These are professional or technical laboratory and radiological services that are:

    - o Ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by State law or ordered and billed by a physician but provided by referral laboratory;
    - o Provided in an office or similar facility other than a hospital inpatient or outpatient department or clinic; and
    - o Provided by a laboratory that meets the requirements for participation in Medicare.

    X-ray services provided by dentists are reported under dental services.

13. Sterilizations (MSIS Code=24) (See 42 CFR 441, Subpart F).--These are medical procedures, treatment or operations for the purpose of rendering an individual permanently incapable of reproducing.

14. Home Health Services (MSIS Code=13) (See 42 CFR 440.70).--These are services provided at the patient's place of residence, in compliance with a physician's written plan of care that is reviewed every 62 days. The following items and services are mandatory.

    - o Nursing services, as defined in the State Nurse Practice Act, that is provided on a part-time or intermittent basis by a home health agency (a public or private agency or organization, or part of any agency or organization, that meets the requirements for participation in Medicare). If there is no agency in the area, a registered nurse who:
        - Is licensed to practice in the State;
        - Receives written orders from the patient's physician;
        - Documents the care and services provided; and
        - Has had orientation to acceptable clinical and administrative record keeping from a health department nurse;
    - o Home health aide services provided by a home health agency; and
    - o Medical supplies, equipment, and appliances suitable for use in the home.

    The following therapy services are optional: physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or by a facility licensed by the State to provide these medical rehabilitation services. (See 42 CFR 441.15.)

    Place of residence is normally interpreted to mean the patient's home and does not apply to hospitals or NFs. Services received in a NF that are different from those normally provided as part of the institution's care may qualify as home health services. For example, a registered nurse may provide short-term care for a recipient in a NF during an acute illness to avoid the recipient's transfer to another NF.

15. Personal Support Services.--Report total unduplicated recipients and payments for services defined in 15a through 15i.

15a. Personal Care Services (MSIS Code=30)(See 42 CFR 440.167).--These are services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are:

- Authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State; and
- Provided by an individual who is qualified to provide such services and who is not a member of the individual's family.

15b. Targeted Case Management Services (MSIS Code=31)(See §1915(g)(2) of the Act).--These are services that are furnished to individuals eligible under the plan to gain access to needed medical, social, educational, and other services. The agency may make available case management services to:

- Specific geographic areas within a State, without regard to statewide requirement in 42 CFR 431.50; and
- Specific groups of individuals eligible for Medicaid, without regard to the comparability requirements in 42 CFR 440.240.

The agency must permit individuals to freely choose any qualified Medicaid provider except when obtaining case management services in accordance with 42 CFR 431.51.

15c. Rehabilitative Services (MSIS Code=33)(See 42 CFR 440.130(d)).--These include any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under State law for maximum reduction of physical or mental disability and restoration of a recipient to his/her best possible functional level.

15d. Physical Therapy, Occupational Therapy, and Services For Individuals With Speech, Hearing, and Language Disorders (MSIS Code=34)(See 42 CFR 440.110).--These are services prescribed by a physician or other licensed practitioner within the scope of his or her practice under State law and provided to a recipient by, or under the direction of, a qualified physical therapist, occupational therapist, speech pathologist, or audiologist. It includes any necessary supplies and equipment.

15e. Hospice Services (MSIS Code=35)(See 42 CFR 418.202).--Whether received in a hospice facility or elsewhere, these are services that are:

- Furnished to a terminally ill individual, as defined in 42 CFR 418.3;
- Furnished by a hospice, as defined in 42 CFR 418.3, that meets the requirements for participation in Medicare specified in 42 CFR 418, Subpart C or by others under an arrangement made by a hospice program that meets those requirements and is a participating Medicaid provider; and
- Furnished under a written plan that is established and periodically reviewed by:
  - The attending physician;
  - The medical director or physician designee of the program, as described in 42 CFR 418.54; and
  - The interdisciplinary group described in 42 CFR 418.68.

15f. Nurse Midwife (MSIS Code=36)(See 42 CFR 440.165 and 441.21).--These are services that are concerned with management and the care of mothers and newborns throughout the maternity cycle and are furnished within the scope of practice authorized by State law or regulation.

15g. Nurse Practitioner (MSIS Code=37) (See 42 CFR 440.166 and 441.22).--These are services furnished by a registered professional nurse who meets State's advanced educational and clinical practice requirements, if any, beyond the 2 to 4 years of basic nursing education required of all registered nurses.

15h. Private Duty Nursing (MSIS Code=38)(See 42 CFR 440.80).--When covered in the State plan, these are services of registered nurses or licensed practical nurses provided under direction of a physician to recipients in their own homes, hospitals or nursing facilities (as specified by the State).

15i. Religious Non-Medical Health Care Institutions (MSIS Code=39)(See 42 CFR 440.170(b)(c)).--These are non-medical health care services equivalent to a hospital or extended care level of care provided in facilities that meet the requirements of Section 1861(ss)(1) of the Act.

16. Other Care (See 42 CFR 440.120(b), (c), and (d), and 440.170(a)).--Report total unduplicated recipients and payments for services in sections 16a, 16b, and 16c. Such services do not meet the definition of, and are not classified under, any of the previously described categories.

16a. Transportation (MSIS Code=26)(See 42 CFR 440.170(a)).--Report totals for services provided under this title to include transportation and other related travel services determined necessary by you to secure medical examinations and treatment for a recipient.

NOTE: Transportation, as defined above, is furnished only by a provider to whom a direct vendor payment can appropriately be made. If other arrangements are made to assure transportation under 42 CFR 431.53, FFP is available as an administrative cost.

16b. Abortions (MSIS Code=25)(See 42 CFR 441, Subpart E).--In accordance with the terms of the DHHS Appropriations Bill and 42 CFR 441, Subpart E, FFP is available for abortions:

- When a physician has certified in writing to the Medicaid agency that, on the basis of his or her professional judgment, the life of the mother would be endangered if the fetus were carried to term; or
- When the abortion is performed to terminate a pregnancy resulting from an act of rape of incest. FFP is not available for an abortion under any other circumstances.

16c. Other Services (MSIS Code=19).--These services do not meet the definitions of any of the previously described service categories. They may include, but are not limited to:

- o Prosthetic devices (see 42 CFR 440.120(c)) which are replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of practice as defined by State law to:
  - Artificially replace a missing portion of the body;
  - Prevent or correct physical deformity or malfunctions; or
  - Support a weak or deformed portion of the body.
- o Eyeglasses (see 42 CFR 440.120 (d)). Eyeglasses mean lenses, including frames, and other aids to vision prescribed by a physician skilled in diseases of the eye or an optician. It includes optician fees for services.
- o Home and Community-Based Waiver services (See §1915(c) of the Act and 42 CFR 440.180) that cannot be associated with other TYPE-OF-SERVICE codes (e.g., community homes for the disabled and adult day care.)

17. Capitated Care (See 42 CFR Part 434).--This includes enrollees and capitated payments for the plan types defined in 17 a and b below. Report unduplicated enrolled eligibles and payments for 17 a and b.

17a. Health Maintenance Organization (HMO) and Health Insuring Organization (HIO)(MSIS Code=20).--These include plans contracted to provide capitated comprehensive services. An HMO is a public or private organization that contracts on a prepaid capitated risk basis to provide a comprehensive set of services and is federally qualified or State-plan defined. An HIO is an entity that provides for or arranges for the provision of care and contracts on a prepaid capitated risk basis to provide a comprehensive set of services.

17b. Prepaid Health Plans (PHP)(MSIS Code=21).--These include plans that are contracted to provide less than comprehensive services. Under a non-risk or risk arrangement, the State may contract with (but not limited to these entities) a physician, physician group, or clinic for a limited range of services under capitation. A PHP is an entity that provides a non-comprehensive set of services on either capitated risk or non-risk basis or the entity provides comprehensive services on a non-risk basis.

NOTE: Include dental, mental health, and other plans covering limited services under PHP.

18. Primary Care Case Management (PCCM) (MSIS Code=22)(See §1915(b)(1) of the Act).--The State contracts directly with primary care providers who agree to be responsible for the provision and/or coordination of medical services to Medicaid recipients under their care. Currently, most PCCM programs pay the primary care physician a monthly case management fee. Report these recipients and associated PCCM fees in this section.

NOTE: Where the fee includes services beyond case management, report the enrollees and fees under prepaid health plans (17b).

SERVICE HIERARCHY

Experience has demonstrated there can be instances when more than one service area category could be applicable for a provided service. The following rules apply to these instances:

- The specific service categories of sterilizations and abortions take precedence over provider categories, such as inpatient hospital or outpatient hospital.

- Services of a physician employed by a clinic are reported under clinic services if the clinic is the billing entity. X-rays processed by the clinic in the course of treatment, however, are reported under X-ray services.

- Services of a registered nurse attending a resident in a NF are reported (if they qualified under the coverage rules) under home health services if they were not billed as part of the NF bill. (See section M.)

MEDICAID STATISTICAL INFORMATION SYSTEM

(MSIS)

Tape Specifications and Data Dictionary Attachments

ATTACHMENT 5 - Program Type Reference

DEFINITIONS OF PROGRAM TYPES

The following definitions describe special Medicaid programs that are coded independently of type of service for MSIS purposes. These programs tend to cover bands of services that cut across many types of service.

Program Type 1. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) (See 42 CFR 440.40(b)).--This includes either general health screening services and vision, dental, and hearing services furnished to Medicaid eligibles under age 21 to fulfill the requirements of the EPSDT program or services rendered based on referrals from EPSDT visits. The Act specifies two sets of EPSDT screenings:

- o Periodic screenings, which are provided at distinct intervals determined by the State, and which must include the following services:
  - A comprehensive health and developmental history assessment (including assessment of both physical and mental health development);
  - A comprehensive unclothed physical exam;
  - Appropriate immunizations according to the Advisory Committee on Immunization Practices schedule;
  - Laboratory tests (including blood lead level assessment); and
  - Health education (including anticipatory guidance); and
- o Interperiodic screenings, which are provided when medically necessary to determine the existence of suspected physical or mental illness or conditions.

Program Type 2. Family Planning (See 42 CFR 440.40(c)).-- Only items and procedures clearly provided or performed for family planning purposes and matched at the 90 percent FFP rate should be included as Family Planning. Services covered under this program include, but are not limited to:

- o Counseling and patient education and treatment furnished by medical professionals in accordance with State law;
- o Laboratory and X-ray services;
- o Medically approved methods, procedures, pharmaceutical supplies, and devices to prevent conception;
- o Natural family planning methods; and
- o Diagnosis and treatment for infertility.

NOTE: CMS's Revised Financial Management Review Guide for Family Planning Services describes items and procedures eligible for the enhanced match as family planning services.

Program Type 3. Rural Health Clinics (RHC)(See 42 CFR 440.20(b)).--These include services (as allowed by State law) furnished by a rural health clinic which has been certified in accordance with the conditions of 42 CFR Part 491 (certification of certain health facilities). Services performed in RHCs include, but are not limited to:

- o Services furnished by a physician within the scope of his or her profession as defined by State law. The physician performs these services in or away from the clinic and has an agreement with the clinic providing that he or she will be paid for these services;

- o Services furnished by a physician assistant, nurse practitioner, nurse midwife, or other specialized nurse practitioner (as defined in 42 CFR 405.2401 and 491.2) if the services are furnished in accordance with the requirements specified in 42 CFR 405.2412(a);

- o Services and supplies provided in conjunction with professional services furnished by a physician, physician assistant, nurse practitioner, nurse midwife, or specialized nurse practitioner. (See 42 CFR 405.2413 and 405.2415 for the criteria determining whether services and supplies are included here.); or

- o Part-time or intermittent visiting nurse care and related medical supplies (other than drugs and biologicals) if:

  - The clinic is located in an area in which the Secretary has determined that there is a shortage of home health agencies (see 42 CFR 405.2417);

  - The services are furnished by a registered nurse or licensed practical or vocational nurse employed, or otherwise compensated for the services, by the clinic;

  - The services are furnished under a written plan of treatment that is either established and reviewed at least every 60 days by a supervising physician of the clinic, or that is established by a physician, physician's assistant, nurse practitioner, nurse midwife, or specialized nurse practitioner and reviewed and approved at least every 60 days by a supervising physician of the clinic; and

  - The services are furnished to a homebound patient. For purposes of visiting nurse services, a homebound recipient means one who is permanently or temporarily confined to a place of residence because of a medical or health condition and leaves the place of residence infrequently. For this purpose, a place of residence does not include a hospital or nursing facility.

Program Type 4. Federally Qualified Health Center (FQHC) (See §1905(a)(2) of the Act).--FQHCs are facilities or programs more commonly known as community health centers, migrant health centers, and health care for the homeless programs. A facility or program qualifies as a FQHC providing services covered under Medicaid if:

- o They receive grants under §§329, 330, or 340 of the Public Health Service Act (PHS);
- o The Health Resources and Services Administration, PHS, certifies the center as meeting FQHC requirements; or
- o The Secretary determines that the center qualifies through waiver of the requirements.

Services performed in FHQCs are defined the same as the services provided by rural health clinics. They may include physician services, services provided by physician assistants, nurse practitioners, clinical psychologists, clinical social workers, and services and supplies incident to such services as are otherwise covered if furnished by a physician or as incident to a physician's services. In certain cases, services to a homebound Medicaid patient may be provided. Any other ambulatory service included in the State's Medicaid plan is considered covered by a FQHC program if the center offers it.

Program Type 5. Indian Health Services (See §1911 of the Act) (See 42 CFR 431.110).--These are services provided by the Indian Health Services (IHS), an agency charged with providing the primary source of health care for American Indian and Alaska Native people who are members of federally recognized tribes and organizations. A State plan must provide that an IHS facility, meeting State plan requirements for Medicaid participants, must be accepted as a Medicaid provider on the same basis as any other qualified provider.

Program Type 6. Home and Community-Based Care for Functionally Disabled Elderly (See §1929 of the Act) and for Individuals Age 65 and Older(MSIS (See 42 CFR 441, Subpart H).--This program is for §1915(d) recipients of home and community-based services for individuals age 65 or older. This is an option within the Medicaid program to provide home and community-based care to functionally disabled individuals age 65 or older who are otherwise eligible for Medicaid or for non-disabled elderly individuals.

Program Type 7. Home and Community-Based Waivers (See §1915(c) of the Act and 42 CFR 440.180).--This program includes services furnished under a waiver approved under the provisions in 42 CFR Part 441, Subpart G (home and community-based services; waiver requirements).