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MEDICAID AND CHIP STATISTICAL INFORMATION SYSTEM

(MSIS)

File Specifications and Data Dictionary

Release 5

February 2014

This release provides additional information for full reporting of person-based eligibility and claims from all Children's Health Insurance Programs (CHIP), regardless of whether it is a Medicaid expansion CHIP (M-CHIP) or a stand-alone, separate CHIP program. Error conditions for data elements related to CHIP reporting have been modified. Clarifications to the reporting of Medicare Coinsurance and Deductible Amounts have been added, and the value set for the reporting of TYPE-OF-SERVICE has been expanded to include reporting of Private Health Insurance.

Additional changes include DIAGNOSIS-CODE and DIAGNOSIS-CODE-FLAG changes to prepare for implementation of ICD-10 on 10/1/2014. Note that the actual implementation of the changes related to ICD-10 does not take place before 10/1/2014.

February 2014 - Changes include adding a data element in the Eligibility (EL) type quarterly file transmissions delivered to CMS. The new element is the 'T-MSIS ELIGIBILITY-GROUP' This change enables states to have the ability to send the T-MSIS Eligibility Group (representing ACA expanded Medicaid eligibility groups) data element within the current MSIS application.

Prepared by:

Centers for Medicare and Medicaid Services
Center for Medicaid and CHIP Services
and
Office of Information Services

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1. INTRODUCTION

1.1 General Overview and Data Security Policy

This document provides State Medicaid and Chidren's Health Insurance Program (CHIP)agency staffs with the information they need to prepare and submit MSIS files. Since MSIS files contain personal information on Medicaid enrollees, CHIP Medicaid expansion enrollees and separate (stand-alone) CHIP enrollees, the data are subject to the Privacy Act and must be safeguarded. For this reason, all MSIS files must be encrypted before they are submitted to CMS. CMS has selected SecureZip from PKWARE as the software solution for encryption of data containing personally identifiable information. This product will allow CMS to receive MSIS data from the mainframe or mid-tier platforms of our external partner's choice.

In order for our external partners to encrypt the data files, they will be required to install the SecureZIP Partner software, a solution which enables the secure exchange of data files between a sponsor (CMS) and its external partners (States and/or contractors).

All CMS partners will be required to have the SecureZIP Partner Link software, which is provided at no cost. To register for the SecureZIP Partner software, go to PKWARE's website:

http://securezippartner.pkware.com/

This URL will allow for the download of the software for each platform on which you plan to encrypt and send the MSIS data. The following *Sponsor* (CMS) ID number: 7708 will need to be entered. If you need assistance with becoming a registered *Partner* with CMS, PKWARE can be contacted via the information listed below.

Normal Business Hours (8:00am – 6:00pm CST)
Phone: 1-937-847-2687
Email: partnersupport@pkware.com

24x7 Priority Support
Phone: 1-937-847-6149

The Sponsor Distribution Package is a Binary File/Key that is needed to prepare encrypted MSIS data files for CMS. This license known as Partner Link is downloadable from PKWARE's site on the Internet and it is limited for just CMS business.

Once MSIS data files have been encrypted with Secure Zip, there are two methods available to send the information to CMS. One is the existing tape submission process (mail and login sheet) and the other is electronic file transfer (EFT) process either through Connect:Direct or the alternative TIBCO Software, Inc. (TIBCO) suite of products.

This document:

- defines terms;
- identifies responsibilities;
- describes the record layouts of the five primary MSIS data files;
- characterizes data formatting requirements and validation rules; and
- describes the methods for encryption and/or tape versus electronic file transfer (EFT).

This document is a reference for the creation of quarterly Eligibles and Claims 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 file that is found to contain errors in excess of the tolerances documented in the following sections will require the State to make corrections and resubmit the file.

1.2 Terms and Abbreviations

Acronym/Abbreviation	Description
ANSI	American National Standards Institute
CMS	Centers for Medicare and Medicaid Services
CMCS	Center for Medicaid, CHIP and Surveys and Certifications
COBOL	Common Business Oriented Language
DSN	Data Set Name
EFT	Electronic File Transfer
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.
M-CHIP	Medicaid Expansion CHIP (Children's Health Insurance Program)
MSIS	Medicaid Statistical Information System
MMIS	Medicaid Management Information System
OIS	Office of Information Services
OS	Operating System
CHIP	Stand-alone, separate CHIP (Children's Health Insurance Program)

1.3 Delivery Schedules

Quarterly Eligible and Claims files, whether they be in the form of tape or EFT submissions, 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	01/15
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 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.

1.5 MSIS Contacts for Assistance - MSIS central E-mail address:

MSIS@CMS.HHS.GOV

Questions may also be directed to the following individuals:

MSIS State Participation and Project Management:
Loretta Schickner
Loretta.Schickner@cms.hhs.gov
(410) 786-5151

MSIS technical contact:
Kathy Ranshous
Kathy.Ranshous@cms.hhs.gov
(410) 786-0958

1.6 Electronic File Transmission (EFT)

EFT is utilized by all States using one of two processes, Connect:Direct or TIBCO products.

The first process is the Connect:Direct process, which has been in use for many years by States to transmit State buy in data and MMA files to CMS. Connect:Direct is free of charge to all of CMS' external partners, as long as they currently hold a license.. The other process used is the Gentran process which is a suite of file transfer software products from TIBCO. The suite of products are licensed by CMS and are provided free of charge to CMS' external business partners. This process allows the state to exchange files in a secure manner over the Internet using inexpensive, readily available client software at the States.

Regardless of which process is used, all of the procedures for encrypting the files through the Secure Zip process up to the point of tape submission remain the same. The only exceptions are that the tape login sheet does not need to be prepared and the dataset name (DSN) for a SecureZipped file that will be transmitted electronically is different. For the EFT process, the following DSN should be used for the name of the SecureZipped file:

P#MSI.@MSIS.st.YccyyQn.ft.EFT

where st = State abbreviation, ccyy = federal fiscal year, n = quarter number from 1 to 4, and ft = the 2 position alpha abbreviation for the file type (EL, IP, LT, OT or RX).

Any questions regarding the processing of Secure Zip files may be directed to the CMS Help Desk at 410-786-2580 or sent to the EFT mailbox at EFT_ADMIN@CMS.HHS.GOV

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. See Section 4.1 (File Formats) for an illustration of 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, the Physical record layouts reflect the order in which fields are physically stored in file records.

   Relational edits involve comparisons of values in two or more fields. These are evaluated when 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 requires 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. Files 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 rationale or formula;

States receive a Validation Report from the MSIS system **ONLY** when files fail the CMS validation edits. 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. FILE FORMATS

CMS no longer accepts tape files.

4.1 Dataset Name Specifications

- The dataset name (DSN) is required to follow the following standard naming convention:

  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., "1999")

  "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 1999, Quarter 4 file of non-institutional claims would have a dataset name of "MW00.CA.YR1999.QTR4.CLAIMOT ".

4.2 Record Length Specifications

Record Length depends on file type, as follows:

File Name	Record Length
ELIGIBLE	375
CLAIMIP	840
CLAIMLT	300
CLAIMOT	280
CLAIMRX	250

4.3 HEADER Record Specifications

The first data record of every MSIS file is a Header Record. The Header Record contains file identification information required for accurate validation of the file 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(802)	39	840
(CLAIMLT)	X(262)	39	300
(CLAIMOT)	X(242)	39	280
(CLAIMRX)	X(212)	39	250

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 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 Dataset Name indicates that the reporting quarter is Quarter 3 of federal fiscal year 2008. The actual start and end dates of this quarter are April 1, 2008 and June 30, 2008, respectively. END-OF-TIME-PERIOD may be any date between June 15, 2008 and July 15, 2008 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 CLAIMIP, CLAIMLT, CLAIMOT, and CLAIMRX 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 = 01, 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 26, 30, 31, 33 through 39.
CLAIMRX	Pharmacy Claims/Encounters File - Claims/encounters with TYPE-OF-SERVICE 16 or 19.

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 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 Production File - ELIGIBLE Production Files must contain:

- one record for each person who was eligible for Medicaid or CHIP 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”	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 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 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 or CHIP for at least one day during the reporting quarter covered by this file;
- 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
1	34567584323569	872	1
2	45673848569310	863	2
3	45673848569310	864	3
4	45673848569310	872	3
5	45673848569310	872	2
6	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. Fields whose values remain fixed for an entire quarter are referred to as quarterly fields; fields that vary monthly are listed separately for each month.

ELIGIBLE RECORD SUMMARY

FIELD NAME	COBOL PICTURE	- POSITION - START	END	DEFAULT ERROR TOLERANCE
QUARTERLY 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	X(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%
CHIP-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%
T-MSIS-ELIGIBILITY-GROUP	X(2)	186	187	2.0%
FILLER	X(6)	188	193	

ELIGIBLE RECORD SUMMARY

FIELD NAME	COBOL PICTURE	- POSITION - START	END	DEFAULT 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	X(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%
CHIP-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%
T-MSIS-ELIGIBILITY-GROUP	X(2)	277	278	2.0%
FILLER	X(6)	279	284	

ELIGIBLE RECORD SUMMARY

FIELD NAME MONTHLY FIELDS	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	X(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%
CHIP-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%
T-MSIS-ELIGIBILITY-GROUP	X(2)	368	369	2.0%
FILLER	X(6)	370	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.

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 2 (Comprehensive Eligibility Crosswalk) FOR DEFINITIONS OF MSIS CODING CATEGORIES

0	Individual was not eligible for Medicaid (or Medicaid expansion CHIP(M-CHIP)) at any time during the month, or Individual WAS eligible for separate CHIP.
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 or M-CHIP for at least one day during the FEDERAL-FISCAL-YEAR-QUARTER, or who are included as non-Medicaid, separate CHIP individuals.

Error Condition	Resulting Error Code
1. Value is ‘9'-filled	301
2. Value not equal to ‘0', ‘1, ‘2', ‘4', ‘5', ‘6', ‘7', ‘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 AND CHIP-CODE <> ‘3’	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: CHIP-CODE

Definition: Monthly Field - A code indicating the individual's inclusion in the CHIP 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 (including M-CHIP) and not eligible for separate CHIP for the month.
1	Individual was Medicaid eligible, but was not included in either Medicaid expansion CHIP (M-CHIP) OR a separate title XXI CHIP program for the month
2	Individual was included in the Medicaid expansion CHIP program (M-CHIP) and subject to enhanced Federal matching for the month
3	Individual was not Medicaid (or M-CHIP) eligible, but was included in a separate title XXI CHIP program for the month.
9	CHIP 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 = '1' OR '2' AND DAYS-OF-ELIGIBILITY = +00	502
5. 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: COUNTY-CODE

Definition: Quarterly Field - FIPS code indicating eligible individual'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: Quarterly Field – Eligible individual'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: Quarterly Field – Eligible individual'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 or CHIP 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 or CHIP 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
02	Eligible is entitled to Medicare- QMB AND Medicaid coverage including RX
03	Eligible is entitled to Medicare- SLMB only
04	Eligible is entitled to Medicare- SLMB AND Medicaid coverage including RX
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
09	Eligible is entitled to Medicare – Other Dual Eligibles
10	Separate CHIP Eligible is entitled to Medicare
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.**

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.

ELIGIBLE FILE

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

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. Individuals in this group qualify for one or more Medicaid benefits excluding prescription drug coverage benefits. Medicaid pays their Medicare Part B premiums and provides one or more Medicaid benefits**.**

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. 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. 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.

10. **Separate CHIP Dual Eligibles –** These individuals are entitled to Medicare Part A and/or Part B and are eligible for separate CHIP benefits.

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 = 07 OR Value is > 10 AND <99	203
4. Relational Field in Error	999
5. If Value={01, 03, 05, OR 06} AND MAINTENANCE-ASSISTANCE-STATUS <>"3"	503

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.

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 CHIP-CODE <> ‘3’	502
5. Value = “000000" AND DAYS-OF-ELIGIBILITY NOT = +00 AND CHIP-CODE <> ‘3’	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: Quarterly 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

ELIGIBLE FILE

Data Element Name: FEDERAL-FISCAL-YEAR-QUARTER

Definition: Quarterly 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 (individual or employer sponsored) health insurance coverage during the month. This includes both coverage purchased or subsidized by the State, purchased by the eligible or a family member, or provided at no cost to the eligible. 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 or CHIP during month
1	Eligible did not have private (individual or employer-sponsored) insurance coverage
2	Eligible had private (individual or employer-sponsored) health insurance coverage purchased whole or in part by eligible or family member, or provided at no cost to eligible
3	Eligible had private (individual or employer-sponsored) health insurance coverage purchased, or subsidized, by the State
4	Both 2 and 3 apply
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 CHIP-CODE <> '3'	502
6. Value = 0 AND DAYS-OF-ELIGIBILITY NOT = +00 AND CHIP-CODE <> '3'	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: Quarterly 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-CODE = {01,02,03,04,05,06, 08,09 OR 10}	537

ELIGIBLE FILE

Data Element Name: INCOME-CODE

Definition: Monthly Field - (OPTIONAL FIELD) A code indicating the family income level associated with the CHIP program reporting requirements for the month. Each code range is specified in relation to the Federal Poverty Level (FPL). This code is to be reported for Medicaid expansion CHIP (M-CHIP) enrollees and non-Medicaid,separate CHIP 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 CHIP for the month
01	Individual's family income is from 0 to 100% of the FPL for the month
02	Individual's family income is from 101 to 200% of the FPL for the month
03	Individual's family income is from 201 to 250% of the FPL for the month
04	Individual's family income is from 251 to 300% of the FPL for the month
05	Individual's family income is over 300 to a State-specified % FLP for the month
09	Individual's State-defined family income is UNKNOWN for the month
88	Individual was eligible for Medicaid, but not enrolled in the M-CHIP or separate CHIP program for the month

.

Error Condition	Resulting Error Code
1. Value is '09'-filled	301
2. Value not equal to '00, '01', '02', '03', '04', '05' 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 2 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 (or M-CHIP) this month. Individual was elgible for separate CHIP 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 AND CHIP-CODE <> '3'	502
5. Value is '0' AND DAYS-OF-ELIGIBILITY NOT = +00 AND CHIP-CODE <> '3'	502
6. Value is = '1', '2', '3', '4', or '5' in any month later than the month that included DATE-OF-DEATH	504

ELIGIBLE FILE

Data Element Name: MSIS-CASE-NUMBER

Definition: Quarterly Field - The state-assigned number which uniquely identifies the 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, 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 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: Quarterly Field - A unique identification number used to identify a Medicaid or CHIP 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 or CHIP 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 CHIP-CODE <> ‘3’	502
3. Value is = “000000000000" AND DAYS-OF-ELIGIBILITY NOT = +00 AND CHIP-CODE <> “3”	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

ELIGIBLE FILE

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 or CHIP 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 OR CHIP, but is NOT enrolled in a managed care plan this month
99	Eligible's managed care plan status is unknown.

Error Condition Code		Resulting Error
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 CHIP-CODE <> '3'	502
6.	Value = 00 AND DAYS-OF-ELIGIBILITY <> +00 AND CHIP-CODE <> '3'	502
7.	Value is > 00 in any month later than the month that included DATE-OF-DEATH	504

ELIGIBLE FILE

Data Element Name: RACE-CODE-1

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

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

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

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 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: Quarterly Field - A code indicating the eligible individual'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 or CHIP during the month.
1	Individual is eligible for Medicaid or CHIP and entitled to the full scope of Medicaid or CHIP benefits.
2	Individual is eligible for Medicaid or M-CHIP, 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 or CHIP but only entitled to restricted benefits for pregnancy-related services.
5	Individual is eligible for Medicaid or M-CHIP 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 or M-CHIP 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, as enacted by the Deficit Reduction Act of 2005.
8	Individual is eligible for Medicaid and entitled to benefits under a “Money Follows the Person” (MFP) rebalancing demonstration, as enacted by the Deficit Reduction Act of 2005, to allow States to develop community based long term care opportunities.
9	Individual's benefit restrictions are unknown.
A	Individual is eligible for Medicaid and entitled to benefits under the Psychiatric Residential Treatment Facilities Demonstration Grant Program (PRTF), as enacted by the Deficit Reduction Act of 2005. PRTF grants assist States to help provide community alternatives to psychiatric resident treatment facilities for children.
B	Individual is eligible for Medicaid and entitled to Medicaid benefits using a Health Opportunity Account (HOA)
C	Individual is eligible for separate CHIP dental coverage (supplemental dental wraparound benefit to employer-sponsored insurance)

Error Condition	Resulting Error Code
1. Value is SPACE FILLED	303
2. Value is 9	301
3. Value is < 0 OR Value is > 8 and not = A, B or C	203

ELIGIBLE FILE

Data Element Name: SEX-CODE

Definition: Quarterly 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: Quarterly 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: T-MSIS-ELIGIBILITY-GROUP

Definition: Monthly Field – The eligibility group applicable to the individual based on the eligibility determination process. The valid value list of eligibility groups aligns with those being used in the Medicaid and CHIP Program Data System (MACPro).

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(2)	2.0%	'29'

Coding Requirements:

1. Value must be equal to a valid value. (See: 'Attachment 5 – T-MSIS Eligibility Group Valid Values Table')

Error Condition	Resulting Error Code
1. Value is not included in the valid code list.	201
2. Value is blank but DAYS-OF-ELIGIBILITY <> +00	502
3. Value present and not 72, 73, 74 or 75 but DAYS-OF-ELIGIBILITY = +00	502

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 or CHIP 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.
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 CHIP-CODE <> '3'	502
6. Value = 0 AND DAYS-OF-ELIGIBILITY <> +00 AND CHIP-CODE <> '3'	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: Quarterly 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 or CHIP 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 CHIP-CODE <> ‘3’	502
4. Value is = “00" AND DAYS-OF-ELIGIBILITY NOT = +00 AND CHIP-CODE <> ‘3’	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

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 or CHIP 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, state wideness, 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 or CHIP, 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.

Error Condition Code		Resulting Error
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 CHIP-CODE <> ‘3’	502
5.	Value = 0 AND DAYS-OF-ELIGIBILITY <> +00 AND CHIP-CODE <> ‘3’	502

ELIGIBLE FILE

Data Element Name: ZIP-CODE

Definition: Quarterly 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 CLAIMS 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 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 or C), 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.

Include any claim that relates to covered Medicaid or CHIP services. Do not include any claim 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 or for all non-claims based service expenditures such as DSH payments, drug rebates and year end settlements. Do not include buy-in payments or payments for claims processing administration. 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). In addition claim types have been added for separate CHIP claims such as fee for service claims (TYPE OF CLAIM=A), capitated payments (TYPE-OF-CLAIM=B), encounter separate CHIP claims (TYPE-OF-CLAIM=3), service tracking claims (TYPE OF CLAIM=D) and adjustment separate CHIP claims (TYPE-OF-CLAIM=E).

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 or CHIP 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 or Title XXI 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 or Title XXI 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 or CHIP 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 or Title XXI 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 or Title XXI 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.

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(7)**	**111**	**117**	**5.0%**
DIAGNOSIS-CODE-FLAG-1	**X(1)**	**118**	**118**	**5.0%**
DIAGNOSIS-CODE-2	**X(7)**	**119**	**125**	**5.0%**
DIAGNOSIS-CODE-FLAG-2	**X(1)**	**126**	**126**	**5.0%**
DIAGNOSIS-CODE-3	**X(7)**	**127**	**133**	**5.0%**
DIAGNOSIS-CODE-FLAG-3	**X(1)**	**134**	**134**	**5.0%**
DIAGNOSIS-CODE-4	**X(7)**	**135**	**141**	**5.0%**
DIAGNOSIS-CODE-FLAG-4	**X(1)**	**142**	**142**	**5.0%**
DIAGNOSIS-CODE-5	**X(7)**	**143**	**149**	**5.0%**
DIAGNOSIS-CODE-FLAG-5	**X(1)**	**150**	**150**	**5.0%**
DIAGNOSIS-CODE-6	**X(7)**	**151**	**157**	**5.0%**
DIAGNOSIS-CODE-FLAG-6	**X(1)**	**158**	**158**	**5.0%**
DIAGNOSIS-CODE-7	**X(7)**	**159**	**165**	**5.0%**
DIAGNOSIS-CODE-FLAG-7	**X(1)**	**166**	**166**	**5.0%**
DIAGNOSIS-CODE-8	**X(7)**	**167**	**173**	**5.0%**
DIAGNOSIS-CODE-FLAG-8	**X(1)**	**174**	**174**	**5.0%**
DIAGNOSIS-CODE-9	**X(7)**	**175**	**181**	**5.0%**
DIAGNOSIS-CODE-FLAG-9	**X(1)**	**182**	**182**	**5.0%**
PROC-CODE-PRINCIPAL	X(8)	183	190	5.0%
PROC-CODE-FLAG-PRINCIPAL	9(2)	191	192	5.0%
PROC-CODE-MOD-PRINCIPAL	X(2)	193	194	5.0%
PROC-CODE-2	X(8)	195	202	5.0%
PROC-CODE-FLAG-2	9(2)	203	204	5.0%
PROC-CODE-MOD-2	X(2)	205	206	5.0%
PROC-CODE-3	X(8)	207	214	5.0%
PROC-CODE-FLAG-3	9(2)	215	216	5.0%
PROC-CODE-MOD-3	X(2)	217	218	5.0%
PROC-CODE-4	X(8)	219	226	5.0%
PROC-CODE-FLAG-4	9(2)	227	228	5.0%
PROC-CODE-MOD-4	X(2)	229	230	5.0%
PROC-CODE-5	X(8)	231	238	5.0%
PROC-CODE-FLAG-5	9(2)	239	240	5.0%
PROC-CODE-MOD-5	X(2)	241	242	5.0%

6.5.1 CLAIMIP Physical Record Layout (continued):

CLAIMIP RECORD SUMMARY - continued

FIELD NAME	COBOL PICTURE	- POSITION - START	END	DEFAULT ERROR TOLERANCE
PROC-CODE-6	X(8)	243	250	5.0%
PROC-CODE-FLAG-6	9(2)	251	252	5.0%
PROC-CODE-MOD-6	X(2)	253	254	5.0%
ADMISSION-DATE	9(8)	255	262	5.0%
PATIENT-STATUS	9(2)	263	264	5.0%
DIAGNOSIS-RELATED-GROUP(DRG)	9(4)	265	268	100.0%
DIAGNOSIS-RELATED-GROUP-INDICATOR	X(4)	269	272	100.0%
PROC-DATE-PRINCIPAL	9(8)	273	280	5.0%
UB-REV-CODE-1	9(4)	281	284	5.0%
UB-REV-UNITS-1	S9(7)	285	291	5.0%
UB-REV-CHARGE-1	S9(8)	292	299	5.0%
UB-REV-CODE-2	9(4)	300	303	5.0%
UB-REV-UNITS-2	S9(7)	304	310	5.0%
UB-REV-CHARGE-2	S9(8)	311	318	5.0%
UB-REV-CODE-3	9(4)	319	322	5.0%
UB-REV-UNITS-3	S9(7)	323	329	5.0%
UB-REV-CHARGE-3	S9(8)	330	337	5.0%
UB-REV-CODE-4	9(4)	338	341	5.0%
UB-REV-UNITS-4	S9(7)	342	348	5.0%
UB-REV-CHARGE-4	S9(8)	349	356	5.0%
UB-REV-CODE-5	9(4)	357	360	5.0%
UB-REV-UNITS-5	S9(7)	361	367	5.0%
UB-REV-CHARGE-5	S9(8)	368	375	5.0%
UB-REV-CODE-6	9(4)	376	379	5.0%
UB-REV-UNITS-6	S9(7)	380	386	5.0%
UB-REV-CHARGE-6	S9(8)	387	394	5.0%
UB-REV-CODE-7	9(4)	395	398	5.0%
UB-REV-UNITS-7	S9(7)	399	405	5.0%
UB-REV-CHARGE-7	S9(8)	406	413	5.0%
UB-REV-CODE-8	9(4)	414	417	5.0%
UB-REV-UNITS-8	S9(7)	418	424	5.0%
UB-REV-CHARGE-8	S9(8)	425	432	5.0%
UB-REV-CODE-9	9(4)	433	436	5.0%
UB-REV-UNITS-9	S9(7)	437	443	5.0%
UB-REV-CHARGE-9	S9(8)	444	451	5.0%
UB-REV-CODE-10	9(4)	452	455	5.0%
UB-REV-UNITS-10	S9(7)	456	462	5.0%
UB-REV-CHARGE-10	S9(8)	463	470	5.0%
UB-REV-CODE-11	9(4)	471	474	5.0%
UB-REV-UNITS-11	S9(7)	475	481	5.0%
UB-REV-CHARGE-11	S9(8)	482	489	5.0%
UB-REV-CODE-12	9(4)	490	493	5.0%
UB-REV-UNITS-12	S9(7)	494	500	5.0%
UB-REV-CHARGE-12	S9(8)	501	508	5.0%
UB-REV-CODE-13	9(4)	509	512	5.0%
UB-REV-UNITS-13	S9(7)	513	519	5.0%
UB-REV-CHARGE-13	S9(8)	520	527	5.0%
UB-REV-CODE-14	9(4)	528	531	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-UNITS-14	S9(7)	532	538	5.0%
UB-REV-CHARGE-14	S9(8)	539	546	5.0%
UB-REV-CODE-15	9(4)	547	550	5.0%
UB-REV-UNITS-15	S9(7)	551	557	5.0%
UB-REV-CHARGE-15	S9(8)	558	565	5.0%
UB-REV-CODE-16	9(4)	566	569	5.0%
UB-REV-UNITS-16	S9(7)	570	576	5.0%
UB-REV-CHARGE-16	S9(8)	577	584	5.0%
UB-REV-CODE-17	9(4)	585	588	5.0%
UB-REV-UNITS-17	S9(7)	589	595	5.0%
UB-REV-CHARGE-17	S9(8)	596	603	5.0%
UB-REV-CODE-18	9(4)	604	607	5.0%
UB-REV-UNITS-18	S9(7)	608	614	5.0%
UB-REV-CHARGE-18	S9(8)	615	622	5.0%
UB-REV-CODE-19	9(4)	623	626	5.0%
UB-REV-UNITS-19	S9(7)	627	633	5.0%
UB-REV-CHARGE-19	S9(8)	634	641	5.0%
UB-REV-CODE-20	9(4)	642	645	5.0%
UB-REV-UNITS-20	S9(7)	646	652	5.0%
UB-REV-CHARGE-20	S9(8)	653	660	5.0%
UB-REV-CODE-21	9(4)	661	664	5.0%
UB-REV-UNITS-21	S9(7)	665	671	5.0%
UB-REV-CHARGE-21	S9(8)	672	679	5.0%
UB-REV-CODE-22	9(4)	680	683	5.0%
UB-REV-UNITS-22	S9(7)	684	690	5.0%
UB-REV-CHARGE-22	S9(8)	691	698	5.0%
UB-REV-CODE-23	9(4)	699	702	5.0%
UB-REV-UNITS-23	S9(7)	703	709	5.0%
UB-REV-CHARGE-23	S9(8)	710	717	5.0%
NATIONAL-PROVIDER-ID	X(12)	718	729	5.0%
PROVIDER-TAXONOMY	X(12)	730	741	5.0%
INTERNAL-CONTROL-NUMBER-ORIG	X(21)	742	762	5.0%
INTERNAL CONTROL-NUMBER-ADJ	X(21)	763	783	5.0%
FILLER	X(57)	784	840	

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(7)**	**111**	**117**	**5.0%**
DIAGNOSIS-CODE-FLAG-1	**X(1)**	**118**	**118**	**5.0%**
DIAGNOSIS-CODE-2	**X(7)**	**119**	**125**	**5.0%**
DIAGNOSIS-CODE-FLAG-2	**X(1)**	**126**	**126**	**5.0%**
DIAGNOSIS-CODE-3	**X(7)**	**127**	**133**	**5.0%**
DIAGNOSIS-CODE-FLAG-3	**X(1)**	**134**	**134**	**5.0%**
DIAGNOSIS-CODE-4	**X(7)**	**135**	**141**	**5.0%**
DIAGNOSIS-CODE-FLAG-4	**X(1)**	**142**	**142**	**5.0%**
DIAGNOSIS-CODE-5	**X(7)**	**143**	**149**	**5.0%**
DIAGNOSIS-CODE-FLAG-5	**X(1)**	**150**	**150**	**5.0%**
ADMISSION-DATE	9(8)	151	158	5.0%
PATIENT-STATUS	9(2)	159	160	5.0%
ICF-MR-DAYS	S9(5)	161	165	2.0%
LEAVE-DAYS	S9(5)	166	170	5.0%
NURSING-FACILITY-DAYS	S9(5)	171	175	2.0%
PATIENT-LIABILITY	S9(6)	176	181	2.0%
NATIONAL-PROVIDER-ID	X(12)	182	193	5.0%
PROVIDER-TAXONOMY	X(12)	194	205	5.0%
INTERNAL-CONTROL-NUMBER-ORIG	X(21)	206	226	5.0%
INTERNAL CONTROL-NUMBER-ADJ	X(21)	227	247	5.0%
FILLER	X(53)	248	300	

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(7)**	**111**	**117**	**5.0%**
DIAGNOSIS-CODE-FLAG-1	**X(1)**	**118**	**118**	**5.0%**
DIAGNOSIS-CODE-2	**X(7)**	**119**	**125**	**5.0%**
DIAGNOSIS-CODE-FLAG-2	**X(1)**	**126**	**126**	**5.0%**
PLACE-OF-SERVICE	9(2)	127	128	5.0%
SPECIALTY-CODE	X(4)	129	132	100.0%
SERVICE-CODE	X(8)	133	140	5.0%
SERVICE-CODE-FLAG	9(2)	141	142	5.0%
SERVICE-CODE-MOD	X(2)	143	144	5.0%
UB-92-REVENUE-CODE	9(4)	145	148	100.0%
PROVIDER-ID-NUMBER-SERVICING	X(12)	149	160	5.0%
NATIONAL-PROVIDER-ID	X(12)	161	172	5.0%
PROVIDER-TAXONOMY	X(12)	173	184	5.0%
INTERNAL-CONTROL-NUMBER-ORIG	X(21)	185	205	5.0%
LINE-NUMBER-ORIG	9(3)	206	208	5.0%
INTERNAL CONTROL-NUMBER-ADJ	X(21)	209	229	5.0%
LINE-NUMBER-ADJ	9(3)	230	232	5.0%
FILLER	X(48)	233	280	

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%
NATIONAL-PROVIDER-ID	X(12)	138	149	5.0%
PROVIDER-TAXONOMY	X(12)	150	161	5.0%
INTERNAL-CONTROL-NUMBER-ORIG	X(21)	162	182	5.0%
INTERNAL CONTROL-NUMBER-ADJ	X(21)	183	203	5.0%
FILLER	X(47)	204	250	

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.

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 type 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

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

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 or C (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, 22 or 23, 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, 23} AND TYPE-OF-CLAIM<>3 AND TYPE-OF-CLAIM <> ‘C’ 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

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, 23}	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 or C); 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%	031

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

Data Element Name: DIAGNOSIS-CODE-PRINCIPAL

Definition: CLAIMIP - The ICD-9/10-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(7)	5.0%	“V8319 “

Coding Requirements:

Code full valid ICD-9/10-CM codes without a decimal point. For example: 210.5 is coded as "2105 “. Include all digits where applicable. ICD-9 codes are up to 5 positions long. ICD-10 codes are up to 7 positions long. Both ICD-9-CM and ICD-10-CM have a minimum length of 3 positions. Embedded blanks are not allowed.

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

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. First character of Value is not {"0" through "9", or alpha character}.....101
2. Second or third character of Value is not {"0" through "9"}.....101
3. Fourth or fifth character of Value is not {" " or "0" through "9"}..... 101
4. Fourth character of Value = " " AND fifth character of Value <> " "..... 101
5. Sixth or seventh character of Value <>“ ” and DIAGNOSIS-CODE-FLAG-1 = 9 101
6. Fifth character of value = “ “ and sixth character of Value <> “ ” and DIAGNOSIS-CODE-FLAG-1 = 0 101
7. Sixth character of value = “ “ and seventh character of Value <> “ ” and DIAGNOSIS-CODE-FLAG-1 = 0 101
8. Value = “9999999”.....301
9. Value= “ “ 303
10. Value = “8888888”.....305
11. Relational Field in Error.....999
    (will be issued when diagnosis code is NOT blank and the corresponding diagnosis code flag IS blank)

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

Definition: DIAGNOSIS-CODE-1 through DIAGNOSIS-CODE-2: CLAIMIP, CLAIMLT, CLAIMOT - The ICD-9/10-CM code for the primary and secondary diagnosis for this claim (For CLAIMIP, DIAGNOSIS-CODE-PRINCIPAL is used in place of DIAGNOSIS-CODE-1).

DIAGNOSIS-CODE-3 through DIAGNOSIS-CODE-5: CLAIMIP, CLAIMLT - The third through fifth ICD-9/10-CM codes that appear on the claim.

DIAGNOSIS-CODE-6 through DIAGNOSIS-CODE-9: CLAIMIP- The sixth through ninth ICD-9/10-CM codes that appear on the claim.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(7)	5.0%	“V8319 “

Coding Requirements:

Code valid ICD-9/10-CM codes (up to nine occurrences, depending on file type) without a decimal point. For example: 210.5 is coded as "2105 “. Include all digits where applicable. ICD-9 codes are up to 5 positions long. ICD-10 codes are up to 7 positions long. Both ICD-9-CM and ICD-10-CM have a minimum length of 3 positions. Embedded blanks are not allowed.

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".

CLAIMOT: Code Specific ICD-9/10-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 tolerance for this field will be adjusted on a State-specific basis to accommodate the absence of diagnosis codes.

CLAIMLT/CLAIMIP: Provide diagnosis coding as submitted on bill.

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 = “8888888".....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 or seventh character of Value <>“ ”AND DIAGNOSIS-CODE-FLAG (1-9) = 9…...101

8. Value <> ‘blank’ AND fifth character of Value = “ “AND sixth character of Value <> “ “ AND DIAGNOSIS-CODE-FLAG (1-9) = 0……..……101

9. Value <> ‘blank’ AND sixth character of Value = “ “AND seventh character of Value <> “ “ AND DIAGNOSIS-CODE-FLAG (1-9) = 0……..……101

10. Value Diagnosis-Code-1= “blank”……..……303

11. Value <> “blank” AND preceding DIAGNOSIS-CODE value(s) = “blank”.....542

12. Value appears in preceding field……..……...542

13. Relational field in error……..……..……...999
(will be issued when diagnosis code is NOT blank and the corresponding diagnosis code flag IS blank)

Data Element Name: DIAGNOSIS-CODE-FLAG (1) THRU DIAGNOSIS-CODE-FLAG (9)

Definition: CLAIMIP, CLAIMLT, CLAIMOT - A flag that identifies the coding system used for the DIAGNOSIS CODE 1 - 9.

DIAGNOSIS-CODE-FLAG-1 through DIAGNOSIS-CODE-FLAG-2: CLAIMIP, CLAIMLT, CLAIMOT – Code flag for the Primary and Second ICD-9/10-CM code found on the claim.

DIAGNOSIS-CODE-FLAG-3 through DIAGNOSIS-CODE-FLAG-5: CLAIMIP, CLAIMLT – Code flag for the third through fifth ICD-9/10-CM codes that appear on the claim.

DIAGNOSIS-CODE-FLAG-6 through DIAGNOSIS-CODE-FLAG9: CLAIMIP- Code flag for the sixth through ninth ICD-9/10-CM codes that appear on the claim.

For implementation date edits, Beginning Date of Service will be used for OT claims, and Ending Date of Service will be used for IP and LT claims. This is to be in alignment with the Medicare requirements.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(01)	5.0%	"0"

Coding Requirements: Required.

Valid Values	Code Definition
9	ICD-9
0	ICD-10

If the diagnosis code is blank-filled, then the corresponding diagnosis code flag should also be blank-filled. Any diagnosis code that IS NOT blank MUST have a diagnosis code flag that is either '9' or '0'.

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

Error Condition — Resulting Error Code

1. For OT Claims, Value = 0 AND Coding Scheme has not yet been implemented 511
(BEGINNING-DATE-OF-SERVICE < implementation date of 10/01/2014)

2. For IP and LT Claims, Value = 0 AND Coding Scheme has not yet been implemented.....517
(ENDING-DATE-OF-SERVICE < implementation date of 10/01/2014)

3. For OT Claims, Value = 9 AND Coding Scheme has been retired 511
(BEGINNING-DATE-OF-SERVICE >= implementation date of 10/01/2014)

4. For IP and LT Claims, Value = 9 AND Coding Scheme has been retired.....517
(ENDING-DATE-OF-SERVICE >= implementation date of 10/01/2014)

5. Relational field in error.....999
(will be issued when diagnosis code is NOT blank and the corresponding diagnosis code flag IS blank, Or

Beginning date of service is in error (OT claims) or Ending Date of Service is in error (IP and LT claims))

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%	0370

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, 23}	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%	+00014

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: INTERNAL-CONTROL-NUMBER-ADJ

Definition: CLAIMIP, CLAIMLT, CLAIMOT and CLAIMRX - A unique claim number (up to 21 alpha/numeric characters) assigned by the State's payment system that identifies the adjustment claim for an original transaction.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(21)	5.0%	"ABC111222333444555666"

Coding Requirements:

Record the value exactly as it appears in the State system. Do not pad.

This field should be 8-filled if the ADJUSTMENT-INDICATOR = 0

If Value is unknown, fill with "99999999999999999999".

Error Condition — Resulting Error Code

THE FOLLOWING EDITS WILL NOT COUNT AGAINST THE ERROR TOLERANCE FOR GROSS ADJUSTMENT RECORDS (ADJUSTMENT INDICATOR=5)

1. Value = "99999999999999999999" 301
2. Value is "Space Filled" 303
3. Value is 0-filled 304
4. Value = "88888888888888888888" AND ADJUSTMENT-INDICATOR IS NE 0 305

Data Element Name: INTERNAL-CONTROL-NUMBER-ORIG

Definition: CLAIMIP, CLAIMLT, CLAIMOT and CLAIMRX - A unique number (up to 21 alpha/numeric characters) assigned by the State's payment system that identifies an original claim.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(21)	5.0%	"ABC000111222444555666"

Coding Requirements:

Record the value exactly as it appears in the State system. Do not pad.

If the ADJUSTMENT-INDICATOR is '0' then this field must include the ICN for the original claim. On adjustment claims this field should show the ICN for the claim being adjusted.

If Value is unknown, or the claims is a service tracking claim, fill with "99999999999999999999".

Error Condition	Resulting Error Code

THE FOLLOWING EDITS WILL NOT COUNT AGAINST THE ERROR TOLERANCE FOR GROSS ADJUSTMENT RECORDS (ADJUSTMENT INDICATOR=5)

1. Value = "99999999999999999999" 301
2. Value is "Space Filled" 303
3. Value is 0-filled 304

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%	+00999

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: LINE-NUMBER-ADJ

Definition: CLAIMOT - A unique number to identify the transaction line number that is being identifies the line number on the adjustment ICN.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(3)	5.0%	“001”

Coding Requirements:

Record the value exactly as it appears in the State system

This field should be 8-filled if the ADJUSTMENT-INDICATOR = 0.

If Value is unknown, fill with "999”.

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 = "999" 301
2. Value is “Space Filled” 303
3. Value is 0-filled 304
4. Value = “888" AND ADJUSTMENT-INDICATOR IS NE 0 306

Data Element Name: LINE-NUMBER-ORIG

Definition: CLAIMOT - A unique number to identify the transaction line number that is being reported on the original claim.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(3)	5.0%	“001”

Coding Requirements:

Record the value exactly as it appears in the State system. Do not pad. This field should also be completed on adjustment claims to reflect the LINE-NUMBER of the INTERNAL-CONTROL-NUMBER on the claim that is being adjusted.

If Value is unknown, fill with "999”.

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 = "999".....301
2. Value is “Space Filled”.....303
3. Value is 0-filled.....304
4. Value = “888" AND ADJUSTMENT-INDICATOR IS = 0.....305

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 or C (encounter): If Medicaid or CHIP had no liability for the bill, 0-fill. Amount Paid should reflect the actual amount paid by Medicaid or CHIP. 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 the Medicaid-Amount–Paid is only available at the header level, include all payment information on the header claim (including Medicaid–Amount-Paid, TPL and Medicare Coinsurance and Deductibles). Submit the line item claims with $0 in all payment fields.

Exclude claims with $0 Medicaid-Paid-Amount if the original claims was denied when it was submitted for payment. Include $0 paid claims if they contain, TPL, Medicare Coinsurance and/or Deductibles OR if they are $0 paid line item claims associated with a header summary claim containing the payment information.

For Crossover claims with Medicare Coinsurance and/or Deductibles, enter the sum of those amounts in the Medicaid-Amount-Paid field, if the providers were reimbursed by Medicaid for them. If the Coinsurance and Deductibles were not paid by the state, then report the Medicaid-Amount-Paid as $0.

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%	+00030

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 or C (encounter record) fill with +88888.

If the state's Medicaid reimbursement rate is lower than the Medicare rate, the state should report the lower Medicaid paid amounts in MEDICARE-DEDUCTIBLE-PAYMENT and fill MEDICARE-COINSURANCE-PAYMENT with +00000.

For Crossover claims with zero Medicaid paid amount, fill MEDICARE-COINSURANCE-PAYMENT and MEDICARE-DEDUCTIBLE-PAYMENT with +00000.

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, +99998)	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 TYPE-OF-CLAIM = 3 or C (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.

If the state's Medicaid reimbursement rate is lower than the Medicare rate, the state should report the lower Medicaid paid amounts in MEDICARE-DEDUCTIBLE-PAYMENT and fill MEDICARE-COINSURANCE-PAYMENT with +00000.

For Crossover claims with zero Medicaid paid amount, fill MEDICARE-COINSURANCE-PAYMENT and MEDICARE-DEDUCTIBLE-PAYMENT with +00000.

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.

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.

For TYPE-OF-CLAIM = 4 or D (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

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: NATIONAL-PROVIDER-ID

Definition: CLAIMIP, CLAIMLT, CLAIMOT, CLAIMRX –

For CLAIMOT files the unique number to identify the provider who treated the recipient (as opposed to the provider "billing" for the service).

For CLAIMIP and CLAIMLT files the NPI should be that of the institution billing/caring for the beneficiary.

For CLAIMRX files, the unique number identifying the billing provider.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(12)	5.0%	"1234567890 "

Coding Requirements:

Record the value exactly as it appears in the State system.

If legacy identifiers are available for providers, then report the legacy IDs in the Provider ID field and the NPI in this field. If only the legacy Provider ID is available, then 9-fill the National Provider ID and enter the legacy IDs in the Provider ID fields.

8-fill field for capitation or premium payments (TYPE-OF-SERVICE = 20, 21, 22, 23)

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. Value = "888888888888" AND TYPE-OF-SERVICE <> {20, 21, 22, 23}.....305
5. Value <> "888888888888" AND TYPE-OF-SERVICE = {20, 21, 22, 23}.....306
6. Value = PROVIDER-ID-NUMBER-BILLING 529

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%	03

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%	+00014

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%	+000200

Coding Requirements:

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

If TYPE-OF-CLAIM = 3 or C (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 MINUS (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%	+000200

Coding Requirements:

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

If TYPE-OF-CLAIM = 3 or C (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

Data Element Name: PATIENT-STATUS

Definition: CLAIMIP, CLAIMLT - A code indicating the Patients status as of the ENDING-DATE-OF-SERVICE. Values used are from UB-04.

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 advice 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

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	Unassigned
01	Pharmacy
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	Prison/Correctional Facility
10	Unassigned
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16	Temporary Lodging
17	Walk-in Retail Health Clinic
18-19	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
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
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 Place of Service

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, 23} (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, 23}	305
6.	Value <> 88 AND TYPE-OF-SERVICE = {20, 21, 22, 23}	306

Data Element Name: PLAN-ID-NUMBER

Definition: CLAIMIP, CLAIMLT, CLAIMOT, CLAIMRX- A unique number that represents the managed care health plan under which the non-fee-for-service encounter was provided or the capitation payment was made.

Field Description:

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

Coding Requirements:

Use the number as it is carried in the State's system. This number should match the number used on the eligible file. (TYPE-OF-CLAIM=3 or 'C' or TYPE-OF-SERVICE=20, 21, 22, 23).

If (TYPE-OF-CLAIM <> (3 and 'C')) (Encounter Record) AND TYPE-OF-SERVICE <> {20, 21, 22, 23}, 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 or 'C')	509
6. Value = all 8's AND TYPE OF SERVICE = {20, 21, 22, 23}	521

Data Element Name: PRESCRIBING-PHYSICIAN-ID-NUMBER

Definition: CLAIMRX - A unique identification number assigned to a provider 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

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(8)	5.0%	“123456 “

Coding Requirements:

If no principal procedure was performed, fill with "88888888".

ICD-9-CM codes are the HIPAA standard for procedure codes on inpatient claims. When ICD-9-CM coding is used, the 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.

When ICD-10-PCS coding is used starting 10/1/2014, the PROC-CODE-FLAG-PRINCIPAL=07. Positions 1-7 must be alpha or numeric. Position 8 must be blank.

Value must be a valid code. If PROC-CODE-FLAG-PRINCIPAL = {10 through 87, state-specific coding systems} 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.

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").

If value is unknown, fill with "99999999".

Note: An eighth character is provided for future expansion of this field.

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 = "99999999"	301
2.	Value = “00000000"	304
3.	Value is “Space Filled”	303
4.	Relational Field In Error	999
5.	Value <> "88888888" AND PROC-CODE-FLAG-PRINCIPAL = 88	306
6.	Value = "88888888" 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
10.	Value is invalid as related to PROC-CODE-FLAG-PRINCIPAL=07 (ICD-10)	203

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(8)	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.)

ICD-9-CM codes are the HIPAA standard for procedure codes on inpatient claims. When ICD-9-CM coding is used, the PROC-CODE-FLAG=02. Positions 1-2 must be numeric, positions 3-4 must be numeric or blank, positions 5-7 must be blank.

When ICD-10-PCS coding is used starting 10/1/2014, the PROC-CODE-FLAG=07. Positions 1-7 must be alpha or numeric. Position 8 must be blank.

Value must be a valid code. If PROC-CODE-FLAG = {10 through 87, state-specific coding systems} 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 6-8 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 5-8 must be blank.

ICD-10-PCS (corresponding PROC-CODE-FLAG = 07): Positions 1-7 must be alpha or numeric. Position 8 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 “99999999".

Note: An eighth character is provided for future expansion of this field.

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 = "99999999" 301
2. Value = “00000000" 304
3. Value is “Space Filled” 303
4. Relational Field in Error 999
5. Value is <> "88888888" 306
   AND corresponding PROC-CODE-FLAG = 88
6. Value is = "88888888" 305
   AND corresponding PROC-CODE-FLAG <> 88
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
10. Value is invalid as related to corresponding PROC-CODE-FLAG = 07 (ICD-10) 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-PCS (Will be implemented on 10/1/2014)
10 - 87	Other Systems
88	Not Applicable
99	Unknown

If no principal procedure was performed, fill with 88.

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

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 99	812
2. Value = 99	301
3. Value is not in the list of valid codes, above	201
4. Relational Field in Error (Issued when Medicaid-Covered-Days is in error, or Ending Date of Service is in error)	999
5. Value <> 88 AND MEDICAID-COVERED-INPATIENT-DAYS= +00000	520
6. Value = 07 AND Coding Scheme has not yet been implemented (ENDING-DATE-OF-SERVICE < implementation date of 10/01/2014)	517
7. Value = 02 AND Coding Scheme has been retired (ENDING-DATE-OF-SERVICE >= implementation date of 10/01/2014)	517

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-PCS (Will be implemented on 10/1/2014)
10 - 87	Other Systems
88	Not Applicable
99	Unknown

If no Second Procedure was performed, fill with 88.

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

Error Condition	Resulting Error Code
1. Value is Non-Numeric - Reset to 99	812
2. Value is = 99	301
3. Value is not in the list of valid codes, above	201
4. Relational Field in Error (Issued when Medicaid-Covered-Days is in error, or Ending Date of Service is 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 (ENDING-DATE-OF-SERVICE < implementation date of 10/01/2014)	517
9. Value = 02 AND Coding Scheme has been retired	517

(ENDING-DATE-OF-SERVICE >= implementation date of 10/01/2014)

CLAIMS FILES

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%	"RT"

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 <> “88888888" 305
3. Value <> “88" AND PROC-CODE-PRINCIPAL = “88888888" 306

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%	"LT"

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 <> “88888888" 305
3. Value <> “88" AND corresponding PROC-CODE = “88888888" 306

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

CLAIMS FILES

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 or C), 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, 23)

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.
If the State's legacy ID number is only available then that number can be entered in this field.

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

CLAIMS FILES

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, 23)

If Value is unknown, fill with "999999999999".

Note: Once a national provider ID numbering system is in place, the national number should be used. If only the State's legacy ID number is available then that number can be entered in this 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 = "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, 23} 305
6. Value <> "888888888888" AND TYPE-OF-SERVICE = {20, 21, 22, 23} 306
7. Value = PROVIDER-ID-NUMBER-BILLING AND TYPE-OF-SERVICE = {11, 12} 529

CLAIMS FILES

Data Element Name: PROVIDER-TAXONOMY

Definition: CLAIMIP, CLAIMLT, CLAIMOT, CLAIMRX

For CLAIMOT files, the taxonomy code for the provider who treated the recipient (as opposed to the provider “billing” for the service).
For CLAIMIP and CLAIMLT files the taxonomy code for the institution billing/caring for the beneficiary.
For CLAIMRX files, the taxonomy code for the billing provider **.**

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
X(12)	5.0%	“2080P0202X”

Coding Requirements:

8-fill field for capitation or premium payments (TYPE-OF-SERVICE = 20, 21, 22, 23)

If Value is unknown, fill with "999999999999".

Generally, the provider taxonomy requires 10 bytes. However, two additional bytes have been provided for future expansion.

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, 23} 305
6. Value <> “888888888888" AND TYPE-OF-SERVICE = {20, 21, 22, 23} 306
7. Value = PROVIDER-ID-NUMBER-BILLING AND TYPE-OF-SERVICE = {11, 12} 529

CLAIMS FILES

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, 19, 20, 21, 22, 23). 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, 23}	306
5. Value = +88888 AND (TYPE-OF-SERVICE = {08, 10 through 13, 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(8)	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 “88888888".

For outpatient claims on which multiple line items are not separately adjudicated and the TYPE-OF-SERVICE = {20, 21, 22, 23}, fill with "88888888". Include service codes on crossover claims if available, otherwise they would be 8-filled.

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 6-8 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 5-8 must be blank.

ICD-10-PCS (SERVICE-CODE-FLAG = 07): Positions 1-7 must be alpha or numeric. Position 8 must be blank.

HCPCS (SERVICE-CODE-FLAG = 06): Position 1 must be an alpha character (“A”-“Z”) and position 6-8 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 "99999999".

Note: An eighth character is provided for future expansion of this field.

Error Condition	Resulting Error Code
1. Value = "99999999"	301
2. Value = “00000000"	304
3. Value is “Space Filled”	303
4. Relational Field in Error	999

5. Value <> "88888888" AND SERVICE-CODE-FLAG = 88 306

6. Value = "88888888" 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. Value is invalid as related to SERVICE-CODE-FLAG= 07 (ICD-10) 203

11. SERVICE-CODE-FLAG = (10 through 87) AND 998
State-specific Values have not been supplied.

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-PCS (Will be implemented on 10/1/2014)
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, 23} 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, 23} 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 of 10/1/2014).	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%	“59”

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

CLAIMS FILES

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 claim.

Field Description:

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

Coding Requirements:

Valid Values	Code Definition
1	Medicaid (including M-CHIP) claim: A Current Fee-For-Service Claim for medical services
2	Medicaid (including M-CHIP) claim: Capitated Payment
3	Medicaid (including M-CHIP) claim: 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	Medicaid (including M-CHIP) claim: 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	Medicaid (including M-CHIP) claim: Supplemental Payment (above capitation fee or above negotiated rate) (e.g., FQHC additional reimbursement)
A	Separate CHIP claim: A Current Fee-For-Service Claim for medical services
B	Separate CHIP claim: Capitated Payment
C	Separate CHIP claim: 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.
D	Separate CHIP claim: 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.
E	Separate CHIP claim: Supplemental Payment (above capitation fee or above negotiated rate) (e.g., FQHC additional reimbursement)
9	Unknown (Counts against error tolerance)

Data Element Name: TYPE-OF-CLAIM (Cont'd.)

Error Condition	Resulting Error Code
1. Value = 9	301
2. Value is not included in the list of valid codes	201
3. Value = 4 or E AND first byte of MSIS-IDENTIFICATION-NUMBER <> "&"	522
4. Value<>4 or E 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 3 – Types of Service References' 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)
23	**Capitated Premium Payments to Private Health Insurance**
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
40+	Invalid codes - included in error tolerance
99	Unknown - included in error tolerance

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

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 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, 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 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-04 revenue code reported on the UB-04 line item that is represented on this claim/encounter record.

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(4)	100%	0305

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-04 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

CLAIMS FILES

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

Definition: CLAIMIP - The total charge for the related UB-04 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-04 Billing Manual)

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
S9(8)	5.0%	+00000450

Coding Requirements:

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

Enter charge for each UB-04 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-04 Billing Manual)

Field Description:

COBOL PICTURE	Error Tolerance	Example Value
9(4)	5.0%	0202

Coding Requirements:

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

Enter all UB-04 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.

CLAIMS FILE

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

Definition: CLAIMIP - Units associated with UB-04 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-04 Billing Manual).

Field Description:

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

Coding Requirements:

Enter units for each UB-04 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 File Label Internal Dataset Name
402	Value is different from file name contained in the File 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. Comparison is done between the beginning and ending quarter dates of the file header record versus the Date-of-Payment-Adjudication on each data record.

MEDICAID AND CHIP STATISTICAL INFORMATION SYSTEM

(MSIS)

File Specifications and Data Dictionary Attachments

MEDICAID AND CHIP STATISTICAL INFORMATION SYSTEM
(MSIS)

File Specifications and Data Dictionary Attachments

ATTACHMENT 1 - 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.

Report Page 2

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 AND CHIP STATISTICAL INFORMATION SYSTEM

(MSIS)

File Specifications and Data Dictionary Attachments

ATTACHMENT 2 - Comprehensive Eligibility Crosswalk

MAS/BOE - INDIVIDUALS COVERED UNDER SEPARATE CHILDREN'S HEALTH INSURANCE PROGRAMS (separate CHIP)
MSIS Coding (MAS-0, BOE-0)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Children covered under a Title XXI separate CHIP	42 CFR 457.310, §2110 (b) of the Act.
2	Legal immigrant children and pregnant women covered under a Title XXI separate CHIP.	§2107(e)(1) of the Act, P.L. 111-3.
3	Children receiving dental-only coverage under a Title XXI separate CHIP	§2102 and 2110 (b) of the Act, PL 111-3.
4	Targeted low-income pregnant women covered under a Title XXI separate CHIP	§2112 of the Act, PL 111-3.
5	Infants under age 1 born to targeted low-income pregnant women made eligible under a Title XXI separate CHIP.	§2112 of the Act, PL 111-3.
6	Children who have been granted presumptive eligibility under a Title XXI separate CHIP.	42 CFR 457.355, §2105 of the Act.
7	Pregnant women who have been granted presumptive eligibility under a Title XXI separate CHIP.	§2112 of the Act, PL 111-3.
8	Caretaker relatives and children covered under the authority of an 1115 waiver and a Title XXI separate CHIP.	§2107(e) of the Act.

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, 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 Child Health Insurance Program (CHIP)	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 Child Health Insurance Program (CHIP).	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.

ITEM	DESCRIPTION	CFR/PL CITATIONS
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 requirements for AFDC, SSI, or an optional State supplement.	42 CFR 435.210, §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	42 CFR 435.133.

ITEM	DESCRIPTION	CFR/PL CITATIONS
	criteria, who have been continuously eligible since 12/73 under the State's 12/73 requirements.	
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 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.
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	§1925 of the Act, PL 100-485, §303.

ITEM	DESCRIPTION	CFR/PL CITATIONS
	4/1/90).	
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.
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.
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.
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 AND CHIP STATISTICAL INFORMATION SYSTEM

(MSIS)

File Specifications and Data Dictionary Attachments

ATTACHMENT 3 - 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 'Attachment 4 – Program Type References.'

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).

6. 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

- 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 specialties.

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.

    Laboratory and 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.

17c. Private Health Insurance (MSIS Code=23) --These include plans marketed by private health insurance companies and enrolled in by individual enrollees on their own choosing.

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.

MEDICAID AND CHIP STATISTICAL INFORMATION SYSTEM

(MSIS)

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ATTACHMENT 4 - 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).

PROGRAM HIERARCHY

If more than one program type could be applicable for a particular claim, the following hierarchy should be applied:

Family Planning
Waiver Services
EPSDT
Indian Health
RHC
FQHC

MEDICAID AND CHIP STATISTICAL INFORMATION SYSTEM

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File Specifications and Data Dictionary Attachments

ATTACHMENT 5 – T-MSIS Eligibility Group Valid Values Table

DEFINITIONS OF NEW FIELD – T-MSIS ELIGIBILITY-GROUP CAN BE FOUND AS #'S 72-75 IN THE TABLE BELOW

This section is located in the T-MSIS Data Dictionary documentation as 'Appendix F: Eligibility Group Table.'

Code	Eligibility Group	Short Description	Citation	Type	Category
MEDICAID MANDATORY COVERAGE					
01	Parents and Other Caretaker Relatives	Parents and other caretaker relatives of dependent children with household income at or below a standard established by the state.	42 CFR 435.110; 1902(a)(10)(A)(i)(I); 1931(b) and (d)	Family/Adult	Mandatory Coverage
02	Transitional Medical Assistance	Families with Medicaid eligibility extended for up to 12 months because of earnings.	408(a)(11)(A); 1902(a)(52); 1902(e)(1)(B); 1925; 1931(c)(2)	Family/Adult	Mandatory Coverage
03	Extended Medicaid due to Earnings	Families with Medicaid eligibility extended for 4 months because of increased earnings.	42 CFR 435.112; 408(a)(11)(A); 1902 (e)(1)(A); 1931 (c)(2)	Family/Adult	Mandatory Coverage
04	Extended Medicaid due to Spousal Support Collections	Families with Medicaid eligibility extended for 4 months as the result of the collection of spousal support.	42 CFR 435.115; 408(a)(11)(B); 1931 (c)(1)	Family/Adult	Mandatory Coverage
05	Pregnant Women	Women who are pregnant or post-partum, with household income at or below a standard established by the state.	42 CFR 435.116; 1902(a)(10)(A)(i)(III) and (IV); 1902(a)(10)(A)(ii)(I), (IV) and (IX); 1931(b) and (d);	Family/Adult	Mandatory Coverage
06	Deemed Newborns	Children born to women covered under Medicaid or a separate CHIP for the date of the child's birth, who are deemed eligible for Medicaid until the child turns age 1	42 CFR 435.117; 1902(e)(4) and 2112€	Family/Adult	Mandatory Coverage
07	Infants and Children under Age 19	Infants and children under age 19 with household income at or below standards established by the state based on age group.	42 CFR 435.118 1902(a)(10)(A)(i)(III), (IV), (VI) and (VII); 1902(a)(10)(A)(ii)(IV) and (IX); 1931(b) and (d)	Family/Adult	Mandatory Coverage

Code	Eligibility Group	Short Description	Citation	Type	Category
08	Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care	Individuals for whom an adoption assistance agreement is in effect or foster care or kinship guardianship assistance maintenance payments are made under Title IV-E of the Act.	42 CFR 435.145; 473(b)(3); 1902(a)(10)(A)(i)(I)	Family/Adult	Mandatory Coverage
09	Former Foster Care Children	Individuals under the age of 26, not otherwise mandatorily eligible, who were in foster care and on Medicaid either when they turned age 18 or aged out of foster care.	42 CFR 435.150; 1902(a)(10)(A)(i)(IX)	Family/Adult	Mandatory Coverage
~~10~~	~~Individuals at or below 133% FPL Age 19 through 64~~	~~Non-pregnant individuals aged 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL.~~	~~42 CFR 435.119; 1902(a)(10)(A)(i)(VIII)~~	~~Family/Adult~~	~~Mandatory Coverage~~
Please note that T-MSIS eligibility grouping # 10 "Individuals at or below 133% FPL Age 19 through 64" **has been removed and replaced with expanded groupings 72-75 (see below).**					
72	Adult Group - Individuals at or below 133% FPL Age 19 through 64 - newly eligible for all states	Non-pregnant individuals aged 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL.	42 CFR 435.119; 1902(a)(10)(A)(i)(VIII)	Family/Adult	Mandatory Coverage
73	Adult Group - Individuals at or below 133% FPL Age 19 through 64- not newly eligible for non 1905z(3) states	Non-pregnant individuals aged 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL.	42 CFR 435.119; 1902(a)(10)(A)(i)(VIII) 1905z(3)	Family/Adult	Mandatory Coverage
74	Adult Group - Individuals at or below 133% FPL Age 19 through 64 – not newly eligible parent/ caretaker-relative(s) in 1905z(3) states	Non-pregnant individuals aged 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL.	42 CFR 435.119; 1902(a)(10)(A)(i)(VIII) 1905z(3)	Family/Adult	Mandatory Coverage
75	Adult Group - Individuals at or below 133% FPL Age 19 through 64- not newly eligible non-parent/ caretaker-relative(s) in 1905z(3) states	Non-pregnant individuals aged 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL.	42 CFR 435.119; 1902(a)(10)(A)(i)(VIII) 1905z(3)	Family/Adult	Mandatory Coverage

Code	Eligibility Group	Short Description	Citation	Type	Category
11	Individuals Receiving SSI	Individuals who are aged, blind or disabled who receive SSI.	42 CFR 435.120; 1902(a)(10)(A)(i)(II)(aa)	ABD	Mandatory Coverage
12	Aged, Blind and Disabled Individuals in 209(b) States	In 209(b) states, aged, blind and disabled individuals who meet more restrictive criteria than used in SSI.	42 CFR 435.121; 1902(f)	ABD	Mandatory Coverage
13	Individuals Receiving Mandatory State Supplements	Individuals receiving mandatory State Supplements to SSI benefits.	42 CFR 435.130	ABD	Mandatory Coverage
14	Individuals Who Are Essential Spouses	Individuals who were eligible as essential spouses in 1973 and who continue be essential to the well-being of a recipient of cash assistance.	42 CFR 435.131; 1905(a)	ABD	Mandatory Coverage
15	Institutionalized Individuals Continuously Eligible Since 1973	Institutionalized individuals who were eligible for Medicaid in 1973 as inpatients of Title XIX medical institutions or intermediate care facilities, and who continue to meet the 1973 requirements.	42 CFR 435.132	ABD	Mandatory Coverage
16	Blind or Disabled Individuals Eligible in 1973	Blind or disabled individuals who were eligible for Medicaid in 1973 who meet all current requirements for Medicaid except for the blindness or disability criteria.	42 CFR 435.133	ABD	Mandatory Coverage
17	Individuals Who Lost Eligibility for SSI/SSP Due to an Increase in OASDI Benefits in 1972	Individuals who would be eligible for SSI/SSP except for the increase in OASDI benefits in 1972, who were entitled to and receiving cash assistance in August, 1972.	42 CFR 435.134	ABD	Mandatory Coverage
18	Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA increases since April, 1977	Individuals who are receiving OASDI and became ineligible for SSI/SSP after April, 1977, who would continue to be eligible if the cost of living increases in OASDI since their last month of eligibility for SSI/SSP/OASDI were deducted from income.	42 CFR 435.135;	ABD	Mandatory Coverage
19	Disabled Widows and Widowers Ineligible for SSI due	Disabled widows and widowers who would be eligible for SSI /SSP, except	42 CFR 435.137; 1634(b)	ABD	Mandatory Coverage

Code	Eligibility Group	Short Description	Citation	Type	Category
	to Increase in OASDI	for the increase in OASDI benefits due to the elimination of the reduction factor in P.L. 98-21, who therefore are deemed to be SSI or SSP recipients.			
20	Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security	Disabled widows and widowers who would be eligible for SSI/SSP, except for the early receipt of OASDI benefits, who are not entitled to Medicare Part A, who therefore are deemed to be SSI recipients.	42 CFR 435.138; 1634(d)	ABD	Mandatory Coverage
21	Working Disabled under 1619(b)	Blind or disabled individuals who participated in Medicaid as SSI cash recipients or who were considered to be receiving SSI, who would still qualify for SSI except for earnings.	1619(b); 1902(a)(10)(A)(i)(II)(bb); 1905(q)	ABD	Mandatory Coverage
22	Disabled Adult Children	Individuals who lose eligibility for SSI at age 18 or older due to receipt of or increase in Title II OASDI child benefits.	1634(c)	ABD	Mandatory Coverage
23	Qualified Medicare Beneficiaries	Individuals with income equal to or less than 100% of the FPL who are entitled to Medicare Part A, who qualify for Medicare cost-sharing.	1902(a)(10)(E)(i); 1905(p)	ABD	Mandatory Coverage
24	Qualified Disabled and Working Individuals	Working, disabled individuals with income equal to or less than 200% of the FPL, who are entitled to Medicare Part A under section 1818A, who qualify for payment of Medicare Part A premiums.	1902(a)(10)(E)(ii); 1905(p)(3)(A)(i); 1905(s)	ABD	Mandatory Coverage
25	Specified Low Income Medicare Beneficiaries	Individuals with income between 100% and 120% of the FPL who are entitled to Medicare Part A, who qualify for payment of Medicare Part B premiums.	1902(a)(10)(E)(iii); 1905(p)(3)(A)(ii)	ABD	Mandatory Coverage
26	Qualifying Individuals	Individuals with income between 120% and 135% of the FPL who are entitled to Medicare Part A, who qualify for payment of Medicare Part B premiums.	1902(a)(10)(E)(iv); 1905(p)(3)(A)(ii)	ABD	Mandatory Coverage

Code	Eligibility Group	Short Description	Citation	Type	Category
MEDICAID OPTIONS FOR COVERAGE					
27	Optional Coverage of Parents and Other Caretaker Relatives	Individuals qualifying as parents or caretaker relatives who are not mandatorily eligible and who have income at or below a standard established by the State.	42 CFR 435.220; 1902(a)(10)(A)(ii)(I)	Family/Adult	Options for Coverage
28	Reasonable Classifications of Individuals under Age 21	Individuals under age 21 who are not mandatorily eligible and who have income at or below a standard established by the State.	42 CFR 435.222; 1902(a)(10)(A)(ii)(I) and (IV)	Family/Adult	Options for Coverage
29	Children with Non-IV-E Adoption Assistance	Children with special needs for whom there is a non-IV-E adoption assistance agreement in effect with a state, who either were eligible for Medicaid or had income at or below a standard established by the state.	42 CFR 435.227; 1902(a)(10)(A)(ii)(VIII);	Family/Adult	Options for Coverage
30	Independent Foster Care Adolescents	Individuals under an age specified by the State, less than age 21, who were in State-sponsored foster care on their 18th birthday and who meet the income standard established by the State.	42 CFR 435.226; 1902(a)(10)(A)(ii)(XVII)	Family/Adult	Options for Coverage
31	Optional Targeted Low Income Children	Uninsured children who meet the definition of optional targeted low income children at 42 CFR 435.4, who have household income at or below a standard established by the State.	42 CFR 435.229 and 435.4; 1902(a)(10)(A)(ii)(XIV); 1905(u)(2)(B)	Family/Adult	Options for Coverage
32	Individuals Electing COBRA Continuation Coverage	Individuals choosing to continue COBRA benefits with income equal to or less than 100% of the FPL.	1902(a)(10)(F); 1902(u)(1)	Family/Adult	Options for Coverage
33	Individuals above 133% FPL under Age 65	Individuals under 65, not otherwise mandatorily or optionally eligible, with income above 133% FPL and at or below a standard established by the State.	CFR 435.218; 1902(hh); 1902(a)(10)(A)(ii)(XX)	Family/Adult	Options for Coverage

Code	Eligibility Group	Short Description	Citation	Type	Category
34	Certain Individuals Needing Treatment for Breast or Cervical Cancer	Individuals under the age of 65 who have been screened for breast or cervical cancer and need treatment.	42 CFR 435.213; 1902(a)(10)(A)(ii)(XVIII); 1902(aa)	Family/Adult	Options for Coverage
35	Individuals Eligible for Family Planning Services	Individuals who are not pregnant, with income equal to or below the highest standard for pregnant women, as specified by the State, limited to family planning and related services.	42 CFR 435.214; 1902(a)(10)(A)(ii)(XXI)	Family/Adult	Options for Coverage
36	Individuals with Tuberculosis	Individuals infected with tuberculosis whose income does not exceed established standards, limited to tuberculosis-related services.	42 CFR 435.215; 1902(a)(10)(A)(ii)(XII); 1902(z)	Family/Adult	Options for Coverage
37	Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash Assistance	Individuals who meet the requirements of SSI or Optional State Supplement, but who do not receive cash.	42 CFR 435.210 & 230; 1902(a)(10)(A)(ii)(I);	ABD	Options for Coverage
38	Individuals Eligible for Cash Assistance except for Institutionalization	Individuals who meet the requirements of AFDC, SSI or Optional State Supplement, and would be eligible if they were not living in a medical institution.	42 CFR 435.211; 1902(a)(10)(A)(ii)(IV);	ABD	Options for Coverage
39	Individuals Receiving Home and Community Based Services under Institutional Rules	Individuals who would be eligible for Medicaid under the State Plan if in a medical institution, who would live in an institution if they did not receive home and community based services.	42 CFR 435.217; 1902(a)(10)(A)(ii)(VI)	ABD	Options for Coverage
40	Optional State Supplement Recipients - 1634 States, and SSI Criteria States with 1616 Agreements	Individuals in 1634 States and in SSI Criteria States with agreements under 1616, who receive a state supplementary payment (but not SSI).	42 CFR 435.232; 1902(a)(10)(A)(ii)(IV)	ABD	Options for Coverage

Code	Eligibility Group	Short Description	Citation	Type	Category
41	Optional State Supplement Recipients - 209(b) States, and SSI Criteria States without 1616 Agreements	Individuals in 209(b) States and in SSI Criteria States without agreements under 1616, who receive a state supplementary payment (but not SSI).	42 CFR 435.234; 1902(a)(10)(A)(ii)(XI)	ABD	Options for Coverage
42	Institutionalized Individuals Eligible under a Special Income Level	Individuals who are in institutions for at least 30 consecutive days who are eligible under a special income level.	42 CFR 435.236; 1902(a)(10)(A)(ii)(V)	ABD	Options for Coverage
43	Individuals participating in a PACE Program under Institutional Rules	Individuals who would be eligible for Medicaid under the State Plan if in a medical institution, who would require institutionalization if they did not participate in the PACE program.	1934	ABD	Options for Coverage
44	Individuals Receiving Hospice Care	Individuals who would be eligible for Medicaid under the State Plan if they were in a medical institution, who are terminally ill, and who will receive hospice care.	1902(a)(10)(A)(ii)(VII); 1905(o)	ABD	Options for Coverage
45	Qualified Disabled Children under Age 19	Certain children under 19 living at home, who are disabled and would be eligible if they were living in a medical institution.	1902(e)(3)	ABD	Options for Coverage
46	Poverty Level Aged or Disabled	Individuals who are aged or disabled with income equal to or less than a percentage of the FPL, established by the state (no higher than 100%).	1902(a)(10)(A)(ii)(X); 1902(m)(1)	ABD	Options for Coverage
47	Work Incentives Eligibility Group	Individuals with a disability with income below 250% of the FPL, who would qualify for SSI except for earned income.	1902(a)(10)(A)(ii)(XIII)	ABD	Options for Coverage
48	Ticket to Work Basic Group	Individuals with earned income between ages 16 and 64 with a disability, with income and resources equal to or below a standard specified by the State.	1902(a)(10)(A)(ii)(XV)	ABD	Options for Coverage

Code	Eligibility Group	Short Description	Citation	Type	Category
49	Ticket to Work Medical Improvements Group	Individuals with earned income between ages 16 and 64 who are no longer disabled but still have a medical impairment, with income and resources equal to or below a standard specified by the State.	1902(a)(10)(A)(ii)(XVI)	ABD	Options for Coverage
50	Family Opportunity Act Children with Disabilities	Children under 19 who are disabled, with income equal to or less than a standard specified by the State (no higher than 300% of the FPL).	1902(a)(10)(A)(ii)(XIX); 1902(cc)(1)	ABD	Options for Coverage
51	Individuals Eligible for Home and Community-Based Services	Individuals with income equal to or below 150% of the FPL, who qualify for home and community based services without a determination that they would otherwise live in an institution.	1902(a)(10)(A)(ii)(XXII); 1915(i)	ABD	Options for Coverage
52	Individuals Eligible for Home and Community-Based Services - Special Income Level	Individuals with income equal to or below 300% of the SSI federal benefit rate, who meet the eligibility requirements for a waiver approved for the State under 1915(c), (d) or (e), or 1115.	1902(a)(10)(A)(ii)(XXII); 1915(i)	ABD	Options for Coverage
MEDICAID MEDICALLY NEEDY					
53	Medically Needy Pregnant Women	Women who are pregnant, who would qualify as categorically needy, except for income.	42 CFR 435.301(b)(1)(i) and (iv); 1902(a)(10)(C)(ii)(II)	Family/Adult	Medically Needy
54	Medically Needy Children under Age 18	Children under 18 who would qualify as categorically needy, except for income.	42 CFR 435.301(b)(1)(ii); 1902(a)(10)(C)(ii)(II)	Family/Adult	Medically Needy

Code	Eligibility Group	Short Description	Citation	Type	Category
55	Medically Needy Children Age 18 through 20	Children over 18 and under an age established by the State (less than age 21), who would qualify as categorically needy, except for income.	42 CFR 435.308; 1902(a)(10)(C)(ii)(II)	Family/Adult	Medically Needy
56	Medically Needy Parents and Other Caretakers	Parents and other caretaker relatives of dependent children, eligible as categorically needy except for income.	42 CFR 435.310	Family/Adult	Medically Needy
	Removed – Do Not Use				
	Removed – Do Not Use				
59	Medically Needy Aged, Blind or Disabled	Individuals who are age 65 or older, blind or disabled, who are not eligible as categorically needy, who meet income and resource standards specified by the State, or who meet the income standard using medical and remedial care expenses to offset excess income.	42 CFR 435.320, 435.322, 435.324,and 435.330; 1902(a)(10)(C)	ABD	Medically Needy
60	Medically Needy Blind or Disabled Individuals Eligible in 1973	Blind or disabled individuals who were eligible for Medicaid as Medically Needy in 1973 who meet all current requirements for Medicaid except for the blindness or disability criteria.	42 CFR 435.340	ABD	Medically Needy
CHIP COVERAGE					
61	Targeted Low-Income Children	Uninsured children under age 19 who do not have access to public employee coverage and whose household income is within standards established by the state.	42 CFR 457.310; 2102(b)(1)(B)(v)	Children	Optional
62	Deemed Newborn	Children born to targeted low-income pregnant women who are deemed eligible for CHIP or Medicaid for one year.	2112(e)	Children	Optional

Code	Eligibility Group	Short Description	Citation	Type	Category
63	Children Ineligible for Medicaid Due to Loss of Income Disregards	Children determined to be ineligible for Medicaid as a result of the elimination of income disregards under the MAGI income methodology.	42 CFR 457.340(d) Section 2101(f) of the ACA	Children	Mandatory
CHIP ADDITIONAL OPTIONS FOR COVERAGE					
64	Coverage from Conception to Birth	Uninsured children from conception to birth who do not have access to public employee coverage and whose household income is within standards established by the state.	42 CFR 457.310 2102(b)(1)(B)(v)	Children	Option for Coverage
65	Children with Access to Public Employee Coverage	Uninsured children under age 19 having access to public employee coverage and whose household income is within standards established by the state.	2110(b)(2)(B) and (b)(6)	Children	Option for Coverage
66	Children Eligible for Dental Only Supplemental Coverage	Children who are otherwise eligible for CHIP but for the fact that they are enrolled in a group health plan or health insurance offered through an employer. Coverage is limited to dental services.	2110(b)(5)	Children	Option for Coverage
67	Targeted Low-Income Pregnant Women	Uninsured pregnant women who do not have access to public employee coverage and whose household income is within standards established by the state.	2112	Pregnant Women	Option for Coverage
68	Pregnant Women with Access to Public Employee Coverage	Uninsured pregnant women having access to public employee coverage and whose household income is within standards established by the state.	2110(b)(2)(B) and (b)(6)	Pregnant Women	Option for Coverage
1115 EXPANSION ELIGIBILITY GROUPS					
69	Individuals with Mental Health Conditions (expansion group)	Individuals with mental health conditions who do not qualify for Medicaid due to the severity or duration of their disability or due to other eligibility factors; and/or those who are otherwise eligible but require benefits or services that are not comparable to those provided to other Medicaid	1115 expansion		

Code	Eligibility Group	Short Description	Citation	Type	Category
		beneficiaries.			
70	Family Planning Participants (expansion group)	Individuals of child bearing age who require family planning services and supplies and for which the state does not choose to, or cannot provide, optional eligibility coverage under the Individuals Eligible for Family Planning Services eligibility group (1902(a)(10)(A)(ii)(XXI)).	1115 expansion		
71	Other expansion group	Individuals who do not qualify for Medicaid or CHIP under a mandatory eligibility or coverage group and for whom the state chooses to provide eligibility and/or benefits in a manner not permitted by title XIX or XXI of the Social Security Act.	1115 expansion		

APPENDIX B – CODING SCHEME
ENROLLMENT OF INDIVIDUALS INTO THE NEW ADULT GROUP – (ACA MEDICAID EXPANSION)
USING T-MSIS ELIGIBILITY GROUP

For states engaging in Medicaid expansion for FFY2014Q1 (calendar Oct-Dec 2013), with the "New Adult Group" (as defined as T-MSIS-ELIGIBILTY-GROUP codes=72, 73, 74, or 75), enrollment can be correctly captured for this quarter by coding each MSIS eligibility file record as follows:

a) Correctly code the T-MSIS-ELIGIBILITY-GROUP for each month; for non-eligible months, record spaces

b) DAYS-OF-ELIGIBILITY should be zeroes

c) ELIGIBILTY-GROUP should be zeroes for individuals who were not eligible for at least one day during the month

d) MAINTENANCE-ASSIATANCE-STATUS should be zero

e) BASIS-OF-ELIGIBILITY should be zero

f) HEALTH-INSURANCE should be zero

g) TANF-CASH-FLAG should be zero

h) RESTRICTED-BENEFITS-FLAG should be zero

i) PLAN-TYPE-1 thru -4 should all be zeroes for individuals who were not eligible for at least one day during the month

j) PLAN-ID-1 thru -4 should all be zeroes for individuals who were not eligible for at least one day during the month

k) CHIP-CODE should be zero

l) WAIVER-TYPE-1 thru -3 should all be zero for individuals who were not eligible for at least one day during the month

m) WAIVER-ID-1 thru -3 should all be zeroes for individuals who were not eligible for at least one day during the month

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