T-MSIS Open Change Requests

(as of 2015-11-05)

CR #	Summary	Issue Type	Status	Priority
TMSIS-1379	RULE-2133 will be deprecated and replaced with a rule that includes PRIMARY-ELIGIBILITY-GROUP-IND	Change Request	Open	Medium
TMSIS-1378	Deprecated RULE-3087 (EC# 2224)	Change Request	Open	Medium
TMSIS-1377	Deprecated RULE-428 (EC# 2146)	Change Request	Open	Medium
TMSIS-1376	Deprecated RULE-1402 (EC#s 2428 & 2431)	Change Request	Open	Medium
TMSIS-1375	Deprecate the following validation rules: RULE-2040; RULE-2046; RULE-2058 & RULE-2060	Change Request	Open	Medium
TMSIS-1374	LICENSE-OR-ACCREDITATION-NUMBER - add to the PROV-LICENSING-INFO (PRV00004) record segment key	Change Request	Open	Medium

TMSIS-1373	Tier 1 edits for DRG-DESCRIPTION / HCPCS-RATE – is there a valid values list	Change Request	Open	Medium
TMSIS-1372	Edits that need to account for historical eligibility spans	Change Request	Open	Medium
TMSIS-1371	Alpha-numeric characters – expanded elements that are accepted	Change Request	Open	High
TMSIS-1370	Modify rules containing MAS and BOE to incorporate date logic that limits the edit to time periods before 2014-01-01	Change Request	Open	High

TMSIS-1369	Update RULE-1973 per Jeff's clarification	Change Request	Open	Medium
TMSIS-1368	Rules currently under discussion that should be deprecated per Jeff Collier's request	Change Request	In Progress	Medium
TMSIS-1320	Add new errors for unrecognizable characters in text fields	Change Request	Open	High
TMSIS-1314	WAIVER-ID data element - implement the Waiver Identifier Look-up Table and Waiver Identifier Crosswalk Table in T-MSIS	Change Request	Open	High

TMSIS-1312	WAIVER-ID data element - add the WAIVER-ID field to the MANAGED-CARE-OPERATING-AUTHORITY-MCR00005 segment key	Change Request	Open	High
TMSIS-1237	Initiatives on hold - - may not be applicable in November 2015	Change Request	Open	High

TMSIS-1236	OCCURRENCE-CODEs–update BR to include logic to only fire if both fields are populated	Change Request	Open	High
TMSIS-1234	CLAIM-HEADER-RECORD-OT - The logic for RULE-1402 is not correct for all claim types.	Change Request	Open	High
TMSIS-1233	PRIMARY-ELIGIBILITY-GROUP-IND (ELG00005) - correct the BR logic to allow for multiple eligibility spans	Change Request	Open	High
TMSIS-1229	PRIMARY-ELIGIBILITY-GROUP-IND (ELG00005) – disable RULE-2133	Change Request	Open	High
TMSIS-1213	DATE-OF-DEATH - Eligibility file - update 2.0 logic for edits	Change Request	Open	High

TMSIS-1205	Deactive rules checking for Nov 2015 dates	Change Request	Open	Medium
TMSIS-1192	FUNDING-SOURCE-NONFEDERAL-SHARE data element - add valid value "06 State appropriations to the CHIP agency"	Change Request	Open	High
TMSIS-1191	Continue to bypass tier 1, 2 & 3 edits on denied claims and denied claim lines in 2.0	Change Request	Open	High
TMSIS-1190	Edits such as 2381, 2382, 2383 need to be corrected to not require a modifier when there is a procedure code	Change Request	Open	High
TMSIS-1188	Edit 2335 logic needs to be corrected – removed “plus 1” requirement from 2.0 logic	Change Request	In Progress	High

TMSIS-1187	Exclude TYPE-OF-SERVICE or TYPE-OF-CLAIM on edits such as 2002, 2004, 2013, 2024 or 2036	Change Request	Open	High
TMSIS-1185	PROV-NPI-NUM/HEALTH-HOME-PROVIDER-NPI: remove algorithm for APIs tier 1 edit	Change Request	Open	High
TMSIS-1016	Provider-id and managed-care-id lookups should be references to provider and managed care files	Change Request	Open	Medium
TMSIS-932	State Issue: Error Code 103 when submitting the group level DIAGNOSIS-CODE-4.	Change Request	Open	Medium

TMSIS-931	State Issue: Error Code 2429 posts to TOT-MEDICARE-COINS-AMT and requires the amount be 8-filled	Change Request	Open	Medium
TMSIS-930	State Issue: Provider license dates overlap with same end-of time date or start and end dates overlap	Change Request	Open	Medium

TMSIS-929	State Issue: Error Code 2425 is being posted to valid values	Change Request	Open	Medium
TMSIS-928	State Issue: Records are rejecting when the TYPE-OF-OTHER-THIRD-PARTY-LIABILITY value is different	Change Request	Open	Medium

TMSIS-927	State Issue: Error Code 2038 because the ENDING-DATE-OF-SERVICE is greater thant he ADJUDICATION-DATE	Change Request	Open	Medium
TMSIS-926	State Issue: Error Code 2126 for reversals	Change Request	Open	Medium

TMSIS-925	State Issue: ACCREDITATION-ORGANIZATION Updates	Change Request	Open	Medium
TMSIS-924	State Issue: Validation rules for email address in the MNGDCARE and PROVIDER files	Change Request	Open	Medium

TMSIS-923	State Issue: Error code 2434 for TYPE-OF-SERVICE	Change Request	Open	Medium
TMSIS-922	State Issue: Error code 103 on the FUNDING-SOURCE-NONFEDERAL-SHARE	Change Request	Open	Medium
TMSIS-921	Error code 2432 absolute value of TOT-TPL-AMT	Change Request	Open	High

TMSIS-920	State Issue: Error Code 2254 when 9-filling the Date of Death	Change Request	Open	Medium
TMSIS-919	State Issue: Error Code 2456 on non-contiguous segments	Change Request	Open	Medium

TMSIS-917	State Issue: Procedure codes and Modifier	Change Request	Open	Medium
TMSIS-916	State Issue:Dual Eligibility for members	Change Request	Open	Medium
TMSIS-915	State Issue: Error Code 2146 doesn't allow for the same surgical procedure code to be repeated on the same claim	Change Request	Open	Medium

TMSIS-914	State Issue: Error Code 2239 functtioning as a Tier 3 edit	Change Request	Open	Medium
TMSIS-912	Error code 2424 for Inpatient or LTC claims	Change Request	Open	Medium
TMSIS-909	Modify program end date and date of death edits	Change Request	Open	Medium

TMSIS-908	Error code 103 for states local codes	Change Request	Open	Medium
TMSIS-906	Error code 127 when submitting 'E' codes in the ADMITTING-DIAGNOSIS-CODE field.	Change Request	Open	Medium
TMSIS-905	Rrror code 2328 when 8-filling the MEDICARE-COMB-DED-IND	Change Request	Open	Medium

TMSIS-904	Format to use for positive/negative non-decimal values in FLF files	Change Request	Open	Medium
TMSIS-901	Relationship of indicator 1 to segment TPL00005	Change Request	Open	Medium
TMSIS-900	Error Code 2477 for members with multiple eligibility periods	Change Request	Open	Medium

TMSIS-899	Error code 151 on non-claim files for both create and replacement	Change Request	Open	Medium
TMSIS-895	Edit 103 is posting to NPI's that are not following the NPI Lunh algorithm	Change Request	Open	Medium

TMSIS-821	Editing against list of valid values	Change Request	Open	Medium
TMSIS-722	BMI (CIP201, CLT143, COT125) data elements - Remove Requirement for States to Report Certain Problematic Data Elements	Change Request	Open	High

TMSIS-656	State Issue: ELG025 Date of Death > Start of time period for 7 year historical files	Change Request	Open	Medium
TMSIS-655	State Issue: MCR069 Discrepancy in the DD for segment MANAGED-CARE-OPERATING-AUTHORITY-MCR00005 in MNGDCARE file.	Change Request	Open	Medium

TMSIS-653	State Issue: PRV065 Multiple Licenses for key	Change Request	Open	Medium
TMSIS-651	State Issue: PRV044 State cannot meet requirement of no gap between effective dates	Change Request	Open	Medium
TMSIS-569	DRUG-UTILIZATION-CODE - CRX143 data element - Update valid values to align w/ NCPDP valid values	Change Request	Open	High

TMSIS-558	STATE-PLAN-ENROLLMENT - PRV101 data element: add to PROV-MEDICAID-ENROLLMENT-PRV00007 segment	Change Request	Open	High

Created	Last Viewed	Updated
11/4/2015 14:06	11/4/2015 14:14	11/4/2015 14:09
11/4/2015 13:58	11/4/2015 14:03	11/4/2015 14:03
11/4/2015 13:53	11/4/2015 13:55	11/4/2015 13:55
11/4/2015 13:48	11/4/2015 13:50	11/4/2015 13:50
11/4/2015 13:37	11/4/2015 13:41	11/4/2015 13:41
11/4/2015 13:11	11/4/2015 13:13	11/4/2015 13:13

11/4/2015 12:59	11/4/2015 13:00	11/4/2015 13:00
11/4/2015 12:47	11/4/2015 12:50	11/4/2015 12:50
11/4/2015 12:15	11/4/2015 12:16	11/4/2015 12:16
11/4/2015 9:39	11/4/2015 11:31	11/4/2015 10:00

11/3/2015 19:43		11/3/2015 19:43
11/3/2015 19:37		11/4/2015 11:46
10/28/2015 2:04		10/30/2015 13:31
10/27/2015 16:35		10/27/2015 16:39

10/27/2015 16:02		11/2/2015 19:08
10/14/2015 16:43	11/4/2015 12:06	10/14/2015 16:49

10/14/2015 16:05		10/14/2015 16:07
10/14/2015 13:07		10/14/2015 13:10
10/14/2015 12:31		10/14/2015 16:03
10/14/2015 10:49		10/14/2015 10:53
10/13/2015 14:25		10/13/2015 14:30

10/9/2015 21:00		10/9/2015 21:01
10/8/2015 16:59		10/8/2015 17:14
10/8/2015 13:55		10/27/2015 11:36
10/8/2015 13:03	11/4/2015 12:38	11/4/2015 12:38
10/8/2015 12:24	11/4/2015 12:08	11/4/2015 12:49

10/8/2015 11:44	11/4/2015 12:31	10/29/2015 12:54
10/8/2015 10:45	11/4/2015 12:04	10/27/2015 12:50
9/22/2015 13:24		11/3/2015 15:12
9/17/2015 22:18		11/4/2015 11:42

9/17/2015 22:11	11/4/2015 14:12	11/4/2015 11:41
9/17/2015 22:06	11/4/2015 10:38	11/4/2015 11:40

9/17/2015 21:55	11/4/2015 10:39	11/4/2015 11:27
9/17/2015 21:39	11/4/2015 10:39	11/4/2015 11:27

9/17/2015 21:34	11/4/2015 10:40	11/4/2015 11:27
9/17/2015 21:26	11/4/2015 10:40	11/4/2015 11:37

9/17/2015 21:20	11/4/2015 10:41	11/4/2015 11:27
9/17/2015 21:12	11/4/2015 10:42	11/4/2015 11:36

9/17/2015 21:07	11/4/2015 10:43	11/4/2015 11:35
9/17/2015 20:49	11/4/2015 10:44	11/4/2015 11:34
9/17/2015 20:39	11/4/2015 10:45	11/4/2015 11:26

9/17/2015 20:32	11/4/2015 10:45	11/4/2015 11:32
9/17/2015 20:25	11/4/2015 10:46	11/4/2015 11:27

9/17/2015 17:52	11/4/2015 10:47	11/4/2015 11:27
9/17/2015 17:45	11/4/2015 10:48	11/4/2015 11:26
9/17/2015 17:37	11/4/2015 10:48	11/4/2015 11:27

9/17/2015 17:32	11/4/2015 10:49	11/4/2015 11:27
9/17/2015 17:12	11/4/2015 10:50	11/4/2015 11:26
9/17/2015 17:02	11/4/2015 10:51	11/4/2015 11:27

9/17/2015 16:59	11/4/2015 10:52	11/4/2015 11:26
9/17/2015 16:51	11/4/2015 10:53	11/4/2015 11:27
9/17/2015 16:47	11/4/2015 10:53	11/4/2015 11:27

9/17/2015 16:43	11/4/2015 10:55	11/4/2015 11:27
9/17/2015 16:34	11/4/2015 10:55	11/4/2015 11:27
9/17/2015 16:29	11/4/2015 10:56	11/4/2015 11:27

9/17/2015 16:22	11/4/2015 10:56	11/4/2015 11:27
9/17/2015 16:02	11/4/2015 10:57	11/4/2015 11:26

9/15/2015 16:02	11/4/2015 10:58	11/4/2015 11:26
9/10/2015 10:12		11/3/2015 16:03

9/3/2015 14:07	11/4/2015 10:58	11/4/2015 11:27
9/3/2015 13:59	11/4/2015 10:59	11/4/2015 11:27

9/3/2015 13:27	11/4/2015 10:59	11/4/2015 11:26
9/3/2015 13:17	11/4/2015 11:37	11/4/2015 11:27
8/24/2015 9:31		10/27/2015 17:27

8/19/2015 17:50		10/27/2015 17:25

Description
Feedback from Beta States after the 2015-09-23 Beta States Conference Call Per JDC - RULE-2133 (EC#s 2444 & 2228) will be deprecated and replaced with a rule that includes PRIMARY-ELIGIBILIT uniqueness criterion. Beta State Feedback "Re: edits 2444 & 2228 – how are states to report primary eligibility when multiple eligibility spans exis overlaps, versus when there are date overlaps?"
Feedback from Beta States after the 2015-09-23 Beta States Conference Call Per JDC - RULE-3087 (EC# 2224) will be deprecated. Beta State Feedback " Error 2224 which says TPL00003 is a child of TPL00004 has not changed. It is still on the 2.0 list as CMS has redesigned TPL once again."
Feedback from Beta States after the 2015-09-23 Beta States Conference Call Per JDC - RULE-428 (EC# 2146) will be deprecated. Beta State feedback "Rule Code 428: The logic for Rule 428 is incorrect. A provider may bill more than one of a procedure surgical) on a single date of service if the modifiers are different. For surgical procedure codes they identify more specifically the service performed, such as right-side or left-side mastecton Home Health visits, more than one procedure code for a visit may be billed if the modifier is there to indicate whether it is a modifier can also be used to identify whether the visit was made by an RN or LPN."
Feedback from Beta States after the 2015-09-23 Beta States Conference Call Per JDC - RULE-428 (EC# 2146) will be deprecated. Beta State Feedback "Rule 1402: The logic for Rule 1402 as it applies to all claim types is not correct. Co-insurance and D fields that are not dependent on one another. See Errors 2428 and 2431If I begin a calendar year with a $1.000 deductible for each visit; the provider will ask me to make payment until I've met my $1000.00 deductible. At that point in time, I will or works the same way with Medicaid. A claims processor will see Medicare cross-overs with both amounts until about mid-ye of claims with just coinsurance because the deductible has been met. If coinsurance is sent on a claim, it is perfectly valid f or "8's". "
Feedback from Beta States after the 2015-09-23 Beta States Conference Call Per JDC - CMS will deprecate the following validation rules: RULE-2040; RULE-2046; RULE-2058 & RULE-2060 (EC#s 22 See attachment (Age Calculation per JDC update 2015Nov04.doc) for Age Calculation explanation and guidance. State feedback "Edits 2131, 2132, 2252, 2253 – should calculate age based off of start of time period and not variable dem
Feedback from Beta States after the 2015-09-23 Beta States Conference Call Per JDC review - A CR will be opened to add LICENSE-OR-ACCREDITATION-NUMBER to the PROV-LICENSING-INFO (key. State feedback "Edit 2309, 2396 – value of 8 = other for License Type. States may have other license types and ID's for th edit between LICENSE-OR-ACCREDITATION-NUMBER and LICENSE-TYPE failed). "

Feedback from Beta States after the 2015-09-23 Beta States Conference Call

T-MSIS only contains the descriptions for the MS-DRGs. The state will use the DRG-DESCRIPTION field to provide the de
classification system other than MS-DRGs.

On inpatient facility claims, the HCPCS-RATE field should be populated with the applicable accommodation rate, when app
maintain a look-up table of valid accommodation rates. On outpatient hospital facility claims, the field is used to capture the
applicable. In such cases, the standard HCPCS code set is to be used.

Feedback from Beta States after the 2015-09-23 Beta States Conference Call

h3. a) RULE-2024 (EC# 2257) will be deprecated (as will RULE-2022 & RULE-2023; (EC#s 2256 & 2258)). The START-O
OF-TIME-PERIOD on the file header segment define the reporting period for which the file was submitted. Currently, T-MS
defined as monthly, so the dates will be for a month's period of time. The Eligibility Files submitted every month are "full file
seven year time span. Therefore, except for the case where the enrollee dies in the reporting period (i.e., the month), the D
the START-OF-TIME-PERIOD.
h3. b) Regarding RULE-2066 & RULE-2128 (EC# 2028): Implementation of the MEDICARE-BENEFICIARY-IDENTIFIER
validation rule should be suspended until the MBI is in use. Regarding RULE-2129, RULE-2130, RULE-2131 & RULE-2153
There should be separate ELG00005 segments for each time span during which the values of all of the data elements are s
data element values changes, the existing segment is end-dated and a new segment created with an eff-date equal to the p
plus 1 day. (See tab entitled "Example for Multiple Segments.") Regarding RULE-2064 (EC# 2029): There should be sepa
ELG00003 segments for each time span during which the values of all of the data elements are static. Whenever one of th
changes, the existing segment is end-dated and a new segment created with an eff-date equal to the previous segment's e
DUAL-ELIGIBLE-CODE and MEDICARE-HIC-NUM are on different segments, the rule logic will be modified to take effectiv
h3. c) Regarding RULE-825; RULE-1257; RULE-1692; RULE-1956; RULE-2023; RULE-2024; RULE-2123; RULE-2124; R
RULE-2130; RULE-2148; RULE-2149; RULE-2150; RULE-2151; RULE-2152; RULE-2153; RULE-2156; RULE-2158; RULE
2187; RULE-2216; RULE-2308; RULE-2312 (EC#s 2014; 2027; 2056; 2065; 2133; 2134; 2135; 2136; 2137; 2138; 2256; 2
3035): These rules will not execute if the MAS or BOE field is blank (or 8-filled).

h3. State feedback - Edits that need to account for historical eligibility spans.
a. Edit 2257 There may be a date of death, but previous eligibility information prior to the person's death.
b. Edit 2027, 2028, 2029 2448, 2280 At one point the person may have been dual eligible, and at a different time not…if at
dual eligible, a HIC number is present.
c. MBOE and MAS edits (e.g. 2014, 2027, 2056, 2326, 2135, 2419, 2420) should account for ACA and new eligibility group

Feedback from Beta States after the 2015-09-23 Beta States Conference Call

In v2.0, validation rules checking alphanumeric fields for acceptable characters have been modified to fire only on | (pipe) o

Feedback from Beta States after the 2015-09-23 Beta States Conference Call

Per CMS - CR will be created to the modify rules containing MAS and BOE to incorporate date logic that limits the edit to ti
and new edits created with comparable logic for time periods on or after 2014-01-01.

Per Brad - see TMSIS-1054 for Nuna solution.

Rules affected: RULE-825; RULE-1257; RULE-1692; RULE-1956; RULE-2023; RULE-2024; RULE-2123; RULE-2124; RUL
2130; RULE-2148; RULE-2149; RULE-2150; RULE-2151; RULE-2152; RULE-2153; RULE-2156; RULE-2158; RULE-2160
RULE-2216; RULE-2308 & RULE-2312 (EC#s 2014; 2027; 2056; 2065; 2133; 2134; 2135; 2136; 2137; 2138; 2256; 2257;
3035)

Beta State feedback {color:#205081}"There appears to be conflicting business rules.V2.0 Coding Requirement: The MEDI
and MAINTENANCE-ASSISTANCE-STATUS fields should be left blank (i.e., submitted as "pipe pipe" with nothing in betwe
filled on FLF files) for enrollment periods encompassing January 1, 2014 and beyond.Yet, for TANF-CASH-CODE, there is
BASIS-OF-ELIGIBILITY and MAINTENANCE-ASSISTANCE-STATUS. How can that logic be applied for enrollment period

From Jeff's comment,

COMMENT
SERVICING-PROV-NUM does not exist in CLAIM-HEADER-RX or CLAIM-LINE-RX
RESPONSE
The field entitled, “DISPENSING-PRESCRIPTION-DRUG-PROV-NUM” in the Claim-RX file captures the state-specific prov
actually dispensed the prescription medication. This field is analogous to the SERVICING-PROV-NUM field in the Claim-IP

Rules should be deprecated per Jeff Collier's request.

This is a follow-up to TMSIS-1319, and "phase 2" of the change to allow files with some un-decodable binary data past rece

Create rules to report back to the state that there was a non-ASCII character in the field. Current validation rules assume th
ASCII, so do not check this.

Two rough options for implementation, to be fleshed out and proposed for approval before we move forward:

a) incorporate into existing format rules (ex: RULE-7006) and null out these fields in the database (following the "formatting
[here|https://tmsis2.atlassian.net/wiki/display/RTD/Handling+bad+data+submitted+by+states]

b) write new rules that warn of having unrecognizable characters, but allow these fields, with replacement characters, to be

JDC - issue – States are populating the WAIVER-ID fields with State IDs and not Federal IDs on claim transactions, enrollr
files.

In T-MSIS, the definition calls for the states to submit federal IDs. In MSIS states had been submitting state waiver IDs.

While the definition in T-MSIS specifically tells states to submit federal IDs, the associated coding instruction was vague an
inaccurate, thus giving rise to confusion about whether states should submit federal waiver IDs to T-MSIS or state IDs.

Consequently, about half of the States report the federal IDs and half report State IDs. State IDs generally seem to be at a
specificity, so there are sometimes multiple state waiver IDs associated with a single federal waiver ID. (The use of state w
states began triggering EC160 edit errors (Overlapping segments with identical record keys are not allowed.))

Remedy/workaround - Implement the Waiver Identifier Look-up Table and Waiver Identifier Crosswalk Table in T-MSIS, see

h3. Summary
add the WAIVER-ID field to the MANAGED-CARE-OPERATING-AUTHORITY-MCR00005 segment primary key

JDC - Issue - When a State inputs multiple MCR00005 segments having overlapping effective time spans into the managed
triggers an EC160 edit error in T-MSIS v1.2 and a RULE-2659 error in T-MSIS v2.0. The current logic is based on the case
would only have a single operating authority at any point in time. This has proven to be false. MCOs can have multiple sim

JDC - Remedy - add the WAIVER-ID field to the MANAGED-CARE-OPERATING-AUTHORITY-MCR00005 segment key

See attached email for more background on issue and proposed solution: From Jeff Collier RE: WAIVER-ID issues in T-MS

h3. Requirements impact
The data validation business rule that will be impacted is RULE-2659, but the key requirement that should be updated is the
published to states. This will need to be updated to include WAIVER-ID as part of the primary key for MANAGED-CARE-OP
MCR00005.

h3. Development impact
Development effort (est. hours): [~everett] to fill out
Dependencies: [~everett] to fill out

h3. Testing impact
Testing effort (est. hours): [~sviswanathan] and [~mtasnim]/[~shana.amadi] to fill out
(TODO: ensure any test cases impacted are linked to the requirements above)

h3. Schedule impact
(pending impacts above; insert any notes about larger impact to the product delivery schedule)

Feedback from Beta States after the 2015-09-23 Beta States Conference Call

Initiatives on hold - - may not be applicable in November:
a. 2332, 2333 - If START-OF-TIME-PERIOD >= 20151105, then NATIONAL-HEALTH-CARE-ENTITY-ID must not be (8-fill

b. 2329 - If END-OF-TIME-PERIOD >= "20151110", CROSSOVER-INDICATOR= "1" and MEDICARE-HIC-NUM is 8-filled,
BENEFICIARY-IDENTIFIER must not be 8-filled

Per BA Lead - Rules will be made inactive until further notice.

Rules potentially impacted:
RULE-1006
RULE-1140
RULE-1181
RULE-1425
RULE-1558
RULE-1593
RULE-1821
RULE-1858
RULE-1898
RULE-2387
RULE-2719
RULE-3187
RULE-567
RULE-713
RULE-749

Feedback from Beta States after the 2015-09-23 Beta States Conference Call

Occurrence code effective and end date relationships - - Occurrence codes only have an effective date - - States may be 8
cases. Occurrence span codes have effective and end dates. OCCURRENCE-CODE-EFF-DATE-* must be <= OCCURRE

Per BA Lead, rule will be updated to include logic to only fire if both fields (OCCURRENCE-CODE-EFF-DATE, OCCURREN
populated.

Feedback from Beta States after the 2015-09-23 Beta States Conference Call

The logic for RULE-1402 as it applies to all claim types is not correct. Co-insurance and Deductible are two discreet fields
another. See Errors 2428 and 2431

If I begin a calendar year with a $1.000 deductible, and $35.00 in coinsurance for each visit; the provider will ask me to mak
$1000.00 deductible. At that point in time, I will only have to pay coinsurance.

It works the same way with Medicaid. A claims processor will see Medicare cross-overs with both amounts until about mid-
lot of claims with just coinsurance because the deductible has been met

If coinsurance is sent on a claim, it is perfectly valid for the deductible field to be 0 or "8's".

2.0 Validation logic: ({color:#205081}if and only if fns.hasValue(@val.TOT-MEDICARE-DEDUCTIBLE-AMT), then fns.hasV
COINS-AMT){color})

Feedback from Beta States after the 2015-09-23 Beta States Conference Call

Re: edits 2444 & 2228 – how are states to report primary eligibility when multiple eligibility spans exist and there are no dat
are date overlaps?

Add the correct logic to allow for multiple eligibility spans when there is more than 1 primary eligibility group indicator for the

Reference defects #13 and 368.

Feedback from Beta States after the 2015-09-23 Beta States Conference Call

Re: edits 2444 & 2228 – how are states to report primary eligibility when multiple eligibility spans exist and there are no dat
are date overlaps?

Disable RULE-2133. The validation logic verifies there is one primary eligibility group.

Reference defects #13 and 368.

Feedback from Beta States after the 2015-09-23 Beta States Conference Call

Edits for relationship between DATE-OF-DEATH (e.g. 2500, 2138, 2543, among others) and eligible file segments where d
date of segment. {color:#d04437}States may not always close out eligibility information until end of month or until after date

see affected edits 2500, 2138, 2543 in the V.2 documentation.

Feedback from Beta States after the 2015-09-23 Beta States Conference Call

"Initiatives on hold - - may not be applicable in November:
a. 2332, 2333 - If START-OF-TIME-PERIOD >= 20151105, then NATIONAL-HEALTH-CARE-ENTITY-ID must not be (8-fill
b. 2329 - If END-OF-TIME-PERIOD >= ""20151110"", CROSSOVER-INDICATOR= ""1"" and MEDICARE-HIC-NUM is 8-fill
BENEFICIARY-IDENTIFIER must not be 8-filled"

RULE-1821 and RULE-1181 should be made inactive until further notice.

Per CMS add "06 State appropriations to the CHIP agency" valid value to the FUNDING-SOURCE-NONFEDERAL-SHARE

This data element is used in all 4 claim files:
CIP127
CLT077
COT063
CRX054

FUNDING-SOURCE-NONFEDERAL-SHARE <new table>
01 State appropriations to the Medicaid agency
02 Intergovernmental transfers (IGT)
03 Certified public expenditures (CPE)
04 Provider taxes
05 Donations
{color:#205081}06 State appropriations to the CHIP agency{color}

Updated the following documents:
T-MSIS DD APPENDICES V1.3

Feedback from Beta States after the 2015-09-23 Beta States Conference Call

Currently all claims and claim lines are treated the same. CMS to enter Change Request (CR) to request this update be ma
as well.

Also include instructions on how to identify a denied /void claim or claim line.

Feedback from Beta States after the 2015-09-23 Beta States Conference Call

Edits such as 2381, 2382, 2383 need to be corrected to NOT require a modifier when there is a procedure code (If PROCE
PROCEDURE-CODE-MOD-2 must be 8-filled).

h3. CR update 2015-11-04 per JDC:
1. Modify logic of rules RULE-417, RULE-430, RULE-443, RULE-456, RULE-470, RULE-483 (EC#s 2382; 2383; 2384; 238
that the mod field is always blank. (ICD-9/10 procedure codes don't have modifiers.)

2. Deprecate RULE-1643; RULE-1704; RULE-1707 and RULE-1719 (EC#s 2382; 2383; 2384 & 2085). (Procedure codes
may not have an associated modifier.)

Feedback from Beta States after the 2015-09-23 Beta States Conference Call

Edit 2335 logic needs to be corrected: Sum (NON-COVERED-DAYS plus MEDICAID-COV-INPATIENT-DAYS {color:#d044
(BEGINNING-DATE-OF-SERVICE minus ENDING-DATE-OF-SERVICE (in days) plus 1).

red plus 1 will be removed from 2.0 logic. Also, confirm BegDOS-EndDOS has been
corrected.

Feedback from Beta States after the 2015-09-23 Beta States Conference Call

Edits such as 2002, 2004, 2013, 2024 or 2036 – need to exclude types of services or types of claims, such as capitation to payments (BEGINNING-DATE-OF-SERVICE must be <= END-OF-TIME-PERIOD or ENDING-DATE-OF-SERVICE must b or ADJUDICATION-DATE must be >= ADMISSION-DATE – where states are instructed to use admit and discharge date to covered by the FT).

Additionally must include guidance on how to recognize when and when not to apply the rule.

Feedback from Beta States after the 2015-09-23 Beta States Conference Call

Open questions:
1. Do we want to continue with the check digit algorithm or simply do an NPI/API lookup?
2 If check digit logic is kept, do API follow same rules as NPIs?

Hi Jeff -

We had a conversation about this back in June, but I wanted to file this to clarify that the coding requirements for rules like something along the lines of

"Value for the ELIGIBLE file must correspond to a managed care ID in a state-provided crosswalk."

should actually be

"Value for the ELIGIBLE file must correspond to a managed care ID in a managed care file the state has submitted via T-M

If you can confirm here, we'll fix the appropriate rules. Thanks!

State Issue: Alabama received error 103 when submitting the group level DIAGNOSIS-CODE-4. According to Jeff C, our po group-level codes on claims/encounters. Therefore, the edit should not set. The group level submitted was 3459.

Alabama received error 103 when submitting the group level DIAGNOSIS-CODE-3.

Alabama received error 103 when submitting the group level ADMITTING-DIAGNOSIS-CODE.

State Reported Issue: AL
SP Issue: 5306, 5308, 5309
CR NO: CIP041-0001, CIP041-0001
DE NO:CIP041, CIP032, CIP038, CIP030
Data Element Name: DIAGNOSIS-CODE-4
Error NO: 103

Business rule: Value is not included in the valid code list

Coding Requirement: DIAGNOSIS-CODE-3 through DIAGNOSIS-CODE-5: The third through fifth ICD-9/10-CM codes that

State Issue: Alex Wright: Edit 2429 posts to TOT-MEDICARE-COINS-AMT and requires the amount be 8-filled if the claim i
CLAIM = '3','C','W'). States are reporting 0000000.00 which would also be valid…no amount. Given that 8/9 fill is changin
revised so amounts for coinsurance and deductible cannot be less than or greater than 0 (if not NULL)?

State Reported Issue: All
SP Issue: n/a
CR NO: CRX044-0006
DE NO: CRX044
Data Element Name: TOT-MEDICARE-COINS-AMT
Error NO: 2429

Business rule: If TYPE-OF-CLAIM = "3", "C", "W", then TOT-MEDICARE-COINS-AMT must be 8-filled

Coding Requirement: Value must be "Not Applicable" if TYPE-OF-CLAIM indicates the claim is an encounter record.

State Issue: Edit should be adjusted to allow for multiple state licenses recorded by the same licensing entity/type. WV data
as given by the provider enrollment. Rule: Overlapping coverage not allowed for same Submitting state & Prov ID, Location
Issuing Entity ID. CMS Edit Issue: Provider license dates overlap with same end-of time date or start and end dates overlap
PRZ0009900193 00001 1 STATE BOARD OF MEDICAL EXAMINERS 19981109*2174 20160630
PRZ0009900193 00001 1 STATE BOARD OF MEDICAL EXAMINERS 20140930*2174 20150401
PRZ0009900311 00001 5 DEPARTMENT OF HEALTH SERVICES (LOCAL) 19780701*2174 99991231
PRZ0009900311 00001 5 DEPARTMENT OF HEALTH SERVICES (LOCAL) 20040422*2174 99991231
It is normal for some providers to have what may be considered "over-lapping" licenses.
1. A provider may have multiple service locations.
2. Those service locations can possibly be in multiple states.
3. The provider has to be licensed in every state they practice in, so there can be multiple licenses on one provider's file.
4. Each state has their own "licensing" expiration policies/dates. So there can be a variety of expiration dates/time frames.
a. Some will have all licenses expire on the same day every year
b. Some in the same month but different days
c. Some will have a license that expires one year from the day the provider originally obtained a license.
Please see the Example below:
Dr. Mark Pretend works for Tri-State Pediatricians. Tri-State

State Reported Issue: WV
SP Issue: 5278
CR NO: PRV065-0007
DE NO: PRV065
Data Element Name: PROV-LICENSE-EFF-DATE
Error NO: 2174

Business rule: If two or more PROV-LICENSING-INFO record segments have the same SUBMITTING-STATE, SUBMITTIN
LOCATION-ID, LICENSE-TYPE, and LICENSE-ISSUING-ENTITY-ID
then for each pair of record segments,
(Segment 1 PROV-LICENSE-EFF-DATE must <> Segment 2 PROV-LICENSE-EFF-DATE)
AND
((If Segment 1 PROV-LICENSE-EFF-DATE < Segment 2 PROV-LICENSE-EFF-DATE,
then
Segment 1 PROV-LICENSE-END-DATE must be < Segment 2 PROV-LICENSE-EFF-DATE)
OR
(If Segment 2 PROV-LICENSE-EFF-DATE < Segment 1 PROV-LICENSE-EFF-DATE,
then
Segment 2 PROV-LICENSE-END-DATE must be < Segment 1 PROV-LICENSE-EFF-DATE))

State Issue: Error is being posted to valid values. Possibly related to defect 489 but this is for service tracking claims where
billed amount. The DD includes the following instruction regarding TOT-BILLED-AMT for Service Tracking Claims on the Cl
Number COT048):
“If TYPE-OF-CLAIM = "4", then TOT-BILLED-AMT must = "00000000".” This should be changed to the total of billed amoun
claims or deleted. See below the conflict with edit error code 2425.
The data dictionary information for the corresponding field on the ClaimOT ‘03’ record, BILLED-AMT (DE Number COT174)
instructions specific to service tracking claims. However, it does state the following:
“This data element must include a valid dollar amount.”
Therefore per these DD instructions: WV is populating TOT-BILLED-AMT with ‘0.00’ and BILLED-AMT with the actual billed
tracking claim. This, in turn, is causing an error 2425 (Relational edit between TOT-BILLED-AMT and BILLED-AMT) on our
should be changed to the total of billed amounts on the service tracking claims so the amounts equal or the edit should be i
claims.
In the CMS financial transaction reporting guidelines:
For service tracking claims, the sum of the claim line MEDICAID-PAID-AMT values on a claim’s claim line record segments
reported in the SERVICE-TRACKING-PAYMENT-AMT data element on the claim’s claim header record segment. This is tr
records.

State Reported Issue: WV
SP Issue: 4897
CR NO: COT048-0005
DE NO: COT048
Data Element Name: TOT-BILLED-AMT
Error NO: 2425

Business rule: The absolute value of the sum of BILLED-AMT on each detail line record must = absolute value of TOT-BILL

Coding Requirement: The absolute value of the sum of the claim line BILLED-AMTs must be equal to the absolute value of

State Issue: Records are rejecting when the TYPE-OF-OTHER-THIRD-PARTY-LIABILITY value is different. Record keys a
Identificiation-Num, and Type-of-Third-Party-Liability. These keys are unique and therefore the edit is setting incorrectly. If t
Type of Third Party Liability, CMS needs to have the edit modified. An individual can have many different types of other thir
Examples: RECORD-NUMBERS - 95836 and 95837 - Dates overlap but the TYPE-OF-OTHER-THIRD-PARTY-LIABILITY
the other is a '5'.”

State Reported Issue: OK
SP Issue: 4716
CR NO: TPL068-0008
DE NO: TPL068
Data Element Name: OTHER-TPL-EFF-DATE
Error NO: 2181

Business rule: If two or more TPL-MEDICAID-ELIGIBLE-OTHER-THIRD-PARTY-COVERAGE-INFORMATION record segm
SUBMITTING-STATE, MSIS-IDENTIFICATION-NUM, and TYPE-OF-OTHER-THIRD-PARTY-LIABILITY
then for each pair of record segments,
(Segment 1 OTHER-TPL-EFF-DATE must <> Segment 2 OTHER-TPL-EFF-DATE) AND
((If Segment 1 OTHER-TPL-EFF-DATE < Segment 2 OTHER-TPL-EFF-DATE, then
Segment 1 OTHER-TPL-END-DATE must be < Segment 2 OTHER-TPL-EFF-DATE)
OR
(If Segment 2 OTHER-TPL-EFF-DATE < Segment 1 OTHER-TPL-EFF-DATE, then
Segment 2 OTHER-TPL-END-DATE must be < Segment 1 OTHER-TPL-EFF-DATE))

Coding Requirement: Records in a file segment that have the same set of values for the segment key data elements exclud
date must not have overlapping coverage dates (e.g., MSIS-IDENTIFICATION-NUMBER and SUBMITTING-STATE in the
ELIGIBILITY segment).

State Issue: Alabama is submitting Type of claim = 2 (capitated payments) and receiving error 2038 because the ENDING-
thant he ADJUDICATION-DATE. The Financial guidance states: Adjudication-Date - Date the line-level transaction's approv
were completed - Medicaid submitted 2015-01-02 Ending-date-of-service - Populate with the last day of the time period cov
transaction (CLAIMOT). Medicaid submitted with 2015-01-31 If states are always to use the end of time period as the endir
needs to be modified to exclude financial transactions.

State Reported Issue: AL
SP Issue: 4575
CR NO: COT034-0004
DE NO: COT034
Data Element Name: ENDING-DATE-OF-SERVICE
Error NO: 2038, 2040

Business rule:
ENDING-DATE-OF-SERVICE must be <= ADJUDICATION-DATE [CLAIM-HEADER-RECORD-OT]
Coding Requirement: Date must be equal to or before ADJUDICATION-DATE.

State Issue: Error is being posted to reversals. Reversals have negative dollar amounts. Relational edit does not take into a
be less than total medicare coinsurance amount on a reversal. Relational edit should be using absolute values of the amou

State Reported Issue: WV
SP Issue: 4469
CR NO: CIP117-0003
DE NO: CIP117
Data Element Name: TOT-MEDICARE-COINS-AMT
Error NO: 2126, 2127

Business rule: TOT-MEDICARE-COINS-AMT must be < TOT-BILLED-AMT

Coding Requirement: Value must be less than TOT-BILLED-AMT.

State Issue: Please update list as follows:
01 National committee for quality assurance – Excellent
02 National committee for quality assurance – Commendable
xx National committee for quality assurance – Accredited
03 National committee for quality assurance – Provisional
xx National committee for quality assurance – Interim
xx National committee for quality assurance – Denied
04 National committee for quality assurance – new plan (no longer a valid accreditation level)
05 URAC - full
06 URAC - conditional
07 URAC – provisional
08 Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) – 3 years
09 Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) – 1 year (no longer a valid accreditation level)
10 Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) – 6 months (no longer a valid accreditation level)
11 Not accredited
12 Other

State Reported Issue: All
SP Issue: n/a
CR NO: MCR086-0002
DE NO: MCR086
Data Element Name: ACCREDITATION-ORGANIZATION
Error NO: 103

Business rule: Value must be equal to a valid value.

Coding Requirement: Value must be equal to a valid value.

State Issue: Validation rules for email address in the MNGDCARE and PROVIDER files differ somewhat. The MNGDCARE
there be an '@' symbol. The PROVIDER file requires the '@' symbol and that the email address be in the following format:
format. There are ISO/ANSI standards of allowable characters in an email address which are not accepted in TMSIS. Thes
characters, e.g.: JOHN`~1!#$%^&*-_=+{|'.b@YAHOO.ORG.

State Reported Issue: All
SP Issue: 4849
CR NO: n/a
DE NO: MCR050, PRV054
Data Element Name: MANAGED-CARE-EMAIL ADDR-EMAIL
Error NO: n/a

Business rule:

Coding Requirement:

State Issue: Alabama is receiving error code 2434 for TYPE-OF-SERVICE when value = 086 (Other Pregnancy). However, notes 22, the Type of Service table, shows 086 being applicable to both CIP and COT.

State Reported Issue: AL
SP Issue: 4458
CR NO: CRX134-0002
DE NO: CRX134
Data Element Name: TYPE-OF-SERVICE
Error NO: 2434

Business rule: If FILE-NAME = "CLAIMRX", then TYPE-OF-SERVICE must = “011”, “033”, “034”, “085” , or “131”

Coding Requirement: Value must equal a prescription TYPE-OF-SERVICE value.

State Issue: Alabama is receiving error code 103 on the FUNDING-SOURCE-NONFEDERAL-SHARE when providing value program is not administered by the state Medicaid Agency. It is administered by the Department of Public Health. Alabama this on October 2014 and was told CMS would add a new value = '06' - State Appropriations to the CHIP Agency and that A new value but they are getting rejections.

State Reported Issue: AL
SP Issue: 4415
CR NO: CIP127-0001
DE NO: CIP127
Data Element Name: FUNDING-SOURCE-NONFEDERAL-SHARE
Error NO: 103

Business rule: Value is not included in the valid code list.

Coding Requirement: A code to indicate the type of non-federal share used by the state to finance its expenditure to the pro

State Issue: Edit 2432 may be written incorrectly. The current rule states: The absolute value of TOT-TPL-AMT must be <= BILLED-AMT minus TOT-MEDICARE-COINS-AMT plus TOT-MEDICARE-DEDUCIBLE-AMT).
Please speak to CMS (Jeff C) about this because this edit should include the TOT-OTHER-INSURANCE-AMT and NOT the OTHER-INSURANCE-AMT is the amount the provider receives from the recipient's health insurance carrier and submits or is the amount that is not submitted by provider's on claims. It is the amount recovered through other means such as; estate

State Reported Issue: AL
SP Issue: 4389
CR NO: CLT069-0002
DE NO: CLT069
Data Element Name: TOT-TPL-AMT
Error NO: 2432

Business rule: The absolute value of TOT-TPL-AMT must be <= the absolute value of (TOT-BILLED-AMT minus TOT-MED MEDICARE-DEDUCIBLE-AMT)

Coding Requirement: The absolute value of TOT-TPL-AMT must be equal to or less than the absolute value of TOT-BILLE MEDICARE-COINS-AMT plus TOT-MEDICARE-DEDUCTIBLE-AMT.

State Issue: Alabama is receiving error 2254 when 9-filling the Date of Death and the S2T mapping has Sometimes. CMS s
deaths. The business rule currently states: If DOD is not 8-filled, DOD must be <= END-OF-TIME-PERIOD. Rule needs to i
filled for completeness.
Also, Alabama is receiving error 2254 when date of death is > end of time period but this is due to full file replacements. If a
the 05/2015 reporting period but extracting on 06/10/2015, it is very possible the date of death could be > than end of time

State Reported Issue: AL
SP Issue: 4364, 4337, 4667, 4744
CR NO: PRV035-0004
DE NO: PRV035
Data Element Name: DATE-OF-DEATH
Error NO: 2254

Business rule: If DATE-OF-DEATH is not 8-filled, DATE-OF-DEATH must be <= END-OF-TIME-PERIOD

Coding Requirement: Date must be equal to or before END-OF-TIME-PERIOD if DATE-OF-DEATH is not "Not Applicable".

State Issue: Error 2456 is being posted on non-contiguous segments which impacts most of the provider file. In this case, e
provider PRV00002 segment dates when the State sends multiple segments with non-contiguous dates. Most States do no
in a contiguous manner. The Provider can be active or inactive during different time periods so the the PRV00002 dates do
only requirement is for the parent record to fully cover all children under the parent segments so dates on the parent should
dates. In many cases, segment date information is never contigous.

State Reported Issue: ME
SP Issue: 3744
CR NO: PRV020-0009
DE NO: PRV020
Data Element Name: PROV-ATTRIBUTES-EFF-DATE
Error NO: 2456

Business rule: If two or more PROV-ATTRIBUTES-MAIN record segments have the same SUBMITTING-STATE and SUBM
these record segments are sorted in ascending order by PROV-ATTRIBUTES-EFF-DATE, then for each consecutive pair (
segments, Segment N PROV-ATTRIBUTES-END-DATE must = Segment (N+1) PROV-ATTRIBUTES-EFF-DATE minus 1

Coding Requirement: Record segments that have the same set of values for the segment key data elements excluding the
not have gaps in coverage dates (e.g., MSIS-IDENTIFICATION-NUMBER and SUBMITTING-STATE in the PRIMARY-DEM
segment).

State Issue: Business Rule for 2385 is: "If PROCEDURE-CODE-4 is not 8-filled, then PROCEDURE-CODE-MOD-4 must n
PROCEDURE-CODE-4 is 8-filled, then PROCEDURE-CODE-MOD-4 must be 8-filled". It is incorrect to validate that if you h
must also have a modifier with it. You can have a Procedure Code without a modifier, but you can not have a Modifier witho
business rule should read: If PROCEDURE-CODE-MOD-4 is not 8-filled, then PROCEDURE-CODE-4 must not be 8-filled
MOD-4 is 8-filled, then PROCEDURE-CODE-4 must be 8-filled. This may also be a duplicate of defect 145. I realize that de
CIP183, but this edit is used on OT and IP files. Defect 145 needs to also include OT DE's identified in Edit 2385. Also note
correct for OT errors. The OT file only contains PROCEDURE-CODE DE. So sharing the error message with IP, where mul
misleading for OT errors.

State Reported Issue: TX
SP Issue: 3942
CR NO: COT219-0002 and COT219-0003
DE NO: COT219
Data Element Name: PROCEDURE-CODE-MOD-4
Error NO: 2385

Business rule: If PROCEDURE-CODE-4 is 8-filled, then PROCEDURE-CODE-MOD-4 must be 8-filled

Coding Requirement: Value must not be "Not Applicable" if PROCEDURE-CODE-4 is not "Not Applicable".

State Issue: Since states are reporting historical information, at some point a member can be dual eligible, while at a differe
dual eligible. Because the member was dual eligible, a HIC-NUMBER is present on the file. TA's recommendation is to requ
when the member is dual eligible. If there is a HIC number and member is not dual eligible, ignore/disregard the edit.

State Reported Issue: n/a
SP Issue: n/a
CR NO: n/a
DE NO: n/a
Data Element Name: n/a
Error NO: 2029

Business rule: n/a

Coding Requirement: n/a

State Issue: Edit 2146 doesn't allow for the same surgical procedure code to be repeated on the same claim when the proc
same as the others. For example, a provider can bill a claim with the same surgical procedure code on different days. The
procedure-code-date when evaluating for duplicate values of procedure-code entered.

The following edits need to EVALUATE the associated PROCEDURE-CODE-DATE (1 through 6) values.

State Reported Issue: n/a
SP Issue: 2846
CR NO: CIP090-0008
DE NO: n/a
Data Element Name: n/a
Error NO: 2146

Business rule: n/a

Coding Requirement: n/a

State Issue: Edit 2239 needs to be "turned-off". It is defined as a Tier 2 edit, but it is functioning as a Tier 3 edit. The edit i
Provider's NPI on the CLAIMIP file to ensure it exists on the PROVIDER file and that the provider is in a group. This is a Ti

State Reported Issue: n/a
SP Issue: 3172
CR NO: CIP180-0006
DE NO:
Data Element Name:
Error NO: n/a

Business rule: n/a

Coding Requirement: n/a

State Issue: Edit 2424 needs to be modified to factor in that not all Inpatient or LTC claims are priced based off of line leve
claims are header paid, e.g., per-diem, percent of charges, coins/deductible (crossovers), etc. Along with edit 2424, the ed
PAYMENT-LEVEL-IND indicates the claim is header paid. If the value for PAYMENT-LEVEL-IND indicates the claim is hea
bypassed.

State Reported Issue: n/a
SP Issue: 3756, 3758
CR NO: CLT064-0002
DE NO: n/a
Data Element Name: n/a
Error NO: 2424, 2409, 2125

Business rule: n/a

Coding Requirement: n/a

State Issue: Issue logged with CMS to determine if the program end date and date of death edits can be modified as many
enrollment after the date of death.
State is reporting 8-filled dates for state plan option segment.

State Reported Issue: n/a
SP Issue: n/a
CR NO: n/a
DE NO: n/a
Data Element Name:n/a
Error NO: 2543, 2538, 2514, 2507, 2501, 2500, 2497, 2477, 2462

Business rule: n/a

Coding Requirement: n/a

State Issue: Maggie Siegmund: New York has "Local Codes" - which many states are still using instead of using the standa
did not take into consideration the "local codes" some states still use. This error is not correct. Local Codes should be acce
9708, 7806.

State Reported Issue: NY
SP Issue: 2752
CR NO: n/a
DE NO:CIP030
Data Element Name: ADMITTING-DIAGNOSIS-CODE
Error NO: 103

Business rule:n/a

Coding Requirement: n/a

State Issue:Rhonda Downey:Ohio is receiving error code 127 when submitting 'E' codes in the ADMITTING-DIAGNOSIS-C
they were removing this edit. Error code still shows up in Sprint 11 deployment

State Reported Issue: OH
SP Issue: 3325
CR NO: n/a
DE NO: CLT027
Data Element Name: ADMITTING-DIAGNOSIS-CODE
Error NO:127

Business rule: n/a

Coding Requirement: n/a

State Issue: Rhonda Downey: Ohio is receiving error code 2328 when 8-filling the MEDICARE-COMB-DED-IND. May need
The coding requirement states: Value must be zero if claim is not a crossover or an encounter record.
Value 0 = Amount not combined with coinsurance amount
If the claim is not a cross-over or encounter, this field should = 8 because it is not applicable.

State Reported Issue: OH
SP Issue: 3340
CR NO: CIP128-0004
DE NO: CIP128
Data Element Name: MEDICARE-COMB-DED-IND
Error NO: 2328

Business rule: If CROSSOVER-INDICATOR = "0" or TYPE-OF-CLAIM = "3", "C", or "W", then MEDICARE-COMB-DED-IND

Coding Requirement: Value must be zero if CROSSOVER-INDICATOR indicates the claim is not a crossover or if TYPE-O
an encounter record.

State Issue: DC is approached DAYS-SUPPLY using instructions from STR (STR 5.4) regarding negative claim values with
quantity values for claims records can be positive or negative. If the cost or count value for any claims record is negative, it
below." The following section "Instructions on negative claims values for FLF files" describes the usage of modified zoned d
All values provided by the state e.g. 0003{ are getting flagged with EC 105.
IV&V conducted additionly testing and found out that values such as "-0006" and "00006" are being accepted. Please provi
use for positive and negative non-decimal values for quantities other than dollar amounts reported in FLF files.

State Reported Issue: DC
SP Issue: 3093
CR NO: CRX138-0001
DE NO: CRX138
Data Element Name: DAYS-SUPPLY
Error NO: 105

Business rule: DAYS-SUPPLY must be >=-365 and <=365

Coding Requirement: Number of days supply dispensed.

State Issue: NY has data that includes Indicator value 1 = Eligible individual does have TPL insurance coverage. NY does n
of this indicator to segment TPL00005. They had to 8-filled OTHER-TPL-END-DATE because they do not have Other TPL
Requesting exemption to this rule.

State Reported Issue: NY
SP Issue: 2720
CR NO: TPL069-0007
DE NO: TPL069
Data Element Name: OTHER-TPL-END-DATE
Error NO: 2359

Business rule: If HEALTH-INSURANCE-COVERAGE-IND = "1", then OTHER-TPL-END-DATE must not be 8-filled

Coding Requirement: Value must not be "Not Applicable" if HEALTH-INSURANCE-COVERAGE-IND indicates the individua
available.

State Issue: NY has 2 issues with this business rule:
1. When a member has multiple eligibility periods, error code 2477 is logged on each record, rather than only on the offend
2. NY data cannot meet this rule.

State Reported Issue: NY
SP Issue: 2729
CR NO: ELG254-0006
DE NO: ELG254
Data Element Name: ENROLLMENT-END-DATE
Error NO: 2477

Business rule: If DATE-OF-DEATH is not 8-filled, then ENROLLMENT-END-DATE must be <= DATE-OF-DEATH

Coding Requirement: Date must be equal to or before DATE-OF-DEATH if DATE-OF-DEATH is not "Not Applicable"

State Issue: States have been reporting error code 151 on non-claim files for both create and replacement. Additional to the segments get flagged with Tier 2 error codes i.e. 2194 on ELG00005 (MSIS-IDENTIFICATION-NUM [ELIGIBILITY-DETER MSIS-IDENTIFICATION-NUM [PRIMARY-DEMOGRAPHICS-ELIGIBILITY-ELG00002] and SUBMITTING-STATE [ELIGIBI ELG00005] must = SUBMITTING-STATE [PRIMARY-DEMOGRAPHICS-ELIGIBILITY-ELG00002] on the same record in th codes are more specific to the parent/child relationships among segments in a file unlike the generic 151. At the same time in the ERF and ESR reports which compounds the problem of trying to identify the missing segments. Misu's suggestion to alleviate this problem and allow us to clearly understand the current behavior of the system.

State Reported Issue: various
SP Issue: n/a
CR NO: various
DE NO: various
Data Element Name: all
Error NO: 151

Business rule: varies per error code

Coding Requirement: varies per error code

State Issue: Edit 103 is posting to NPI's that are not following the NPI Lunh algorithm. States assigned atypical provider NP not required to have an NPI. Per conversation with Jeff C. and Jeff S. the system needs to allow for these atypical provider needs to be removed to allow these identifiers (which may even include alpha-characters.
Please note that this issue applies to all claims, provider and eligibility files. Any NPI field is currently using this Lunh algorit need to be updated.
Also, if this field is 8-filled (ten 8's) the edit is also posting.

State that reported issue: VA
SP Issue: n/a
CR NO: n/a
DE NO: various
Data Element Name: *PROVIDER-NPI*
Error NO: 103

Business rule: If SERVICING-PROV-NPI-NUM not numeric. If NPI <> 8888888888 or 9999999999 then NPI must pass NP

Coding Requirement: The value must consist of digits 0 through 9 only. NPI must be valid. Record the value exactly as it ap field for capitation or premium payments (TYPE-OF-SERVICE = 119, 120, 121, 122)

State Issue: Alex W: This field should not be editing against a list of valid values unless each state provides a set against w
numeric fields that should allow all characters and special characters, excluding the pipe delimiter.
Maggie S: NY has a problem with the DRG-DESCRIPTION that CMS has put out as acceptable because they use a compl
This was brought up to Jeff Collier & Jeff Silverman many months back. To date they have not come bck with an answer to
set up by this state. This needs to again be pointed out to CMS.

State that Reported Issue: NY and RI
SP Issue NO: n/a
CR NO: n/a
DE NO: CIP029
Data Element Name: DRG-DESCRIPTION
Error NO: 103

Business rule: Value is not included in the valid code list

Coding Requirement: Value must originate from the DRGS list or be blank. States using the federal code should leave DRG
they should use a code that legitimately belongs to their code set.

BMI (CIP201, CLT143, COT125) data elements - Changed NECESSITY requirement from "Required" to "Optional" in Data

Per release note #45 - The table below lists the data elements in the T-MSIS v1.1 data dictionary that have proven to be pa
majority of states to populate.

	DE#		DE Name				Record Segment		File Name	
CIP201	BMI		CLAIM-HEADER-RECORD-IP-CIP00002	Claim-IP
CLT143	BMI		CLAIM-HEADER-RECORD-LT-CLT00002	Claim-LT
COT125	BMI		CLAIM-HEADER-RECORD-OT-COT00002	Claim-OT

Therefore, CMS is relieving states of the responsibility to:
(a) Provide these data
(b) Document a mitigation plan in the Source-to-Target-Mapping Matrix Addendum B whenever the data elements cannot b

Please note, however, if a state determines it can populate one or more of these fields and wishes to do so, they are encou
incur any Addendum B mitigation plan documentation expectations.

Reference: T-MSIS v1.1 Release Notes 1-47 2015-05-25b final

State Issue: The issue is that with a 7 year historical file, the date of death will never be > Start of time period. The edit says not 8-filled and MAINTENANCE-ASSISTANCE-STATUS (other than not eligible for Medicaid) = "1", "2", "3", "4", or "5", then >= START-OF-TIME-PERIOD. Historical information will have old dates of death. The TA does not have a recommendation rule is required. Perhaps the recommendation is to remove the edit altogether.

State that Reported issue: NY, CO
SP Issue NO: 2723, 4668, 3237, 5172
CR NO: ELG025-0011
DE NO: ELG025
Data Element Name: DATE-OF-DEATH
Error NO:2256

Business Rule: If DATE-OF-DEATH is not 8-filled and MAINTENANCE-ASSISTANCE-STATUS = "1", "2", "3", "4", or "5", th >= START-OF-TIME-PERIOD

Coding Requirement: Date must be equal to or after START-OF-TIME-PERIOD if value for MAINTENANCE-ASSISTANCE individual is eligible for Medicaid and if DATE-OF-DEATH is not "Not Applicable".

State Issue: Discrepancy in the DD for segment MANAGED-CARE-OPERATING-AUTHORITY-MCR00005 in MNGDCARE
In the Record Keys and Constraints tab of the DD v1.1 the WAIVER-ID is not part of the listed keys in that segment.
RECORD-ID
1 SUBMITTING-STATE
RECORD-NUMBER
2 STATE-PLAN-ID-NUM
3 OPERATING-AUTHORITY
WAIVER-ID
(a) MANAGED-CARE-OP-AUTHORITY-EFF-DATE
MANAGED-CARE-OP-AUTHORITY-END-DATE
STATE-NOTATION
FILLER
In the same tab, the following information is shown (including the WAIVER-ID).
No overlapping date spans for a given combination of SUBMTTING-STATE, STATE-PLAN-ID-NUM, OPERATING-AUTHO
Edit 2162 would post in this case. GA, NV and SC have reported the same WAIVER-ID for multiple records in the segment modified to include WAIVER-ID in the edit.

State that Reported Issue: SC, GA, NV
SP Issue: 3207
CR NO: MCR069-0007
DE NO: MCR069
Data Element Name: MANAGED-CARE-OP-AUTHORITY-EFF-DATE
Error NO: 2457

Business Rule: If two or more MANAGED-CARE-OPERATING-AUTHORITY record segments have the same SUBMITTIN NUM, and OPERATING-AUTHORITY
then for each pair of record segments, (Segment 1 MANAGED-CARE-OP-AUTHORITY-EFF-DATE must <> Segment 2 MA AUTHORITY-EFF-DATE)
AND ((If Segment 1 MANAGED-CARE-OP-AUTHORITY-EFF-DATE < Segment 2 MANAGED-CARE-OP-AUTHORITY-EF MANAGED-CARE-OP-AUTHORITY-END-DATE must be < Segment 2 MANAGED-CARE-OP-AUTHORITY-EFF-DATE) O CARE-OP-AUTHORITY-EFF-DATE < Segment 1 MANAGED-CARE-OP-AUTHORITY-EFF-DATE, then Segment 2 MANA END-DATE must be < Segment 1 MANAGED-CARE-OP-AUTHORITY-EFF-DATE))

Coding Requirement: Records in a file segment that have the same set of values for the segment key data elements exclu date must not have overlapping coverage dates (e.g., MSIS-IDENTIFICATION-NUMBER and SUBMITTING-STATE in the ELIGIBILITY segment).

State Issue: The key for PRV00004 is SUBMITTING-STATE, SUBMITTING-STATE-PROV-ID, PROV-LOCATION-ID, LICE
ISSUING-ENTITY-ID. NY is using the 000 All Locations for licenses since they apply to all. However, NY has multiple licen
adding LICENSE-OR-ACCREDITATION-NUMBER, NY will only be able to report one license of each type for a provider. C
dataset.

State that Reported issue: NY
SP Issue NO: 2751
CR NO: PRV065-0007
DE NO: PRV065
Date Element Name: PROV-LICENSE-EFF-DATE
Error NO: 2174

Business Rule: If two or more PROV-LICENSING-INFO record segments have the same SUBMITTING-STATE, SUBMITTI
LOCATION-ID, LICENSE-TYPE, and LICENSE-ISSUING-ENTITY-ID
then for each pair of record segments, (Segment 1 PROV-LICENSE-EFF-DATE must <> Segment 2 PROV-LICENSE-EFF
PROV-LICENSE-EFF-DATE < Segment 2 PROV-LICENSE-EFF-DATE, then Segment 1 PROV-LICENSE-END-DATE mus
LICENSE-EFF-DATE) OR (If Segment 2 PROV-LICENSE-EFF-DATE < Segment 1 PROV-LICENSE-EFF-DATE, then Seg
DATE must be < Segment 1 PROV-LICENSE-EFF-DATE))

Coding Requirement: 'Records in a file segment that have the same set of values for the segment key data elements exclu
date must not have overlapping coverage dates (e.g., MSIS-IDENTIFICATION-NUMBER and SUBMITTING-STATE in the
ELIGIBILITY segment).

State Issue: The business rule states that segment effective dates must not have gaps. NY data does not meet this require
will always be flagged with code 2457.

State that reported issue: NY
SP Issue NO: 2754
CR NO: PRV044-0009
DE NO: PRV044
Data Element Name: PROV-LOCATION-AND-CONTACT-INFO-EFF-DATE
Error NO: 2457

Business Rule: If two or more PROV-LOCATION-AND-CONTACT-INFO record segments have the same SUBMITTING-ST
PROV-ID, PROV-LOCATION-ID, and RECORD-NUMBER and these record segments are sorted in ascending order by PR
CONTACT-INFO-EFF-DATE, then for each consecutive pair (1,2; 2,3; 3,4; etc.) of record segments, Segment N PROV-LO
INFO-END-DATE must = Segment (N+1) PROV-LOCATION-AND-CONTACT-INFO-EFF-DATE minus 1 day

Coding Requirement: Record segments that have the same set of values for the segment key data elements excluding the
not have gaps in coverage dates (e.g., MSIS-IDENTIFICATION-NUMBER and SUBMITTING-STATE in the PRIMARY-DEM
segment).

CRX143 DRUG-UTILIZATION-CODE valid values in v1.1 are not aligned with the NCPDP Valid Values. CMS is advising st
UTILIZATION-CODE Valid Value codes are to be those as defined by the NCPDP see attachment for list of valid values.

The DD Appendix A is updated w/ the NCPDP valid values.

References:
T-MSIS v1.1 Release Notes 1-47 2015-05-25b final
T-MSIS DD APPENDICES V1.3

Per release note #41, add the PRV101:STATE-PLAN-ENROLLMENT data element to the PROV-MEDICAID-ENROLLMEN

The key structure for the PROV-MEDICAID-ENROLLMENT-PRV00007 record segment, does not include the data element as part of the key. Because of this, States are not able to report multiple STATE-PLAN-ENROLLMENT records in PROV-M PRV00007 record segment for a single provider, when the provider has enrolled in Medicaid and CHIP at different times.

Until the STATE-PLAN-ENROLLMENT data element is added to PRV00007, release note# 41 provides further guidance to assemble PROVIDER records.

Reference:
T-MSIS v1.1 Release Notes 1-47 2015-05-25b final