Centers for Medicaid and CHIP Services (CMCS)

T-MSIS Data Dictionary - Changes Between Versions 2.4.0 and 4.0.0 - Redline

PRA Disclosure Statement: The Transformed Medicaid Statistical Information System (T-MSIS) is used to assist the Centers for Medicare & Medicaid Services (CMS) with monitoring and oversight of Medicaid and CHIP programs, to enable evaluation of demonstrations under section 1115 of the Social Security Act and to calculate quality measures and other metrics, including those reported through the new Medicaid and CHIP Scoreboard. Section 4735 of the Balanced Budget Act of 1997 included a statutory requirement for states to submit claims data, enrollee encounter data, and supporting information. Section 6504 of the Affordable Care Act strengthened this provision by requiring states to include data elements the Secretary determines necessary for program integrity, program oversight, and administration. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0345 (Expires: 03/31/2026). The time required to complete this information collection is estimated to average 10 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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T-MSIS Data Dictionary – CIP File Changes Between Versions 2.4.0 and 4.0.0

Data Element Number	System Data Element Number	Data Element	Data Element Name Text	Data Element Necessity	Definition	Valid Value List (VVL)	File Segment Number	File Segment Name	Size	Pipe Separated Value Segment Data Element Order	Fixed Length Field Start Position	Fixed Length Field Stop Position	Coding Requirements
CIP001	CIP.001.001	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	CIP00001	FILE-HEADER-RECORD-IP	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~ 3. Value must be in Record ID List (VVL) 4. Value must equal "CIP00001"
CIP002	CIP.001.002	DATA-DICTIONARY-VERSION	Data Dictionary Version	Mandatory	A data element to capture the version of the T-MSIS data dictionary that was used to build the file. ~~Use the version number specified on the Cover Sheet of the data dictionary" to V2.4.~~	DATA-DICTIONARY-VERSION	CIP00001	FILE-HEADER-RECORD-IP	X(10)	2	9	18	1. Value must be 10 characters or less 2. Value must be in Data Dictionary Version List (VVL) 3. Value must not include the pipe ("|") symbol ~~3~~4. Mandatory
CIP003	CIP.001.003	SUBMISSION-TRANSACTION-TYPE	Submission Transaction Type	Mandatory	A data element to identify the whether the transactions in the file are original submissions of the data, a resubmission of a previously submitted file, or corrections of edit rejects.	SUBMISSION-TRANSACTION-TYPE	CIP00001	FILE-HEADER-RECORD-IP	X(1)	3	19	19	~~1.~~1. Value must be 1 character 2. Value must be in Submission Transaction Type List (VVL)

													~~2. Value must be 1 character~~ ~~3.~~3. Mandatory
CIP004	CIP.001.004	FILE-ENCODING-SPECIFICATION	File Encoding Specification	Mandatory	Denotes which supported file encoding standard was used to create the file.	FILE-ENCODING-SPECIFICATION	CIP00001	FILE-HEADER-RECORD-IP	X(3)	4	20	22	~~1.~~1. Value must be 3 characters 2. Value must be in File Encoding Specification List (VVL) ~~2. Value must be 3 characters~~ ~~3.~~3. Mandatory
CIP005	CIP.001.005	DATA-MAPPING-DOCUMENT-VERSION	Data Mapping Document Version	Mandatory	Identifies the version of the T-MSIS data mapping document used to build a state submission file. ~~Use the version number specified on the title page of the data mapping document~~	N/A	CIP00001	FILE-HEADER-RECORD-IP	X(9)	5	23	31	1. Value must be 9 characters or less 2. Mandatory
CIP006	CIP.001.006	FILE-NAME	File Name	Mandatory	A code to identify the subject area to which the records in its file relate. Each T-MSIS submission file should only contain records for one subject area (i.e., Eligible, Third-party liability, Provider, Managed Care Plan Information, Inpatient, Long-Term Care, Other, ~~and~~ Pharmacy Claim, and Financial Transactions).	N/A	CIP00001	FILE-HEADER-RECORD-IP	X(8)	6	32	39	1. Value must equal ~~'CLAIM-IP'~~"CLAIM-IP" 2. Mandatory ~~3. For TYPE-OF-SERVICE = 001, 058, 060, 084, 086, 090, 091, 092, 093, 123, 132, or 135, FILE-NAME must be CLAIM-IP.~~
CIP007	CIP.001.007	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	CIP00001	FILE-HEADER-RECORD-IP	X(2)	7	40	41	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ 3. Mandatory
CIP008	CIP.001.008	DATE-FILE-CREATED	Date File Created	Mandatory	The date on which the file was created.	N/A	CIP00001	FILE-HEADER-RECORD-IP	9(8)	8	42	49	~~1.~~1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" ~~2~~3. Value must be ~~8 characters in the form "CCYYMMDD"~~ ~~3. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~4.~~less than current date 4. Value must be equal to or after the value

													of associated End of Time Period 5. Mandatory
CIP009	CIP.001.009	START-OF-TIME-PERIOD	Start of Time Period	Mandatory	This value must be the first day of the reporting month, regardless of the actual date span of the data in the file.	N/A	CIP00001	FILE-HEADER-RECORD-IP	9(8)	9	50	57	~~1. Value of the CC component must be "20"~~ ~~2. Value must be 8 characters in the form "CCYYMMDD"~~ ~~3.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~4. Value must be less than current date~~ ~~5.~~in the form "CCYYMMDD" 2. Value must be equal to or earlier than associated Date File Created ~~6~~3. Value must be before associated End of Time Period ~~7~~4. Mandatory 5. Value of the CC component must be "20"
CIP010	CIP.001.010	END-OF-TIME-PERIOD	End of Time Period	Mandatory	This value must be the last day of the reporting month, regardless of the actual date span.	N/A	CIP00001	FILE-HEADER-RECORD-IP	9(8)	10	58	65	1. ~~Value~~The date must be ~~8 characters~~a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" 3. ~~The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~4.~~Value must be equal to or earlier than associated Date File Created ~~5~~ 4. Value must be equal to or after associated Start of Time Period ~~6~~ 5. Mandatory

CIP011	CIP.001.011	FILE-STATUS-INDICATOR	File Status Indicator	Mandatory	A code to indicate whether the records in the file are test or production records.	FILE-STATUS-INDICATOR	CIP00001	FILE-HEADER-RECORD-IP	X(1)	11	66	66	~~1.~~1. Value must be 1 character 2. For production files, value must be equal to ~~'P'~~ ~~2. Value must be 1 character~~ "P" 3. Value must be in File Status Indicator List (VVL) 4. Mandatory
CIP012	CIP.001.012	SSN-INDICATOR	SSN Indicator	Mandatory	Indicates whether the state uses the eligible person's social security number instead of an MSIS Identification Number as the unique, unchanging eligible person identifier. A state's SSN/Non-SSN designation on the eligibility file should match on the claims and third party liability files.	SSN-INDICATOR	CIP00001	FILE-HEADER-RECORD-IP	X(1)	12	67	67	~~1.~~1. Value must be 1 character 2. Value must be in SSN Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory
CIP013	CIP.001.013	TOT-REC-CNT	Total Record Count	Mandatory	A count of all records in the file except for the file header record. This count will be used as a control total to help assure that the file did not become corrupted during transmission.	N/A	CIP00001	FILE-HEADER-RECORD-IP	9(11)	13	68	78	~~1.~~1. Value must be 11 digits or less 2. Value must be a positive integer ~~2~~3. Value must be between 0:99999999999 (inclusive) ~~3. Value must be 11 digits or less~~ ~~4.~~4. Value must equal the number of records included in the file submission except for the file header record. 5. Mandatory
CIP014	CIP.001.014	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	CIP00001	FILE-HEADER-RECORD-IP	X(500)	15	83	582	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational

CIP016	CIP.002.016	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	CIP00002	CLAIM-HEADER-RECORD-IP	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "CIP00002"
CIP017	CIP.002.017	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (CIP.001.007)
CIP018	CIP.002.018	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ 3. ~~Value must be 11 digits or less~~ ~~4.~~Mandatory
CIP019	CIP.002.019	ICN-ORIG	Original ICN	Mandatory	A unique number assigned by the state's payment system that identifies an original or adjustment claim.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(50)	4	22	71	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory

CIP020	CIP.002.020	ICN-ADJ	Adjustment ICN	Conditional	A unique claim number assigned by the state's payment system that identifies the adjustment claim for an original transaction.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(50)	5	72	121	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value ~~is~~ equals "0~~,~~", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
CIP021	CIP.002.021	SUBMITTER-ID	Submitter ID	Mandatory	The Submitter Identification number is the value that identifies the provider/trading partner/clearing house organization to the state's claim adjudication system.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(12)	6	122	133	1. Value must be 12 characters or less 2. Mandatory
CIP022	CIP.002.022	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual ~~(except on service tracking payments).~~ . Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47572~~reporting-shared-msis-identification-numbers-eligibility/	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(20)	7	134	153	~~1. Mandatory~~ ~~2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN~~ ~~3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN~~ ~~4. Value must be 20 characters or less~~ ~~5. When Type of Claim not in (4, D, X, Z, U, V, Y, W),~~1. Value must be 20 characters or less 2. Mandatory 3. Value must match MSIS Identification Number (ELG.021.251) and the Admission Date (CIP.002.094) must be between Enrollment Effective Date (ELG.021.253) and Enrollment End Date (ELG.021.254) ~~6. When Type of Claim (CIP.002.100) equals 4, D or X (lump sum payment) value must begin with an '&'~~

CIP023	CIP.002.023	CROSSOVER-INDICATOR	Crossover Indicator	~~Conditional~~ Mandatory	An indicator specifying whether the claim is a crossover claim where a portion is paid by Medicare.	CROSSOVER-INDICATOR	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	8	154	154	~~1.~~1. Value must be 1 character 2. Value must be in Crossover Indicator List (VVL) ~~2~~3. If Crossover Indicator value ~~is~~equals "1", then associated Dual Eligible Code (ELG.005.085) value must be in ~~"[~~01~~",~~ ~~",~~ 02~~",~~ ~~",~~ 04~~",~~ ~~",~~ 08~~",~~ ~~",~~ 09~~", or ",~~ 10~~"]~~ for the same time period (by date of service) ~~3. Value must be 1 character~~ ~~4. Conditional~~ ~~5. If the TYPE-OF-CLAIM value is in ["1", "3", "A", "C"], then value is mandatory and must be reported.~~4. Mandatory
CIP024	CIP.002.024	TYPE-OF-HOSPITAL	Type of Hospital	Mandatory	This code denotes the type of hospital on the claim (servicing facility).	TYPE-OF-HOSPITAL	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	9	155	156	~~1.~~1. Value must be 2 characters 2. Value must be in Type of Hospital List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory
CIP025	CIP.002.025	1115A-DEMONSTRATION-IND	1115A Demonstration Indicator	Conditional	~~Indicates that~~In the claims files this data element indicates whether the claim or encounter was covered under the authority of an ~~1115(A)~~1115A demonstration. ~~1115(A) is a Center for Medicare and Medicaid Innovation~~In the Eligibility file, this data element indicates whether the individual participates in an 1115A demonstration.	1115A-DEMONSTRATION-IND	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	10	157	157	~~1.~~1. Value must be 1 character 2. Value must be in 1115A Demonstration Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Conditional 4. When value equals ~~'~~"0~~'~~", is invalid or not populated, then the associated 1115A Demonstration Indicator (ELG.018.2~~2~~33) must equal ~~'~~"0~~'~~", is invalid or not populated
CIP026	CIP.002.026	ADJUSTMENT-IND	Adjustment Indicator	Mandatory	Indicates the type of adjustment record.	ADJUSTMENT-IND	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	11	158	158	~~1.~~1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) ~~2. If associated Type of Claim value is in [1,~~ 3~~, 5, A, C, E, U, W, Y], then value must be in [0, 1, 4]~~ ~~3. If associated Type of Claim value is '4, D, X',~~ ~~then.~~ Value must be in [~~5, 6~~ 0,1,4] 4. ~~Value must be 1 character~~ ~~5.~~Mandatory 5. If value equals "0", then associated

													Adjustment ICN must not be populated 6. Value must equal "1", when associated Claim Status equals "686"
CIP027	CIP.002.027	ADJUSTMENT-REASON-CODE	Adjustment Reason Code	Conditional	Claim adjustment reason codes communicate why a claim was paid differently than it was billed. ~~If the amount paid is different from the amount billed you need an adjustment reason code.~~	ADJUSTMENT-REASON-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(3)	12	159	161	~~1.~~1. Value must be 3 characters or less 2. Value must be in Adjustment Reason Code List (VVL) ~~2. Value must be 3 characters or less~~ ~~3.~~3. Conditional 4. Value must ~~not~~ be populated when ~~associated Adjustment Indicator equals "0"~~the total paid amount is different from the total billed amount
CIP028	CIP.002.028	ADMISSION-TYPE	Admission Type	Mandatory	The basic types of admission for Inpatient hospital stays and a code indicating the priority of this admission.	ADMISSION-TYPE	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	13	162	162	~~1.~~1. Value must be 1 character 2. Value must be in Admission Type List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory
CIP029	CIP.002.029	DRG-DESCRIPTION	DRG Description	Conditional	Description of the associated state-specific DRG code. If using standard MS-DRG classification system, ~~a DRG Description is not required.~~leave blank.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(20)	14	163	182	1. Value must be 20 characters or less 2. Conditional
~~CIP030~~	~~CIP.002.030~~	~~ADMITTING-DIAGNOSIS-CODE~~	~~Admitting Diagnosis Code~~	~~Conditional~~	~~ICD-9 or ICD-10 diagnosis codes used as a tool to group and identify diseases, disorders, symptoms, poisonings, adverse effects of drugs and chemicals, injuries and other reasons for patient encounters. Diagnosis codes should be passed through to T-MSIS exactly as they were submitted by the provider on their claim (with the exception of removing the decimal). For example: 210.5 is coded as "2105".~~	~~DIAGNOSIS-CODE~~	~~CIP00002~~	~~CLAIM-HEADER-RECORD-IP~~	~~X(7)~~	~~15~~	~~183~~	~~189~~	~~1. When populated, a Diagnosis Code Flag is required~~ ~~2. If associated Diagnosis Code Flag value is "1" (ICD-9), then value must be in ICD-9 Diagnosis Codes List (VVL)~~ ~~3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Codes List (VVL)~~ ~~4. Value must be a minimum of 3 characters~~ ~~5. Value must not contain a decimal point~~

													6. If associated Diagnosis Code Flag value is '"1" (ICD-9), value must not exceed 5 characters 7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 characters 8. When there is more than one diagnosis code on a claim, each value must be unique 9. Conditional
CIP031	CIP.002.031	ADMITTING-DIAGNOSIS-CODE-FLAG	Admitting Diagnosis Code Flag	Mandatory	A flag that identifies the coding system used for the Admitting Diagnosis Code.	ADMITTING-DIAGNOSIS-CODE-FLAG	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	16	190	190	1. Value must be in Diagnosis Code Flag(VVL) 2. Value must be 1 character 3. Mandatory
CIP032	CIP.002.032	DIAGNOSIS-CODE-1	Diagnosis Code 1	Conditional	The primary/principal ICD-9/10-CM diagnosis code as reported on the claim.	DIAGNOSIS-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(7)	17	191	197	1. When populated, a Diagnosis Code Flag is required 2. If associated Diagnosis Code Flag value is "1" (ICD-9), then value must be in ICD-9 Diagnosis Codes List (VVL) 3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Codes List (VVL) 4. Value must be a minimum of 3 characters 5. Value must not contain a decimal point 6. If associated Diagnosis Code Flag value is '"1" (ICD-9), value must not exceed 5 characters 7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 characters 8. When there is more than one diagnosis code on a claim, each value must be unique 9. Conditional 10. If Type of Claim (CIP.002.100) in ("1", "3", "A", "C", "U", "W") then value must be populated.
CIP033	CIP.002.033	DIAGNOSIS-CODE-FLAG-1	Diagnosis Code Flag 1	Conditional	Flag used to identify if associated Diagnosis Code field is reported with ICD-9 or ICD-10 code. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.	DIAGNOSIS-CODE-FLAG	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	18	198	198	1. Value must be in Diagnosis Code Flag List (VVL) 2. Value must be 1 character 3. Conditional 4. Value should not be populated, if the associated diagnosis code is not populated

CIP034	CIP.002.034	DIAGNOSIS POA FLAG 1	Diagnosis POA Flag 1	Conditional	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator is used to identify certain preventable conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence based guidelines. *States that do not use the grouper methodology may use CMS approved methodology that is prospective in nature. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.	DIAGNOSIS POA FLAG	CIP00002	CLAIM HEADER RECORD IP	X(1)	19	199	199	1. Value must be in Diagnosis POA Flag List (VVL) 2. Value must be 1 character 3. Conditional
CIP035	CIP.002.035	DIAGNOSIS CODE 2	Diagnosis Code 2	Conditional	ICD 9 or ICD 10 diagnosis codes used as a tool to group and identify diseases, disorders, symptoms, poisonings, adverse effects of drugs and chemicals, injuries and other reasons for patient encounters. Diagnosis codes should be passed through to T MSIS exactly as they were submitted by the provider on their claim (with the exception of removing the decimal). For example: 210.5 is coded as "2105".	DIAGNOSIS CODE	CIP00002	CLAIM HEADER RECORD IP	X(7)	20	200	206	1. When populated, a Diagnosis Code Flag is required 2. If associated Diagnosis Code Flag value is "1" (ICD 9), then value must be in ICD 9 Diagnosis Codes List (VVL) 3. If associated Diagnosis Code Flag value is "2" (ICD 10), then value must be in ICD 10 Diagnosis Codes List (VVL) 4. Value must be a minimum of 3 characters 5. Value must not contain a decimal point 6. If associated Diagnosis Code Flag value is '"1" (ICD 9), value must not exceed 5 characters 7. If associated Diagnosis Code Flag value is "2" (ICD 10), value must not exceed 7 characters 8. When there is more than one diagnosis code on a claim, each value must be unique 9. Conditional

													10. Value must not be populated when Diagnosis Code 1 (CIP.002.032) is not populated
CIP036	CIP.002.036	DIAGNOSIS CODE FLAG 2	Diagnosis Code Flag 2	Conditional	Flag used to identify if associated Diagnosis Code field is reported with ICD-9 or ICD-10 code. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.	DIAGNOSIS CODE FLAG	CIP00002	CLAIM HEADER RECORD IP	X(1)	21	207	207	1. Value must be in Diagnosis Code Flag List (VVL) 2. Value must be 1 character 3. Conditional 4. Value should not be populated, if the associated diagnosis code is not populated
CIP037	CIP.002.037	DIAGNOSIS POA FLAG 2	Diagnosis POA Flag 2	Conditional	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator is used to identify certain preventable conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* that has a higher payment when present as a secondary diagnosis, and (c) could reasonablyhave been prevented through the application of evidence-based guidelines. *States that do not use the grouper methodology may use CMS-approved methodology that is prospective in nature. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.	DIAGNOSIS POA FLAG	CIP00002	CLAIM HEADER RECORD IP	X(1)	22	208	208	1. Value must be in Diagnosis POA Flag List (VVL) 2. Value must be 1 character 3. Conditional
CIP038	CIP.002.038	DIAGNOSIS CODE 3	Diagnosis Code 3	Conditional	ICD-9 or ICD-10 diagnosis codes used as a tool to group and identify diseases, disorders, symptoms, poisonings, adverse effects of drugs and chemicals, injuries and other reasons for patient encounters. Diagnosis	DIAGNOSIS CODE	CIP00002	CLAIM HEADER RECORD IP	X(7)	23	209	215	1. When populated, a Diagnosis Code Flag is required 2. If associated Diagnosis Code Flag value is "1" (ICD-9), then value must be in ICD-9 Diagnosis Codes List (VVL) 3. If associated Diagnosis Code Flag value is "2"

					codes should be passed through to T-MSIS exactly as they were submitted by the provider on their claim (with the exception of removing the decimal). For example: 210.5 is coded as "2105".								(ICD-10), then value must be in ICD-10 Diagnosis Codes List (VVL) 4. Value must be a minimum of 3 characters 5. Value must not contain a decimal point 6. If associated Diagnosis Code Flag value is '"1" (ICD-9), value must not exceed 5 characters 7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 characters 8. When there is more than one diagnosis code on a claim, each value must be unique 9. Conditional 10. Value must not be populated when Diagnosis Code 2 (CIP.002.035) is not populated
CIP039	CIP.002.039	DIAGNOSIS CODE FLAG 3	Diagnosis Code Flag 3	Conditional	Flag used to identify if associated Diagnosis Code field is reported with ICD-9 or ICD-10 code. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.	DIAGNOSIS CODE FLAG	CIP00002	CLAIM HEADER RECORD IP	X(1)	24	216	216	1. Value must be in Diagnosis Code Flag List (VVL) 2. Value must be 1 character 3. Conditional 4. Value should not be populated, if the associated diagnosis code is not populated
CIP040	CIP.002.040	DIAGNOSIS POA FLAG 3	Diagnosis POA Flag 3	Conditional	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator is used to identify certain preventable conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. *States that do not use the grouper methodology may use CMS-approved methodology that is prospective in nature. Each Diagnosis Code Flag is associated with one, and	DIAGNOSIS POA FLAG	CIP00002	CLAIM HEADER RECORD IP	X(1)	25	217	217	1. Value must be in Diagnosis POA Flag List (VVL) 2. Value must be 1 character 3. Conditional

					only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.								
CIP041	CIP.002.041	DIAGNOSIS-CODE-4	Diagnosis Code 4	Conditional	ICD-9 or ICD-10 diagnosis codes used as a tool to group and identify diseases, disorders, symptoms, poisonings, adverse effects of drugs and chemicals, injuries and other reasons for patient encounters. Diagnosis codes should be passed through to T-MSIS exactly as they were submitted by the provider on their claim (with the exception of removing the decimal). For example: 210.5 is coded as "2105".	DIAGNOSIS-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(7)	26	218	224	1. When populated, a Diagnosis Code Flag is required 2. If associated Diagnosis Code Flag value is "1" (ICD-9), then value must be in ICD-9 Diagnosis Codes List (VVL) 3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Codes List (VVL) 4. Value must be a minimum of 3 characters 5. Value must not contain a decimal point 6. If associated Diagnosis Code Flag value is '"1" (ICD-9), value must not exceed 5 characters 7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 characters 8. When there is more than one diagnosis code on a claim, each value must be unique 9. Conditional 10. Value must not be populated when Diagnosis Code 3 (CIP.002.038) is not populated
CIP042	CIP.002.042	DIAGNOSIS-CODE-FLAG-4	Diagnosis Code Flag 4	Conditional	Flag used to identify if associated Diagnosis Code field is reported with ICD-9 or ICD-10 code. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.	DIAGNOSIS-CODE-FLAG	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	27	225	225	1. Value must be in Diagnosis Code Flag List (VVL) 2. Value must be 1 character 3. Conditional 4. Value should not be populated, if the associated diagnosis code is not populated
CIP043	CIP.002.043	DIAGNOSIS-POA-FLAG-4	Diagnosis POA Flag 4	Conditional	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator is used to identify certain preventable conditions that are: (a) high cost or high volume or	DIAGNOSIS-POA-FLAG	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	28	226	226	1. Value must be in Diagnosis POA Flag List (VVL) 2. Value must be 1 character 3. Conditional

					both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. *States that do not use the grouper methodology may use CMS-approved methodology that is prospective in nature. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.								
CIP044	CIP.002.044	DIAGNOSIS CODE 5	Diagnosis Code 5	Conditional	ICD-9 or ICD-10 diagnosis codes used as a tool to group and identify diseases, disorders, symptoms, poisonings, adverse effects of drugs and chemicals, injuries and other reasons for patient encounters. Diagnosis codes should be passed through to T-MSIS exactly as they were submitted by the provider on their claim (with the exception of removing the decimal). For example: 210.5 is coded as "2105".	DIAGNOSIS CODE	CIP00002	CLAIM HEADER RECORD IP	X(7)	29	227	233	1. When populated, a Diagnosis Code Flag is required 2. If associated Diagnosis Code Flag value is "1" (ICD-9), then value must be in ICD-9 Diagnosis Codes List (VVL) 3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Codes List (VVL) 4. Value must be a minimum of 3 characters 5. Value must not contain a decimal point 6. If associated Diagnosis Code Flag value is '"1" (ICD-9), value must not exceed 5 characters 7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 characters 8. When there is more than one diagnosis code on a claim, each value must be unique 9. Conditional 10. Value must not be populated when Diagnosis Code 4 (CIP.002.041) is not populated
CIP045	CIP.002.045	DIAGNOSIS CODE FLAG 5	Diagnosis Code Flag 5	Conditional	Flag used to identify if associated Diagnosis Code field is reported with ICD-9 or ICD-10 code. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with	DIAGNOSIS CODE FLAG	CIP00002	CLAIM HEADER RECORD IP	X(1)	30	234	234	1. Value must be in Diagnosis Code Flag List (VVL) 2. Value must be 1 character 3. Conditional

					Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.								4. Value should not be populated, if the associated diagnosis code is not populated
CIP046	CIP.002.046	DIAGNOSIS POA FLAG 5	Diagnosis POA Flag 5	Conditional	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator is used to identify certain preventable conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. *States that do not use the grouper methodology may use CMS-approved methodology that is prospective in nature. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.	DIAGNOSIS POA FLAG	CIP00002	CLAIM HEADER RECORD IP	X(1)	31	235	235	1. Value must be in Diagnosis POA Flag List (VVL) 2. Value must be 1 character 3. Conditional
CIP047	CIP.002.047	DIAGNOSIS CODE 6	Diagnosis Code 6	Conditional	ICD-9 or ICD-10 diagnosis codes used as a tool to group and identify diseases, disorders, symptoms, poisonings, adverse effects of drugs and chemicals, injuries and other reasons for patient encounters. Diagnosis codes should be passed through to T-MSIS exactly as they were submitted by the provider on their claim (with the exception of removing the decimal). For example: 210.5 is coded as "2105".	DIAGNOSIS CODE	CIP00002	CLAIM HEADER RECORD IP	X(7)	32	236	242	1. When populated, a Diagnosis Code Flag is required 2. If associated Diagnosis Code Flag value is "1" (ICD-9), then value must be in ICD-9 Diagnosis Codes List (VVL) 3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Codes List (VVL) 4. Value must be a minimum of 3 characters 5. Value must not contain a decimal point 6. If associated Diagnosis Code Flag value is '"1" (ICD-9), value must not exceed 5 characters 7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 characters

													8. When there is more than one diagnosis code on a claim, each value must be unique 9. Conditional 10. Value must not be populated when Diagnosis Code 5 (CIP.002.044) is not populated
CIP048	CIP.002.048	DIAGNOSIS CODE FLAG 6	Diagnosis Code Flag 6	Conditional	Flag used to identify if associated Diagnosis Code field is reported with ICD-9 or ICD-10 code. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.	DIAGNOSIS CODE FLAG	CIP00002	CLAIM HEADER RECORD IP	X(1)	33	243	243	1. Value must be in Diagnosis Code Flag List (VVL) 2. Value must be 1 character 3. Conditional 4. Value should not be populated, if the associated diagnosis code is not populated
CIP049	CIP.002.049	DIAGNOSIS POA FLAG 6	Diagnosis POA Flag 6	Conditional	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator is used to identify certain preventable conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. *States that do not use the grouper methodology may use CMS-approved methodology that is prospective in nature. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.	DIAGNOSIS POA FLAG	CIP00002	CLAIM HEADER RECORD IP	X(1)	34	244	244	1. Value must be in Diagnosis POA Flag List (VVL) 2. Value must be 1 character 3. Conditional
CIP050	CIP.002.050	DIAGNOSIS CODE 7	Diagnosis Code 7	Conditional	ICD-9 or ICD-10 diagnosis codes used as a tool to group and identify diseases, disorders, symptoms, poisonings, adverse effects of drugs and chemicals,	DIAGNOSIS CODE	CIP00002	CLAIM HEADER RECORD IP	X(7)	35	245	251	1. When populated, a Diagnosis Code Flag is required 2. If associated Diagnosis Code Flag value is "1"

					injuries and other reasons for patient encounters. Diagnosis codes should be passed through to T-MSIS exactly as they were submitted by the provider on their claim (with the exception of removing the decimal). For example: 210.5 is coded as "2105".								(ICD-9), then value must be in ICD-9 Diagnosis Codes List (VVL) 3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Codes List (VVL) 4. Value must be a minimum of 3 characters 5. Value must not contain a decimal point 6. If associated Diagnosis Code Flag value is '"1" (ICD-9), value must not exceed 5 characters 7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 characters 8. When there is more than one diagnosis code on a claim, each value must be unique 9. Conditional 10. Value must not be populated when Diagnosis Code 6 (CIP.002.047) is not populated
CIP051	CIP.002.051	DIAGNOSIS-CODE-FLAG-7	Diagnosis Code Flag 7	Conditional	Flag used to identify if associated Diagnosis Code field is reported with ICD-9 or ICD-10 code. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.	DIAGNOSIS-CODE-FLAG	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	36	252	252	1. Value must be in Diagnosis Code Flag List (VVL) 2. Value must be 1 character 3. Conditional 4. Value should not be populated, if the associated diagnosis code is not populated
CIP052	CIP.002.052	DIAGNOSIS-POA-FLAG-7	Diagnosis POA Flag 7	Conditional	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator is used to identify certain preventable conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. *States that do not use the grouper methodology may use CMS-approved methodology that is	DIAGNOSIS-POA-FLAG	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	37	253	253	1. Value must be in Diagnosis POA Flag List (VVL) 2. Value must be 1 character 3. Conditional

					prospective in nature. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.								
CIP053	CIP.002.053	DIAGNOSIS CODE 8	Diagnosis Code 8	Conditional	ICD-9 or ICD-10 diagnosis codes used as a tool to group and identify diseases, disorders, symptoms, poisonings, adverse effects of drugs and chemicals, injuries and other reasons for patient encounters. Diagnosis codes should be passed through to T-MSIS exactly as they were submitted by the provider on their claim (with the exception of removing the decimal). For example: 210.5 is coded as "2105".	DIAGNOSIS CODE	CIP00002	CLAIM HEADER RECORD IP	X(7)	38	254	260	1. When populated, a Diagnosis Code Flag is required 2. If associated Diagnosis Code Flag value is "1" (ICD-9), then value must be in ICD-9 Diagnosis Codes List (VVL) 3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Codes List (VVL) 4. Value must be a minimum of 3 characters 5. Value must not contain a decimal point 6. If associated Diagnosis Code Flag value is '"1" (ICD-9), value must not exceed 5 characters 7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 characters 8. When there is more than one diagnosis code on a claim, each value must be unique 9. Conditional 10. Value must not be populated when Diagnosis Code 7 (CIP.002.050) is not populated
CIP054	CIP.002.054	DIAGNOSIS CODE FLAG 8	Diagnosis Code Flag 8	Conditional	Flag used to identify if associated Diagnosis Code field is reported with ICD-9 or ICD-10 code. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.	DIAGNOSIS CODE FLAG	CIP00002	CLAIM HEADER RECORD IP	X(1)	39	261	261	1. Value must be in Diagnosis Code Flag List (VVL) 2. Value must be 1 character 3. Conditional 4. Value should not be populated, if the associated diagnosis code is not populated
CIP055	CIP.002.055	DIAGNOSIS POA FLAG 8	Diagnosis POA Flag 8	Conditional	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery.	DIAGNOSIS POA FLAG	CIP00002	CLAIM HEADER RECORD IP	X(1)	40	262	262	1. Value must be in Diagnosis POA Flag List (VVL) 2. Value must be 1 character 3. Conditional

					POA indicator is used to identify certain preventable conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. *States that do not use the grouper methodology may use CMS-approved methodology that is prospective in nature. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.								
CIP056	CIP.002.056	DIAGNOSIS CODE 9	Diagnosis Code 9	Conditional	ICD-9 or ICD-10 diagnosis codes used as a tool to group and identify diseases, disorders, symptoms, poisonings, adverse effects of drugs and chemicals, injuries and other reasons for patient encounters. Diagnosis codes should be passed through to T-MSIS exactly as they were submitted by the provider on their claim (with the exception of removing the decimal). For example: 210.5 is coded as "2105".	DIAGNOSIS CODE	CIP00002	CLAIM HEADER RECORD IP	X(7)	41	263	269	1. When populated, a Diagnosis Code Flag is required 2. If associated Diagnosis Code Flag value is "1" (ICD-9), then value must be in ICD-9 Diagnosis Codes List (VVL) 3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Codes List (VVL) 4. Value must be a minimum of 3 characters 5. Value must not contain a decimal point 6. If associated Diagnosis Code Flag value is '"1" (ICD-9), value must not exceed 5 characters 7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 characters 8. When there is more than one diagnosis code on a claim, each value must be unique 9. Conditional 10. Value must not be populated when Diagnosis Code 8 (CIP.002.053) is not populated

CIP057	CIP.002.057	DIAGNOSIS-CODE-FLAG-9	Diagnosis Code Flag 9	Conditional	Flag used to identify if associated Diagnosis Code field is reported with ICD-9 or ICD-10 code. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.	DIAGNOSIS-CODE-FLAG	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	42	270	270	1. Value must be in Diagnosis Code Flag List (VVL) 2. Value must be 1 character 3. Conditional 4. Value should not be populated, if the associated diagnosis code is not populated
CIP058	CIP.002.058	DIAGNOSIS-POA-FLAG-9	Diagnosis POA Flag 9	Conditional	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator is used to identify certain preventable conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. *States that do not use the grouper methodology may use CMS-approved methodology that is prospective in nature. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.	DIAGNOSIS-POA-FLAG	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	43	271	271	1. Value must be in Diagnosis POA Flag List (VVL) 2. Value must be 1 character 3. Conditional
CIP059	CIP.002.059	DIAGNOSIS-CODE-10	Diagnosis Code 10	Conditional	ICD-9 or ICD-10 diagnosis codes used as a tool to group and identify diseases, disorders, symptoms, poisonings, adverse effects of drugs and chemicals, injuries and other reasons for patient encounters. Diagnosis codes should be passed through to T-MSIS exactly as they were submitted by the provider on their claim (with the exception of removing the decimal). For example: 210.5 is coded as "2105".	DIAGNOSIS-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(7)	44	272	278	1. When populated, a Diagnosis Code Flag is required 2. If associated Diagnosis Code Flag value is "1" (ICD-9), then value must be in ICD-9 Diagnosis Codes List (VVL) 3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Codes List (VVL) 4. Value must be a minimum of 3 characters

													5. Value must not contain a decimal point 6. If associated Diagnosis Code Flag value is '"1" (ICD-9), value must not exceed 5 characters 7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 characters 8. When there is more than one diagnosis code on a claim, each value must be unique 9. Conditional 10. Value must not be populated when Diagnosis Code 9 (CIP.002.056) is not populated
CIP060	CIP.002.060	DIAGNOSIS-CODE-FLAG-10	Diagnosis Code Flag 10	Conditional	Flag used to identify if associated Diagnosis Code field is reported with ICD-9 or ICD-10 code. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.	DIAGNOSIS-CODE-FLAG	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	45	279	279	1. Value must be in Diagnosis Code Flag List (VVL) 2. Value must be 1 character 3. Conditional 4. Value should not be populated, if the associated diagnosis code is not populated
CIP061	CIP.002.061	DIAGNOSIS-POA-FLAG-10	Diagnosis POA Flag 10	Conditional	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator is used to identify certain preventable conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. *States that do not use the grouper methodology may use CMS-approved methodology that is prospective in nature. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated	DIAGNOSIS-POA-FLAG	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	46	280	280	1. Value must be in Diagnosis POA Flag List (VVL) 2. Value must be 1 character 3. Conditional

					with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.								
CIP062	CIP.002.062	DIAGNOSIS CODE 11	Diagnosis Code 11	Conditional	ICD-9 or ICD-10 diagnosis codes used as a tool to group and identify diseases, disorders, symptoms, poisonings, adverse effects of drugs and chemicals, injuries and other reasons for patient encounters. Diagnosis codes should be passed through to T-MSIS exactly as they were submitted by the provider on their claim (with the exception of removing the decimal). For example: 210.5 is coded as "2105".	DIAGNOSIS CODE	CIP00002	CLAIM HEADER RECORD IP	X(7)	47	281	287	1. When populated, a Diagnosis Code Flag is required 2. If associated Diagnosis Code Flag value is "1" (ICD-9), then value must be in ICD-9 Diagnosis Codes List (VVL) 3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Codes List (VVL) 4. Value must be a minimum of 3 characters 5. Value must not contain a decimal point 6. If associated Diagnosis Code Flag value is '"1" (ICD-9), value must not exceed 5 characters 7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 characters 8. When there is more than one diagnosis code on a claim, each value must be unique 9. Conditional 10. Value must not be populated when Diagnosis Code 10 (CIP.002.059) is not populated
CIP063	CIP.002.063	DIAGNOSIS CODE FLAG 11	Diagnosis Code Flag 11	Conditional	Flag used to identify if associated Diagnosis Code field is reported with ICD-9 or ICD-10 code. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.	DIAGNOSIS CODE FLAG	CIP00002	CLAIM HEADER RECORD IP	X(1)	48	288	288	1. Value must be in Diagnosis Code Flag List (VVL) 2. Value must be 1 character 3. Conditional 4. Value should not be populated, if the associated diagnosis code is not populated
CIP064	CIP.002.064	DIAGNOSIS POA FLAG 11	Diagnosis POA Flag 11	Conditional	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator is used to identify certain preventable conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* that has a higher	DIAGNOSIS POA FLAG	CIP00002	CLAIM HEADER RECORD IP	X(1)	49	289	289	1. Value must be in Diagnosis POA Flag List (VVL) 2. Value must be 1 character 3. Conditional

					payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. *States that do not use the grouper methodology may use CMS-approved methodology that is prospective in nature. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.								
CIP065	CIP.002.065	DIAGNOSIS CODE 12	Diagnosis Code 12	Conditional	ICD-9 or ICD-10 diagnosis codes used as a tool to group and identify diseases, disorders, symptoms, poisonings, adverse effects of drugs and chemicals, injuries and other reasons for patient encounters. Diagnosis codes should be passed through to T-MSIS exactly as they were submitted by the provider on their claim (with the exception of removing the decimal). For example: 210.5 is coded as "2105".	DIAGNOSIS CODE	CIP00002	CLAIM HEADER RECORD IP	X(7)	50	290	296	1. When populated, a Diagnosis Code Flag is required 2. If associated Diagnosis Code Flag value is "1" (ICD-9), then value must be in ICD-9 Diagnosis Codes List (VVL) 3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Codes List (VVL) 4. Value must be a minimum of 3 characters 5. Value must not contain a decimal point 6. If associated Diagnosis Code Flag value is '"1" (ICD-9), value must not exceed 5 characters 7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 characters 8. When there is more than one diagnosis code on a claim, each value must be unique 9. Conditional 10. Value must not be populated when Diagnosis Code 11 (CIP.002.062) is not populated
CIP066	CIP.002.066	DIAGNOSIS CODE FLAG 12	Diagnosis Code Flag 12	Conditional	Flag used to identify if associated Diagnosis Code field is reported with ICD-9 or ICD-10 code. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with	DIAGNOSIS CODE FLAG	CIP00002	CLAIM HEADER RECORD IP	X(1)	51	297	297	1. Value must be in Diagnosis Code Flag List (VVL) 2. Value must be 1 character 3. Conditional 4. Value should not be populated, if the associated diagnosis code is not populated

					~~Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.~~								
~~CIP067~~	~~CIP.002.067~~	~~DIAGNOSIS-POA-FLAG-12~~	~~Diagnosis POA Flag 12~~	~~Conditional~~	~~A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery.~~ ~~POA indicator is used to identify certain preventable conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines.~~ ~~*States that do not use the grouper methodology may use CMS-approved methodology that is prospective in nature.~~ ~~Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.~~	~~DIAGNOSIS-POA-FLAG~~	~~CIP00002~~	~~CLAIM-HEADER-RECORD-IP~~	~~X(1)~~	~~52~~	~~298~~	~~298~~	~~1. Value must be in Diagnosis POA Flag List (VVL)~~ ~~2. Value must be 1 character~~ ~~3. Conditional~~
CIP068	CIP.002.068	DIAGNOSIS-RELATED-GROUP	Diagnosis Related Group	Conditional	A code representing the Diagnosis Related Group (DRG) that is applicable for the inpatient services being rendered. This field is required on FFS claims and encounters records in which diagnosis related groups are used to determine paid amounts.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(4)	~~53~~15	~~299~~183	~~302~~186	1. Value must be 4 characters or less 2. Conditional

CIP069	CIP.002.069	DIAGNOSIS-RELATED-GROUP-IND	Diagnosis Related Group Indicator	Conditional	An indicator identifying the grouping algorithm used to assign Diagnosis Related Group (DRG) values. 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'.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(4)	~~54~~16	~~303~~187	~~306~~190	1. Value must be 4 characters or less 2. The right-most 2 positions must be found in [01-99] 3. Conditional 4. Value must be populated, when associated Diagnosis Related Group (CIP.002.068) is populated
CIP070	CIP.002.070	PROCEDURE-CODE-1	Procedure Code 1	Conditional	A procedure code based on ICD-9 and ICD-10 used by the state to identify the procedures performed during the hospital stay referenced by this claim. The principal procedure and related info should be recorded in Procedure~~-CODE-1, PROCEDURE-CODE-~~ Code1, Procedure Code Date-1, and Procedure~~-CODE-FLAG-~~ Code Flag 1. The 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. Use Procedure~~-CODE-~~ Code 2 through Procedure~~-CODE-~~ Code 6 (and related data elements) to record secondary, tertiary, etc. procedures.	PROCEDURE-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(8)	~~55~~17	~~307~~191	~~314~~198	~~1.~~1. Value must be 8 characters or less 2. When populated, there must be a corresponding Procedure Code Flag ~~2~~3. If associated Procedure Code Flag ~~List (VVL)~~ value indicates an ICD-9-CM encoding ~~'~~"02~~'~~", then value must be a valid ICD-9-CM procedure code ~~3~~4. If associated Procedure Code Flag ~~List (VVL)~~ value indicates an ICD-10-CM encoding ~~'~~"07~~'~~", then value must be a valid ICD-10-CM procedure code ~~4~~5. If associated Procedure Code Flag ~~List (VVL)~~ value indicates an "Other" encoding ~~'10-87',~~"10-87", then State must provide T-MSIS system with State-specific procedure code list, and value must be a valid State-specific procedure code ~~5~~6. Value must be ~~8 characters or less~~ ~~6.~~ in Procedure Code List (VVL) 7. Conditional
~~CIP071~~	~~CIP.002.071~~	~~PROCEDURE-CODE-MOD-1~~	~~Procedure Code Modifier 1~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for~~	~~N/A~~	~~CIP00002~~	~~CLAIM-HEADER-RECORD-IP~~	~~X(2)~~	~~56~~	~~315~~	~~316~~	~~1. Not Applicable~~

					~~specific definition and coding requirement description(s).]~~								
CIP072	CIP.002.072	PROCEDURE-CODE-FLAG-1	Procedure Code Flag 1	Conditional	A flag that identifies the coding system used for an associated procedure code.	PROCEDURE-CODE-FLAG	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	~~57~~18	~~317~~199	~~318~~200	~~1.~~1. Value must be 2 characters 2. Value must be in Procedure Code Flag List (VVL) 3. Conditional 4. When populated, there must be a corresponding Procedure Code ~~2. Value must be in Procedure Code Flag List (VVL)~~ ~~3. Value must be 2 characters~~ ~~4.~~5. If Procedure Code 1 (CIP.002.070) is populated, Procedure Code Flag 1 (CIP.002.072) must be :"02:" (ICD-9 CM) or :"07:" (ICD-10 - CM PCS~~).~~ ~~5. Conditional~~)
CIP073	CIP.002.073	PROCEDURE-CODE-DATE-1	Procedure Code Date 1	Conditional	The date upon which a reported medical procedure was performed.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~58~~19	~~319~~201	~~326~~208	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only~~ in the form "CCYYMMDD" 2. Value must be on ~~the leap year, never April 31st~~ or ~~Sept 31st)~~ ~~3. Value must be~~ before associated ~~Ending~~Discharge Date ~~of Service~~ value ~~4~~3. Value must be provided with an associated Procedure Code value ~~5~~4. Value must be on or after associated Beginning Date of Service value ~~6~~5. Value must be on or before associated Eligible Date of Death value ~~7~~6. Value must be not be populated when associated Procedure Code is not populated ~~8~~7. Conditional

CIP074	CIP.002.074	PROCEDURE-CODE-2	Procedure Code 2	Conditional	A procedure code based on ICD-9 and ICD-10 used by the state to identify the procedures performed during the hospital stay referenced by this claim. The principal procedure and related info should be recorded in Procedure Code 1, Procedure ~~CODE-DATE-~~ Code 1, and Procedure ~~CODE-FLAG-~~ Code Flag 1. The 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. Use Procedure ~~CODE-~~ Code 2 through Procedure ~~CODE-~~ Code 6 (and related data elements) to record secondary, tertiary, etc. procedures.	PROCEDURE-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(8)	~~59~~20	~~327~~209	~~334~~216	~~1.~~1. Value must be 8 characters or less 2. When populated, there must be a corresponding Procedure Code Flag ~~2~~3. If associated Procedure Code Flag ~~List (VVL)~~ value indicates an ICD-9-CM encoding ~~'~~"02~~'~~", then value must be a valid ICD-9-CM procedure code ~~3~~4. If associated Procedure Code Flag ~~List (VVL)~~ value indicates an ICD-10-CM encoding ~~'~~"07~~'~~", then value must be a valid ICD-10-CM procedure code ~~4~~5. If associated Procedure Code Flag ~~List (VVL)~~ value indicates an "Other" encoding ~~'10-87',~~"10-87", then State must provide T-MSIS system with State-specific procedure code list, and value must be a valid State-specific procedure code ~~5~~6. Value must be ~~8 characters or less~~ ~~6.~~ in Procedure Code List (VVL) 7. Conditional
~~CIP075~~	~~CIP.002.075~~	~~PROCEDURE-CODE-MOD-2~~	~~Procedure Code Modifier 2~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~CIP00002~~	~~CLAIM-HEADER-RECORD-IP~~	~~X(2)~~	~~60~~	~~335~~	~~336~~	~~1. Not Applicable~~
CIP076	CIP.002.076	PROCEDURE-CODE-FLAG-2	Procedure Code Flag 2	Conditional	A flag that identifies the coding system used for an associated procedure code.	PROCEDURE-CODE-FLAG	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	~~61~~21	~~337~~217	~~338~~218	1. ~~When populated, there~~Value must be ~~a corresponding Procedure Code~~2 characters 2. Value must be in Procedure Code Flag List (VVL) 3. ~~Value must be 2 characters~~ ~~4.~~ Conditional 4. When populated, there must be a corresponding Procedure Code

CIP077	CIP.002.077	PROCEDURE-CODE-DATE-2	Procedure Code Date 2	Conditional	The date upon which a reported medical procedure was performed.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~62~~22	~~339~~219	~~346~~226	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only~~ in the form "CCYYMMDD" 2. Value must be on ~~the leap year, never April 31st~~ or ~~Sept 31st)~~ ~~3. Value must be~~ before associated ~~Ending~~Discharge Date ~~of Service~~ value ~~4~~3. Value must be provided with an associated Procedure Code value ~~5~~4. Value must be on or after associated Beginning Date of Service value ~~6~~5. Value must be on or before associated Eligible Date of Death value ~~7~~6. Value must be not be populated when associated Procedure Code is not populated ~~8~~7. Conditional
CIP078	CIP.002.078	PROCEDURE-CODE-3	Procedure Code 3	Conditional	A procedure code based on ICD-9 and ICD-10 used by the state to identify the procedures performed during the hospital stay referenced by this claim. The principal procedure and related info should be recorded in Procedure~~-CODE-~~ Code 1, Procedure~~-CODE-DATE-~~ Code Date 1, and Procedure~~-CODE-FLAG-~~ Code Flag 1. The 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. Use Procedure~~-CODE-~~ Code 2 through Procedure~~-CODE-~~ Code 6 (and related data elements) to record secondary, tertiary, etc. procedures.	PROCEDURE-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(8)	~~63~~23	~~347~~227	23~~5~~4	~~1.~~1. Value must be 8 characters or less 2. When populated, there must be a corresponding Procedure Code Flag ~~2~~3. If associated Procedure Code Flag ~~List (VVL)~~ value indicates an ICD-9-CM encoding ~~'~~"02~~'~~", then value must be a valid ICD-9-CM procedure code ~~3~~4. If associated Procedure Code Flag ~~List (VVL)~~ value indicates an ICD-10-CM encoding ~~'~~"07~~'~~", then value must be a valid ICD-10-CM procedure code ~~4~~5. If associated Procedure Code Flag ~~List (VVL)~~ value indicates an "Other" encoding ~~'10-87',~~"10-87", then State must provide T-MSIS system with State-specific procedure code list, and value must be a valid State-specific procedure code ~~5~~6. Value must be ~~8 characters or less~~

													6. in Procedure Code List (VVL) 7. Conditional
CIP079	CIP.002.079	PROCEDURE-CODE-MOD-3	Procedure Code Modifier 3	Not Applicable	[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	64	355	356	1. Not Applicable
CIP080	CIP.002.080	PROCEDURE-CODE-FLAG-3	Procedure Code Flag 3	Conditional	A flag that identifies the coding system used for an associated procedure code.	PROCEDURE-CODE-FLAG	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	6524	2357	358236	1. When populated, thereValue must be a corresponding Procedure Code2 characters 2. Value must be in Procedure Code Flag List (VVL) 3. Value must be 2 characters 4. Conditional 4. When populated, there must be a corresponding Procedure Code

CIP081	CIP.002.081	PROCEDURE-CODE-DATE-3	Procedure Code Date 3	Conditional	The date upon which a reported medical procedure was performed.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~66~~25	~~359~~237	~~366~~244	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only~~ in the form "CCYYMMDD" 2. Value must be on ~~the leap year, never April 31st~~ or ~~Sept 31st)~~ ~~3. Value must be~~ before associated ~~Ending~~Discharge Date ~~of Service~~ value ~~4~~3. Value must be provided with an associated Procedure Code value ~~5~~4. Value must be on or after associated Beginning Date of Service value ~~6~~5. Value must be on or before associated Eligible Date of Death value ~~7~~6. Value must be not be populated when associated Procedure Code is not populated ~~8~~7. Conditional
CIP082	CIP.002.082	PROCEDURE-CODE-4	Procedure Code 4	Conditional	A procedure code based on ICD-9 and ICD-10 used by the state to identify the procedures performed during the hospital stay referenced by this claim. The principal procedure and related info should be recorded in Procedure~~-CODE-~~ Code 1, Procedure~~-CODE-DATE-~~ Code Date 1, and Procedure~~-CODE-FLAG-~~ Code Flag 1. The 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. Use Procedure~~-CODE-~~ Code 2 through Procedure~~-CODE-~~ Code 6 (and related data elements) to record secondary, tertiary, etc. procedures.	PROCEDURE-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(8)	~~6~~726	~~367~~245	~~374~~252	~~1.~~1. Value must be 8 characters or less 2. When populated, there must be a corresponding Procedure Code Flag ~~2~~3. If associated Procedure Code Flag ~~List (VVL)~~ value indicates an ICD-9-CM encoding ~~'"~~02~~'"~~, then value must be a valid ICD-9-CM procedure code ~~3~~4. If associated Procedure Code Flag ~~List (VVL)~~ value indicates an ICD-10-CM encoding ~~'"~~07~~'"~~, then value must be a valid ICD-10-CM procedure code ~~4~~5. If associated Procedure Code Flag ~~List (VVL)~~ value indicates an "Other" encoding ~~'10-87',~~"10-87", then State must provide T-MSIS system with State-specific procedure code list, and value must be a valid State-specific procedure code ~~5~~6. Value must be ~~8 characters or less~~

													6. in Procedure Code List (VVL) 7. Conditional
CIP083	CIP.002.083	PROCEDURE-CODE-MOD-4	Procedure Code Modifier 4	Not Applicable	[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	68	375	376	1. Not Applicable
CIP084	CIP.002.084	PROCEDURE-CODE-FLAG-4	Procedure Code Flag 4	Conditional	A flag that identifies the coding system used for an associated procedure code.	PROCEDURE-CODE-FLAG	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	6927	377253	378254	1. When populated, thereValue must be a corresponding Procedure Code2 characters 2. Value must be in Procedure Code Flag List (VVL) 3. Value must be 2 characters 4. Conditional 4. When populated, there must be a corresponding Procedure Code

CIP085	CIP.002.085	PROCEDURE-CODE-DATE-4	Procedure Code Date 4	Conditional	The date upon which a reported medical procedure was performed.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~70~~28	~~379~~255	~~386~~262	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only~~ in the form "CCYYMMDD" 2. Value must be on ~~the leap year, never April 31st~~ or ~~Sept 31st)~~ ~~3. Value must be~~ before associated ~~Ending~~Discharge Date ~~of Service~~ value ~~4~~3. Value must be provided with an associated Procedure Code value ~~5~~4. Value must be on or after associated Beginning Date of Service value ~~6~~5. Value must be on or before associated Eligible Date of Death value ~~7~~6. Value must be not be populated when associated Procedure Code is not populated ~~8~~7. Conditional
CIP086	CIP.002.086	PROCEDURE-CODE-5	Procedure Code 5	Conditional	A procedure code based on ICD-9 and ICD-10 used by the state to identify the procedures performed during the hospital stay referenced by this claim. The principal procedure and related info should be recorded in Procedure~~-CODE-~~ Code 1, Procedure~~-CODE-DATE-~~ Code Date 1, and Procedure~~-CODE-FLAG-~~ Code Flag 1. The 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. Use Procedure~~-CODE-~~ Code 2 through Procedure~~-CODE-~~ Code 6 (and related data elements) to record secondary, tertiary, etc. procedures.	PROCEDURE-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(8)	~~71~~29	~~387~~263	~~394~~270	~~1.~~1. Value must be 8 characters or less 2. When populated, there must be a corresponding Procedure Code Flag ~~2~~3. If associated Procedure Code Flag ~~List (VVL)~~ value indicates an ICD-9-CM encoding ~~'"~~02~~'"~~, then value must be a valid ICD-9-CM procedure code ~~3~~4. If associated Procedure Code Flag ~~List (VVL)~~ value indicates an ICD-10-CM encoding ~~'"~~07~~'"~~, then value must be a valid ICD-10-CM procedure code ~~4~~5. If associated Procedure Code Flag ~~List (VVL)~~ value indicates an "Other" encoding ~~'10-87',~~"10-87", then State must provide T-MSIS system with State-specific procedure code list, and value must be a valid State-specific procedure code ~~5~~6. Value must be ~~8 characters or less~~

													~~6.~~ in Procedure Code List (VVL) 7. Conditional
~~CIP087~~	~~CIP.002.087~~	~~PROCEDURE-CODE-MOD-5~~	~~Procedure Code Modifier 5~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~CIP00002~~	~~CLAIM-HEADER-RECORD-IP~~	~~X(2)~~	~~72~~	~~395~~	~~396~~	~~1. Not Applicable~~
CIP088	CIP.002.088	PROCEDURE-CODE-FLAG-5	Procedure Code Flag 5	~~Not Applicable~~Conditional	A flag that identifies the coding system used for an associated procedure code.	PROCEDURE-CODE-FLAG	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	~~73~~30	~~397~~271	~~398~~272	~~1.~~1. Value must be 2 characters 2. Value must be in Procedure Code Flag List (VVL) 3. Conditional 4. When populated, there must be a corresponding Procedure Code ~~2. Value must be in Procedure Code Flag List (VVL)~~ ~~3. Value must be 2 characters~~

CIP089	CIP.002.089	PROCEDURE-CODE-DATE-5	Procedure Code Date 5	Conditional	The date upon which a reported medical procedure was performed.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~74~~31	~~399~~273	~~406~~280	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only~~ in the form "CCYYMMDD" 2. Value must be on ~~the leap year, never April 31st~~ or ~~Sept 31st)~~ ~~3. Value must be~~ before associated ~~Ending~~Discharge Date ~~of Service~~ value ~~4~~3. Value must be provided with an associated Procedure Code value ~~5~~4. Value must be on or after associated Beginning Date of Service value ~~6~~5. Value must be on or before associated Eligible Date of Death value ~~7~~6. Value must be not be populated when associated Procedure Code is not populated ~~8~~7. Conditional
CIP090	CIP.002.090	PROCEDURE-CODE-6	Procedure Code 6	Conditional	A procedure code based on ICD-9 and ICD-10 used by the state to identify the procedures performed during the hospital stay referenced by this claim. The principal procedure and related info should be recorded in Procedure Code 1, Procedure ~~CODE-DATE~~ Code Date 1, and Procedure ~~CODE-FLAG~~ Code Flag 1. The 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. Use Procedure ~~CODE~~ Code 2 through Procedure ~~CODE~~ Code 6 (and related data elements) to record secondary, tertiary, etc. procedures.	PROCEDURE-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(8)	~~75~~32	~~407~~281	~~414~~288	~~1.~~1. Value must be 8 characters or less 2. When populated, there must be a corresponding Procedure Code Flag ~~2~~3. If associated Procedure Code Flag ~~List (VVL)~~ value indicates an ICD-9-CM encoding ~~'~~"02~~'~~", then value must be a valid ICD-9-CM procedure code ~~3~~4. If associated Procedure Code Flag ~~List (VVL)~~ value indicates an ICD-10-CM encoding ~~'~~"07~~'~~", then value must be a valid ICD-10-CM procedure code ~~4~~5. If associated Procedure Code Flag ~~List (VVL)~~ value indicates an "Other" encoding ~~'10-87',~~"10-87", then State must provide T-MSIS system with State-specific procedure code list, and value must be a valid State-specific procedure code ~~5~~6. Value must be ~~8 characters or less~~

													~~6.~~ in Procedure Code List (VVL) 7. Conditional
~~CIP091~~	~~CIP.002.091~~	~~PROCEDURE-CODE-MOD-6~~	~~Procedure Code Modifier 6~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~PROCEDURE-CODE-MOD~~	~~CIP00002~~	~~CLAIM-HEADER-RECORD-IP~~	~~X(2)~~	~~76~~	~~415~~	~~416~~	~~1. Not Applicable~~
CIP092	CIP.002.092	PROCEDURE-CODE-FLAG-6	Procedure Code Flag 6	Conditional	A flag that identifies the coding system used for an associated procedure code.	PROCEDURE-CODE-FLAG	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	~~77~~33	~~417~~289	~~418~~290	1. ~~When populated, there~~Value must be ~~a corresponding Procedure Code~~2 characters 2. Value must be in Procedure Code Flag List (VVL) 3. ~~Value must be 2 characters~~ ~~4.~~ Conditional 4. When populated, there must be a corresponding Procedure Code

CIP093	CIP.002.093	PROCEDURE-CODE-DATE-6	Procedure Code Date 6	~~Not Applicable~~Conditional	The date upon which a reported medical procedure was performed.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~78~~34	~~419~~291	~~426~~298	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only~~ in the form "CCYYMMDD" 2. Value must be on ~~the leap year, never April 31st~~ or ~~Sept 31st)~~ ~~3. Value must be~~ before associated ~~Ending~~Discharge Date ~~of Service~~ value ~~4~~3. Value must be provided with an associated Procedure Code value ~~5~~4. Value must be on or after associated Beginning Date of Service value ~~6~~5. Value must be on or before associated Eligible Date of Death value ~~7~~6. Value must be not be populated when associated Procedure Code is not populated 7. Conditional
CIP094	CIP.002.094	ADMISSION-DATE	Admission Date	Mandatory	The date on which the recipient was admitted to a hospital.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~79~~35	~~427~~299	~~434~~306	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be less than or equal to associated Discharge Date value in the claim header~~.~~ ~~4~~ 3. Value must be greater than or equal to associated eligible Date of Birth value~~.~~ ~~5~~ 4. Value must be less than or equal to associated eligible Date of Death value~~.~~ ~~6~~ 5. Mandatory ~~7~~6. Value must be between Enrollment Effective Date (ELG.021.253) and Enrollment End Date (ELG.021.254)

													~~8. (capitated payment) when associated Type of Claim (CIP.002.100) is not '2','B' or 'V' and Type of Service (CIP.002.257) is not '119, '120', '121', 122'~~7. Value must be before Adjudication Date (CIP.003.286)
CIP095	CIP.002.095	ADMISSION-HOUR	Admission Hour	Conditional	The hour of admission to a hospital.	HOUR	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	~~80~~36	~~435~~307	~~436~~308	~~1.~~1. Value must be 2 characters 2. Value must be in Hour List (VVL) ~~2. Value must be 2 characters~~ 3. Conditional

CIP096	CIP.002.096	DISCHARGE-DATE	Discharge Date	Conditional	The date on which the recipient was discharged from a hospital.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~81~~37	~~437~~309	~~444~~316	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be less than or equal to associated Adjudication Date value. ~~4~~3. Value must be greater than or equal to associated Admission Date value. ~~5~~4. Value must be greater than or equal to associated eligible Date of Birth value. ~~6~~5. Value must be less than or equal to associated eligible Date of Death value. ~~7~~6. Conditional ~~8~~7. If associated Adjustment Indicator (CIP.002.026) does not equal "1" (Non-denied claims) and Patient Status (CIP.002.199) is not equal to "30" value must be populated. 8. When populated, Discharge Hour (CIP.002.097) must be populated
CIP097	CIP.002.097	DISCHARGE-HOUR	Discharge Hour	Conditional	The hour of discharge from a hospital.	HOUR	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	~~82~~38	~~445~~317	~~446~~318	~~1.~~1. Value must be 2 characters 2. Value must be in Hour List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~ 3. Conditional 4. When populated, Discharge Date (CIP.002.096) must be populated
CIP098	CIP.002.098	ADJUDICATION-DATE	Adjudication Date	Mandatory	The date on which the payment status of the claim was finally adjudicated by the state. For Encounter Records (Type of Claim = 3, C, W), use date the encounter was processed by the state.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~83~~39	~~447~~319	~~454~~326	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value should be on or before End of Time Period ~~value found in associated T-MSIS File Header Record~~

													~~4.~~(CIP.001.010) 3. Mandatory ~~5~~4. Value should be on or after associated Admission Date value
CIP099	CIP.002.099	MEDICAID-PAID-DATE	Medicaid Paid Date	Mandatory	The date Medicaid paid this claim or adjustment. For Encounter Records (Type of Claim = 3, C, W), the date the managed care organization paid the provider for the claim or adjustment.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~8~~440	~~455~~327	~~462~~334	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Total Medicaid Paid Amount ~~4~~3. Mandatory
CIP100	CIP.002.100	TYPE-OF-CLAIM	Type of Claim	Mandatory	A code to indicate what type of payment is covered in this claim. For sub-capitated encounters from a sub-capitated entity or sub-capitated network provider, report TYPE-OF-CLAIM = "3" for a Medicaid sub-capitated encounter record or “C” for an S-CHIP sub-capitated encounter record.	TYPE-OF-CLAIM	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	~~8~~541	~~463~~335	~~463~~335	~~1.~~1. Value must be 1 character 2. Value must be in Type of Claim List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory ~~4. When value equals 'Z', claim denied indicator must equal '0'~~
CIP101	CIP.002.101	TYPE-OF-BILL	Type of Bill	Mandatory	A data element corresponding with UB-04 form locator FL4 that classifies the claim as to the type of facility (2nd digit), type of care (3rd digit) and the billing record's sequence in the episode of care (4th digit). (Note that the 1st digit is always zero.)	TYPE-OF-BILL	CIP00002	CLAIM-HEADER-RECORD-IP	X(4)	~~8~~642	~~464~~336	~~467~~339	~~1.~~1. Value must be 4 characters 2. Value must be in Type of Bill List (VVL) ~~2. Value must be 4 characters~~ ~~3.~~3. First character must be a ~~'0'~~"0" 4. Mandatory

CIP102	CIP.002.102	CLAIM-STATUS	Claim Status	Conditional	The health care claim status codes convey the status of an entire claim~~.~~ status codes from the 277 transaction set. Only report the claim status for the final, adjudicated claim.	CLAIM-STATUS	CIP00002	CLAIM-HEADER-RECORD-IP	X(3)	~~87~~43	~~468~~340	~~470~~342	~~1.~~1. Value must be 3 characters or less 2. Value must be in Claim Status List (VVL) ~~2. Value must be 3 characters or less~~ ~~3.~~3. Conditional 4. If value in [~~ 26, 87,~~ 542,585,654~~],~~], then Claim Denied Indicator must be ~~'0'~~"0" and Claim Status Category must be "F2"
CIP103	CIP.002.103	CLAIM-STATUS-CATEGORY	Claim Status Category	Mandatory	The general category of the claim status (accepted, rejected, pended, finalized, additional information requested, etc.), which is then further detailed in the companion data element claim ~~STATUS~~ status.	CLAIM-STATUS-CATEGORY	CIP00002	CLAIM-HEADER-RECORD-IP	X(3)	~~88~~44	~~471~~343	~~473~~345	~~1.~~1. Value must be 3 characters or less 2. Value must be in Claim Status Category List (VVL) ~~2~~3. (Denied Claim) if associated Claim Denied Indicator indicates the claim was denied, then value must be "F2" ~~3~~4. (Denied Claim) if associated ~~Type of Claim equals Z or associated~~ Claim Status is in [~~ 26, 87,~~ 542,~~ 8~~585,654], then value must be "F2" ~~4. Value must be 3 characters or less~~ 5. Mandatory

CIP104	CIP.002.104	SOURCE-LOCATION	Source Location	Mandatory	~~The field denotes the claims payment system from which the claim was extracted.~~The field denotes the claims payment system from which the claim was extracted. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report a SOURCE-LOCATION = '22' to indicate that the sub-capitated entity paid a provider for the service to the enrollee on a FFS basis. For sub-capitated encounters from a sub-capitated network provider that were submitted to sub-capitated entity, report a SOURCE-LOCATION = '23' to indicate that the sub-capitated network provider provided the service directly to the enrollee. For sub-capitated encounters from a sub-capitated network provider, report a SOURCE-LOCATION = “23” to indicate that the sub-capitated network provider provided the service directly to the enrollee.	SOURCE-LOCATION	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	~~89~~45	~~474~~346	3~~47~~5	~~1.~~1. Value must be 2 characters 2. Value must be in Source Location List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory
CIP105	CIP.002.105	CHECK-NUM	Check Number	Conditional	The check or electronic funds transfer number.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(15)	~~90~~46	~~476~~348	~~490~~362	1. Value must be 15 characters or less 2. Value must have an associated Check Effective Date 3. Value must not contain a pipe or asterisk symbols 4. Conditional
CIP106	CIP.002.106	CHECK-EFF-DATE	Check Effective Date	Conditional	The date a check is issued to the payee. In the case of electronic funds transfer, it is the date the transfer is made.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~91~~47	~~491~~363	~~498~~370	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3. Value may be the same as associated~~

													~~Remittance Date~~ ~~4.~~ in the form "CCYYMMDD" 2. Must have an associated Check Number ~~5~~3. Conditional
~~CIP107~~	~~CIP.002.107~~	~~ALLOWED-CHARGE-SRC~~	~~Allowed Charge Source~~	~~Conditional~~	~~These codes indicate how each allowed charge was determined. Claims records for an eligible individual should not indicate Medicare as the source to indicate how an allowed charge was determined on the claim, if the eligible individual is not a dual eligible~~	~~ALLOWED-CHARGE-SRC~~	~~CIP00002~~	~~CLAIM-HEADER-RECORD-IP~~	~~X(1)~~	~~92~~	~~499~~	~~499~~	~~1. Value must be in Allowed Charge Source List (VVL)~~ ~~2. Value must be 1 character~~ ~~3. Conditional~~ ~~4. (not a Medicare Beneficiary) if Dual Eligible (ELG.005.085) equals '00', then value must not be in ['1','I', 'K', 'M']~~
CIP108	CIP.002.108	CLAIM-PYMT-REM-CODE-1	~~Claim Payment~~Remittance Advice Remark Code 1	Conditional	Remittance Advice Remark Codes are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Each Remittance Advice Remark Code identifies a specific message as shown in the Remittance Advice Remark Code List. It is a code set used by the health care industry to convey non-financial information critical to understanding the adjudication of a health care claim for payment. It is an external code set whose use is as mandated by the Administrative Simplification provisions of the Health Insurance Portability and Accountably Act of 1996 (P.L.104-191, commonly referred to as HIPAA).	CLAIM-PYMT-REM-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(5)	~~93~~48	~~500~~371	~~504~~375	~~1.~~1. Value must be 5 characters or less 2. Value must be in Claim Payment Remittance Code List (VVL) ~~2. Value must be 5 characters or less~~ ~~3.~~3. Conditional 4. When more than one ~~code~~occurrence of Claim Payment Remark Code 1 through Claim Payment Remark Code 4 is populated on a claim, all values must be unique

CIP109	CIP.002.109	CLAIM-PYMT-REM-CODE-2	~~Claim Payment~~Remittance Advice Remark Code 2	Conditional	Remittance Advice Remark Codes are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Each Remittance Advice Remark Code identifies a specific message as shown in the Remittance Advice Remark Code List. It is a code set used by the health care industry to convey non-financial information critical to understanding the adjudication of a health care claim for payment. It is an external code set whose use is as mandated by the Administrative Simplification provisions of the Health Insurance Portability and Accountably Act of 1996 (P.L.104-191, commonly referred to as HIPAA).	CLAIM-PYMT-REM-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(5)	~~94~~49	~~505~~376	~~509~~380	~~1.~~1. Value must be 5 characters or less 2. Value must be in Claim Payment Remittance Code List (VVL) ~~2. Value must be 5 characters or less~~ ~~3.~~3. Conditional 4. When more than one ~~code~~occurrence of Claim Payment Remark Code 1 through Claim Payment Remark Code 4 is populated on a claim, all values must be unique 5. Value must not be populated when ~~Claim Payment~~Remittance Advice Remark Code 1 (CIP.002.108) is not populated
CIP110	CIP.002.110	CLAIM-PYMT-REM-CODE-3	~~Claim Payment~~Remittance Advice Remark Code 3	Conditional	Remittance Advice Remark Codes are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Each Remittance Advice Remark Code identifies a specific message as shown in the Remittance Advice Remark Code List. It is a code set used by the health care industry to convey non-financial information critical to understanding the adjudication of a health care claim for payment. It is an external code set whose use is as mandated by the Administrative Simplification provisions of the Health Insurance Portability and Accountably Act of 1996 (P.L.104-191, commonly referred to as HIPAA).	CLAIM-PYMT-REM-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(5)	~~95~~50	~~510~~381	~~514~~385	~~1.~~1. Value must be 5 characters or less 2. Value must be in Claim Payment Remittance Code List (VVL) ~~2. Value must be 5 characters or less~~ ~~3.~~3. Conditional 4. When more than one ~~code~~occurrence of Claim Payment Remark Code 1 through Claim Payment Remark Code 4 is populated on a claim, all values must be unique 5. Value must not be populated when ~~Claim Payment~~Remittance Advice Remark Code 2 (CIP.002.109) is not populated

CIP111	CIP.002.111	CLAIM-PYMT-REM-CODE-4	~~Claim Payment~~Remittance Advice Remark Code 4	Conditional	Remittance Advice Remark Codes are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Each Remittance Advice Remark Code identifies a specific message as shown in the Remittance Advice Remark Code List. It is a code set used by the health care industry to convey non-financial information critical to understanding the adjudication of a health care claim for payment. It is an external code set whose use is as mandated by the Administrative Simplification provisions of the Health Insurance Portability and Accountably Act of 1996 (P.L.104-191, commonly referred to as HIPAA).	CLAIM-PYMT-REM-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(5)	~~96~~51	~~515~~386	~~519~~390	~~1.~~1. Value must be 5 characters or less 2. Value must be in Claim Payment Remittance Code List (VVL) ~~2. Value must be 5 characters or less~~ ~~3.~~3. Conditional 4. When more than one ~~code~~occurrence of Claim Payment Remark Code 1 through Claim Payment Remark Code 4 is populated on a claim, all values must be unique 5. Value must not be populated when ~~Claim Payment~~Remittance Advice Remark Code 3 (CIP.002.110) is not populated
CIP112	CIP.002.112	TOT-BILLED-AMT	Total Billed Amount	Conditional	The total amount billed for this claim at the claim header level as submitted by the provider. For encounter records, when Type of Claim value is ~~[~~in [3, C, ~~or~~ W], then value must equal amount the provider billed to the managed care plan. ~~Total Billed Amount~~For sub-capitated encounters from a sub-capitated entity that is not ~~expected on financial transactions~~a sub-capitated network provider, report the total amount that the provider billed the sub-capitated entity for the service. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11) V99	~~97~~52	~~520~~391	~~532~~403	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Value must equal the sum of all Billed Amount instances for the associated claim 4. Conditional 5. ~~Value should not be populated when associated Type of Claim is in [2, 4, 5, B, D E or X]~~ ~~6.~~ (individual line item payments) when populated and Payment Level Indicator (CIP.002.132) equals ~~= '2'~~"2" value must be greater than or equal to the sum of all claim line Revenue Charges (CIP.003.251) ~~7. If associated Type of Claim value is 2, 4, 5, B, D, or E, then value should not be populated~~

CIP113	CIP.002.113	TOT-ALLOWED-AMT	Total Allowed Amount	Conditional	The claim header level maximum amount determined by the payer as being 'allowable' under the provisions of the contract prior to the determination of actual payment. On FFS claims the Allowed Amount is determined by the state's MMIS. On managed care encounters the Allowed Amount is determined by the managed care organization. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the total amount that the sub-capitated entity allowed for the service. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11) V99	~~98~~53	~~533~~404	~~545~~416	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. When populated and Payment Level Indicator ~~= '2'~~equals "2", then value must equal the sum of all claim line Allowed Amount values 4. Conditional

CIP114	CIP.002.114	TOT-MEDICAID-PAID-AMT	Total Medicaid Paid Amount	Conditional	The total amount paid by Medicaid/CHIP or the managed care plan on this claim or adjustment at the claim header level, which is the sum of the amounts paid by Medicaid or the managed care plan at the detail level for the claim. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the total amount that the sub-capitated entity paid the provider for the service. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11) V99	~~99~~54	~~546~~417	~~558~~429	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Must have an associated Medicaid Paid Date 4. If Total Medicare Coinsurance Amount and Total Medicare Deductible Amount is reported it must equal Total Medicaid Paid Amount 5. When Payment Level Indicator equals '2', value must equal the sum of line level Medicaid Paid Amounts. 6. Conditional 7. Value must not be populated or equal to "0.00" when associated Claim Status is in [542,585,654] 8. Value must not be greater than Total Allowed Amount (CIP.002.113)
~~CIP115~~	~~CIP.002.115~~	~~TOT-COPAY-AMT~~	~~Total Copayment Amount~~	~~Conditional~~	~~The total amount paid by Medicaid/CHIP enrollee for each office or emergency department visit or purchase of prescription drugs in addition to the amount paid by Medicaid/CHIP.~~	~~N/A~~	~~CIP00002~~	~~CLAIM-HEADER-RECORD-IP~~	~~S9(11) V99~~	~~100~~	~~559~~	~~571~~	~~1. Value must be between -99999999999.99 and 99999999999.99~~ ~~2. Value must be expressed as a number with 2-digit precision (e.g. 100.50)~~ ~~3. If associated Crossover Indicator value is '0' (not a crossover claim), then value should not be populated.~~ ~~4. (Medicare Enrolled) if associated Dual Eligible Code (ELG.005.085) value is in ["01", "02", "03", "04", "05", "06", "08", "09", or "10"], then value is mandatory and must be provided~~ ~~5. Conditional~~ ~~6. When populated, value must be less than or equal to Total Billed Amount~~

CIP116	CIP.002.116	TOT-MEDICARE-DEDUCTIBLE-AMT	Total Medicare Deductible Amount	Conditional	The amount paid by Medicaid/CHIP, on this claim at the claim header level, toward the beneficiary's Medicare deductible. 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, code Medicare Combined Indicator a "1"'1' and leave Total Medicare Coinsurance Amount unpopulated.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11) V99	10155	572430	584442	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Crossover Indicator value is '0'equals "0" (not a crossover claim), then value should not be populated. 4. (Medicare Enrolled) if associated Dual Eligible Code (ELG.005.085) value is in ["[01", "¿02", "¿03", "¿04", "¿05", "¿06", "¿08", "¿09", or "¿10"],, then value is mandatory and must be provided 5. Conditional 6. When populated, value must be less than or equal to Total Billed Amount
CIP117	CIP.002.117	TOT-MEDICARE-COINS-AMT	Total Medicare Coinsurance Amount	Conditional	The total amount paid by the Medicaid/CHIP agency or a managed care plan towards the portion of the Medicare allowed charges that Medicare applied to coinsurance.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11) V99	10256	585443	597455	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Crossover Indicator value is '0'equals "0" (not a crossover claim), then value should not be populated. 4. Conditional 5. If associated Medicare Combined Deductible Indicator is '1',equals "1", then value must not be populated 6. When populated, value must be less than or equal to Total Billed Amount

CIP118	CIP.002.118	TOT-TPL-AMT	Total ~~Third Party Liability~~TPL Amount	Conditional	Third-party liability refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a state plan. This is the total amount denoted at the claim header level paid by the third party.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11) V99	~~103~~57	~~598~~456	~~610~~468	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Value must be less than associated Total Billed Amount - (Total Medicare Coinsurance Amount + Total Medicare Deductible Amount) 4. Conditional
CIP119	CIP.002.119	TOT-OTHER-INSURANCE-AMT	Total Other Insurance Amount	Conditional	The amount paid by insurance other than Medicare or Medicaid on this claim.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11) V99	~~104~~58	~~611~~469	~~623~~481	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CIP121	CIP.002.121	OTHER-INSURANCE-IND	Other Insurance Indicator	Conditional	The field denotes whether the insured party is covered under ~~another~~an other insurance plan other than Medicare or Medicaid.	OTHER-INSURANCE-IND	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	~~105~~59	~~624~~482	~~624~~482	~~1.~~1. Value must be 1 character 2. Value must be in Other Insurance Indicator List (VVL) ~~2~~3. Value must be in [0,1~~ character 3.~~] or not populated 4. Conditional
CIP122	CIP.002.122	OTHER-TPL-COLLECTION	Other TPL Collection	~~Conditional~~ Mandatory	This data element indicates that the claim is for a beneficiary for whom other third party resource development and collection activities are in progress, when the liability is not another health insurance plan for which the eligible is a beneficiary.	OTHER-TPL-COLLECTION	CIP00002	CLAIM-HEADER-RECORD-IP	X(3)	~~106~~60	~~625~~483	~~627~~485	1. Value must be in Other TPL Collection List (VVL) 2. Value must be 3 characters 3. ~~Conditional~~Mandatory
~~CIP123~~	~~CIP.002.123~~	~~SERVICE-TRACKING-TYPE~~	~~Service Tracking Type~~	~~Conditional~~	~~A code to categorize service tracking claims. A "service tracking claim" is used to report lump sum payments that cannot be attributed to a single enrollee.~~	~~SERVICE-TRACKING-TYPE~~	~~CIP00002~~	~~CLAIM-HEADER-RECORD-IP~~	~~X(2)~~	~~107~~	~~628~~	~~629~~	~~1. Value must be in Service Tracking Type List (VVL)~~ ~~2. (Service Tracking Claim) if associated Type of Claim is in ['4','D', 'X'] then value is mandatory and must be reported~~ ~~3. Value must be 2 characters~~ ~~4. Conditional~~

~~CIP124~~	~~CIP.002.124~~	~~SERVICE-TRACKING-PAYMENT-AMT~~	~~Service Tracking Payment Amount~~	~~Conditional~~	~~On service tracking claims, the payment amount is the lump sum that cannot be attributed to any one beneficiary paid to the provider.~~	~~N/A~~	~~CIP00002~~	~~CLAIM-HEADER-RECORD-IP~~	~~S9(11) V99~~	~~108~~	~~630~~	~~642~~	~~1. Value must be between -99999999999.99 and 99999999999.99~~ ~~2. Value must be expressed as a number with 2-digit precision (e.g. 100.50)~~ ~~3. If associated Type of Claim value is in [4, D, or X], then value is mandatory and must be provided~~ ~~4. Conditional~~ ~~5. When populated, Service Tracking Type must be populated~~ ~~6. When populated, Total Medicaid Amount must not be populated~~
CIP125	CIP.002.125	FIXED-PAYMENT-IND	Fixed Payment Indicator	Conditional	This indicator indicates that the reimbursement amount included on the claim is for a fixed payment. Fixed payments are made by the state to insurers or providers for premiums or eligible coverage, not for a particular service. For example, some states have Primary Care Case Management programs where the state pays providers a monthly patient management fee of $3.50 for each eligible participant under their care. This fee is considered a fixed payment. It is very important for states to correctly identify fixed payments. Fixed payments do not have a defined ~~"medical record"~~'medical record' associated with the payment; therefore, fixed payments are not subject to medical record request and medical record review.	FIXED-PAYMENT-IND	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	~~109~~61	~~643~~486	~~643~~486	~~1.~~1. Value must be 1 character 2. Value must be in Fixed Payment Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Conditional
CIP126	CIP.002.126	FUNDING-CODE	Funding Code	~~Mandatory~~Conditional	A code to indicate the source of non-federal share funds.	FUNDING-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	~~110~~62	~~644~~487	~~645~~488	~~1.~~1. Value must be 1 character 2. Value must be in Funding Code List (VVL) ~~2.~~3. If Type of Claim is not in [3,C,W], then value must be ~~1 character~~ ~~3. Mandatory~~populated 4. Conditional

CIP127	CIP.002.127	FUNDING-SOURCE-NONFEDERAL-SHARE	Funding Source Non-Federal Share	~~Not Applicable~~Conditional	A code to indicate the type of non-federal share used by the state to finance its expenditure to the provider. In the event of two sources, states are to report the portion which represents the largest proportion not funded by the Federal government.	FUNDING-SOURCE-NONFEDERAL-SHARE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	~~111~~63	~~646~~489	~~647~~490	~~1.~~1. Value must be 2 characters 2. Value must be in Funding Source Non-Federal Share List (VVL) ~~2.~~3. If Type of Claim is in [3,C,W], then value must be ~~2 characters~~ ~~3. Required~~populated 4. Conditional
CIP128	CIP.002.128	MEDICARE-COMB-DED-IND	Medicare Combined Deductible Indicator	Conditional	Code indicating that the amount paid by Medicaid/CHIP on this claim toward the recipient's Medicare deductible was combined with their coinsurance amount because the amounts could not be separated.	MEDICARE-COMB-DED-IND	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	~~112~~64	~~648~~491	~~648~~491	~~1.~~1. Value must be 1 character 2. Value must be in Medicare Combined Deductible Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. If value equals ~~'~~'1~~'~~', then Total Medicare Coinsurance amount ~~is~~must not be populated~~.~~ 4. ~~Value must equal '0' if associated Type of Claim is '3', 'C' or 'W'~~If value equals "0", then Crossover Indicator must equals "0" 5. If value equals "1", then Crossover Indicator must equals "1" 6. Conditional
CIP129	CIP.002.129	PROGRAM-TYPE	Program Type	Mandatory	A code to indicate special Medicaid program under which the service was provided.	PROGRAM-TYPE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	~~113~~65	~~6~~492	~~650~~493	~~1.~~1. Value must be 2 characters 2. Value must be in Program Type List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. (Community First Choice) If value equals ~~'~~'11~~'~~', then State Plan Option Type (ELG.011.163) must equal ~~'~~'01~~'~~' for the same time period 5. If value equals ~~'~~'13~~'~~', then State Plan Option Type (ELG.011.163) must equal ~~'~~'02~~'~~' for the same time period

CIP130	CIP.002.130	PLAN-ID-NUMBER	Plan ID Number	Conditional	A unique number assigned by the state which represents a distinct comprehensive managed care plan, prepaid health plan, primary care case management program, a program for all-inclusive care for the elderly entity, or other approved plans.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(12)	~~114~~66	~~651~~494	~~662~~505	1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional 4. Value must match Managed Care Plan ID (ELG.014.192) 5. Value must match State Plan ID Number (MCR.002.019) 6. When Type of Claim (CIP.002.100) in ~~{~~[3,C,W~~, 2, B, V)~~] value must have a managed care enrollment (ELG.014) for the beneficiary where the Admission Date (CIP.002.094) occurs between the managed care plan enrollment eff/end dates (ELG.014.197/198) 7. When Type of Claim (CIP.002.100) in ~~{~~[3,C,W~~, 2, B, V)~~] value must have a managed care main record (MCR.002) for the plan where the Admission Date (CIP.002.094) occurs between the managed care contract eff/end dates (MCR.002.020/021)
~~CIP131~~	~~CIP.002.131~~	~~NATIONAL-HEALTH-CARE-ENTITY-ID~~	~~National Health Care Entity ID~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~CIP00002~~	~~CLAIM-HEADER-RECORD-IP~~	~~X(10)~~	~~115~~	~~663~~	~~672~~	~~1. Not Applicable~~

CIP132	CIP.002.132	PAYMENT-LEVEL-IND	Payment Level Indicator	Mandatory	~~The field denotes whether the payment amount was determined at the claim header or line/detail level.~~The field denotes whether the payment amount was determined at the claim header or line/detail level. For claims where payment is NOT determined at the individual line level (PAYMENT-LEVEL-IND = 1), the claim lines' associated allowed (ALLOWED-AMT) and paid (MEDICAID-PAID-AMT) amounts are left blank and the total allowed (TOT-ALLOWED-AMT) and total paid (TOT-MEDICAID-PAID-AMT) amount is reported at the header level only. For claims where payment/allowed amount is determined at the individual lines and when applicable, cost-sharing and/or coordination of benefits were deducted from one or more specific line-level payment/allowed amounts (PAYMENT-LEVEL-IND = 2), the allowed (ALLOWED-AMT) and paid (MEDICAID-PAID-AMT) amounts on the associated claim lines should sum to the total allowed (TOT-ALLOWED-AMT) and total paid (TOT-MEDICAID-PAID-AMT) amounts reported on the claim header. For claims where payment/allowed amount is determined at the individual lines but then cost sharing or coordination of benefits was deducted from the total paid/allowed amount at the header only (PAYMENT-LEVEL-IND = 3), then the line-level paid amount (MEDICAID-PAID-AMT) would be blank and line-level allowed (ALLOWED-AMT) and header level total allowed (TOT-ALLOWED-AMT) and total paid (TOT-MEDICAID-PAID-AMT) amounts must all be populated but the line level allowed amounts are not expected to sum exactly to the header level total allowed.	PAYMENT-LEVEL-IND	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	~~116~~67	~~673~~506	~~673~~506	~~1.~~1. Value must be 1 character 2. Value must be in Payment Level Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory

					For example, if a claim for an office visit and a procedure is assigned a separate line-level allowed amount for each line, but then at the header level a copay is deducted from the header-level total allowed and/or total paid amounts, then the sum of line-level allowed amounts may not be equal to the header-level total allowed amounts or correspond directly to the total paid amount. If the state cannot distinguish between the scenarios for value 1 and value 3, then value 1 can be used for all claims with only header-level total allowed/paid amounts.								
CIP133	CIP.002.133	MEDICARE-REIM-TYPE	Medicare Reimbursement Type	Conditional	A code to indicate the type of Medicare reimbursement.	MEDICARE-REIM-TYPE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	~~117~~68	~~674~~507	~~675~~508	~~1.~~1. Value must be 2 characters 2. Value must be in Medicare Reimbursement Type List (VVL) ~~2. (Crossover Claim) if associated Crossover Indicator value indicates a crossover claim,~~3. Value is mandatory and must be provided ~~3. Value must be 2 characters~~ , when Crossover Indicator is equal to "1"

													(Crossover Claim) 4. Conditional
CIP134	CIP.002.134	NON-COV-DAYS	Non-Covered Days	Conditional	The number of days of inpatient care not covered by the payer for this sequence as qualified by the payer organization. The number of non-covered days does not refer to days not covered for any other service.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(5)	~~118~~69	~~676~~509	~~680~~513	~~1. Value must be a positive integer~~ ~~2. Value must be between 0:99999999999 (inclusive)~~ ~~3. Conditional~~ ~~4.~~1. Value must be 5 digits or less 2. Conditional
CIP135	CIP.002.135	NON-COV-CHARGES	Non-Covered Charges	Conditional	The charges for inpatient care, which are not reimbursable by the primary payer. The non-covered charges do not refer to charges not covered for any other service.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11) V99	~~119~~70	~~681~~514	~~693~~526	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CIP136	CIP.002.136	MEDICAID-COV-INPATIENT-DAYS	Medicaid Covered Inpatient Days	Conditional	The number of 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.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(7)	~~120~~71	~~694~~527	~~700~~533	1. Value must be a positive integer 2. Value must be between ~~0:99999999999~~0000000:9999999 (inclusive) 3. Conditional 4. Value must be less than or equal to double the number of days between Admission Date Discharge Date (CIP.002.094) and Discharge Date Discharge Date (CIP.002.096) plus one day 5. Value must be 7 digits or less 6. Value is required if the associated Type of Service (CIP.002.257) ~~is~~ in [001,058,060,084,086,090,091,092,093~~, 123, 132~~] 7. Value is required if at least one associated Revenue Code (CIP.003.245) ~~is~~ in [100-219]

CIP137	CIP.002.137	CLAIM-LINE-COUNT	Claim Line Count	Mandatory	The total number of lines on the claim.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(4)	~~121~~72	~~701~~534	~~704~~537	1. Value must be 4 characters or less 2. Value must be a positive integer ~~2~~3. Value must be between ~~0~~0000:9999 (inclusive) ~~3~~4. Value must not include commas or other non-numeric characters ~~4~~5. Value must be equal to the number of claim lines (e.g. Original Claim Line Number or Adjustment Claim Line Number instances) reported in the associated claim record being reported ~~5. Value must be 4 characters or less~~ 6. Mandatory
CIP138	CIP.002.138	FORCED-CLAIM-IND	Forced Claim Indicator	Conditional	Indicates if the claim was processed by forcing it through a manual override process.	FORCED-CLAIM-IND	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	~~122~~73	~~705~~538	~~705~~538	~~1.~~1. Value must be 1 character 2. Value must be in Forced Claim Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Conditional
CIP139	CIP.002.139	HEALTH-CARE-ACQUIRED-CONDITION-IND	Healthcare Acquired Condition Indicator	Conditional	This code indicates whether the claim has a Health Care Acquired Condition. For additional coding information refer to the following site~~:~~: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html?redirect=/hospitalacqcond/05_Coding.asp#TopOfPage	HEALTH-CARE-ACQUIRED-CONDITION-IND	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	~~123~~74	~~706~~539	~~706~~539	~~1.~~1. Value must be 1 character 2. Value must be in Healthcare Acquired Condition Indicator List (VVL~~).~~ ~~2. Value must be 1 character~~) 3. Conditional
CIP140	CIP.002.140	OCCURRENCE-CODE-01	Occurrence Code 1	Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are ~~FLs~~From Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.	OCCURRENCE-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	~~124~~75	~~707~~540	~~708~~541	~~1.~~1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional

CIP141	CIP.002.141	OCCURRENCE-CODE-02	Occurrence Code 2	Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are ~~FLs~~From Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.	OCCURRENCE-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	~~125~~76	~~709~~542	~~710~~543	~~1.~~1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional
CIP142	CIP.002.142	OCCURRENCE-CODE-03	Occurrence Code 3	Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are ~~FLs~~From Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.	OCCURRENCE-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	~~126~~77	~~711~~544	~~712~~545	~~1.~~1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional
CIP143	CIP.002.143	OCCURRENCE-CODE-04	Occurrence Code 4	Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are ~~FLs~~From Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.	OCCURRENCE-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	~~127~~78	~~713~~546	~~714~~547	~~1.~~1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional
CIP144	CIP.002.144	OCCURRENCE-CODE-05	Occurrence Code 5	Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are ~~FLs~~From Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.	OCCURRENCE-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	~~128~~79	~~715~~548	~~716~~549	~~1.~~1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional
CIP145	CIP.002.145	OCCURRENCE-CODE-06	Occurrence Code 6	Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are ~~FLs~~From Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.	OCCURRENCE-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	~~129~~80	~~717~~550	~~718~~551	~~1.~~1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional

CIP146	CIP.002.146	OCCURRENCE-CODE-07	Occurrence Code 7	Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are ~~FLs~~From Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.	OCCURRENCE-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	~~130~~81	~~719~~552	~~720~~553	~~1.~~1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional
CIP147	CIP.002.147	OCCURRENCE-CODE-08	Occurrence Code 8	Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are ~~FLs~~From Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.	OCCURRENCE-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	~~131~~82	~~721~~554	~~722~~555	~~1.~~1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional
CIP148	CIP.002.148	OCCURRENCE-CODE-09	Occurrence Code 9	Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are ~~FLs~~From Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.	OCCURRENCE-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	~~132~~83	~~723~~556	~~724~~557	~~1.~~1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional
CIP149	CIP.002.149	OCCURRENCE-CODE-10	Occurrence Code 10	Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are ~~FLs~~From Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.	OCCURRENCE-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	~~133~~84	~~725~~558	~~726~~559	~~1.~~1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional
CIP150	CIP.002.150	OCCURRENCE-CODE-EFF-DATE-01	Occurrence Code Effective Date 1	Conditional	The start date of the corresponding occurrence code or occurrence span codes.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~134~~85	~~727~~560	~~734~~567	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code ~~4~~3. Conditional

													~~5~~4. Value must be less than or equal to Occurrence Code End Date
CIP151	CIP.002.151	OCCURRENCE-CODE-EFF-DATE-02	Occurrence Code Effective Date 2	Conditional	The start date of the corresponding occurrence code or occurrence span codes.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~135~~86	~~735~~568	~~742~~575	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code ~~4~~3. Conditional ~~5~~4. Value must be less than or equal to Occurrence Code End Date
CIP152	CIP.002.152	OCCURRENCE-CODE-EFF-DATE-03	Occurrence Code Effective Date 3	Conditional	The start date of the corresponding occurrence code or occurrence span codes.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~136~~87	~~743~~576	~~750~~583	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code ~~4~~3. Conditional ~~5~~4. Value must be less than or equal to Occurrence Code End Date

CIP153	CIP.002.153	OCCURRENCE-CODE-EFF-DATE-04	Occurrence Code Effective Date 4	Conditional	The start date of the corresponding occurrence code or occurrence span codes.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~137~~88	~~751~~584	~~758~~591	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code ~~4~~3. Conditional ~~5~~4. Value must be less than or equal to Occurrence Code End Date
CIP154	CIP.002.154	OCCURRENCE-CODE-EFF-DATE-05	Occurrence Code Effective Date 5	Conditional	The start date of the corresponding occurrence code or occurrence span codes.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~138~~89	~~7~~592	~~766~~599	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code ~~4~~3. Conditional ~~5~~4. Value must be less than or equal to Occurrence Code End Date
CIP155	CIP.002.155	OCCURRENCE-CODE-EFF-DATE-06	Occurrence Code Effective Date 6	Conditional	The start date of the corresponding occurrence code or occurrence span codes.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~139~~90	~~767~~600	~~774~~607	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code ~~4~~3. Conditional ~~5~~4. Value must be less than or equal to Occurrence Code End Date

CIP156	CIP.002.156	OCCURRENCE-CODE-EFF-DATE-07	Occurrence Code Effective Date 7	Conditional	The start date of the corresponding occurrence code or occurrence span codes.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~140~~91	~~775~~608	~~782~~615	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code ~~4~~3. Conditional ~~5~~4. Value must be less than or equal to Occurrence Code End Date
CIP157	CIP.002.157	OCCURRENCE-CODE-EFF-DATE-08	Occurrence Code Effective Date 8	Conditional	The start date of the corresponding occurrence code or occurrence span codes.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~141~~92	~~783~~616	~~790~~623	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code ~~4~~3. Conditional ~~5~~4. Value must be less than or equal to Occurrence Code End Date
CIP158	CIP.002.158	OCCURRENCE-CODE-EFF-DATE-09	Occurrence Code Effective Date 9	Conditional	The start date of the corresponding occurrence code or occurrence span codes.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~142~~93	~~791~~624	~~798~~631	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code ~~4~~3. Conditional ~~5~~4. Value must be less than or equal to Occurrence Code End Date

CIP159	CIP.002.159	OCCURRENCE-CODE-EFF-DATE-10	Occurrence Code Effective Date 10	Conditional	The start date of the corresponding occurrence code or occurrence span codes.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~143~~94	~~799~~632	~~806~~639	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code ~~4~~3. Conditional ~~5~~4. Value must be less than or equal to Occurrence Code End Date
CIP160	CIP.002.160	OCCURRENCE-CODE-END-DATE-01	Occurrence Code End Date 1	Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~144~~95	~~807~~640	~~814~~647	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional
CIP161	CIP.002.161	OCCURRENCE-CODE-END-DATE-02	Occurrence Code End Date 2	Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~145~~96	~~815~~648	~~822~~655	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional

CIP162	CIP.002.162	OCCURRENCE-CODE-END-DATE-03	Occurrence Code End Date 3	Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~146~~97	~~823~~656	~~830~~663	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional
CIP163	CIP.002.163	OCCURRENCE-CODE-END-DATE-04	Occurrence Code End Date 4	Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~147~~98	~~831~~664	~~838~~671	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional
CIP164	CIP.002.164	OCCURRENCE-CODE-END-DATE-05	Occurrence Code End Date 5	Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~148~~99	~~839~~672	~~846~~679	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional

CIP165	CIP.002.165	OCCURRENCE-CODE-END-DATE-06	Occurrence Code End Date 6	Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~149~~100	~~847~~680	~~854~~687	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional
CIP166	CIP.002.166	OCCURRENCE-CODE-END-DATE-07	Occurrence Code End Date 7	Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	1~~5~~01	~~855~~688	~~862~~695	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional
CIP167	CIP.002.167	OCCURRENCE-CODE-END-DATE-08	Occurrence Code End Date 8	Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~151~~102	~~863~~696	~~8~~703	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional

CIP168	CIP.002.168	OCCURRENCE-CODE-END-DATE-09	Occurrence Code End Date 9	Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~152~~103	~~871~~704	~~878~~711	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional
CIP169	CIP.002.169	OCCURRENCE-CODE-END-DATE-10	Occurrence Code End Date 10	Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~153~~104	~~879~~712	~~886~~719	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional
CIP170	CIP.002.170	BIRTH-WEIGHT-GRAMS	Birth Weight Grams	Conditional	The weight of a newborn at time of birth in grams (applicable to newborns only). The field is required when a claim involves a child birth.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(6)V999	105~~4~~	~~887~~720	~~895~~728	1. Value must not be greater than 6 digits to the left of the decimal and have no more than 3 digits to the right of the decimal (i.e. 999999.999) 2. Conditional
CIP171	CIP.002.171	PATIENT-CONTROL-NUM	Patient Control Number	Conditional	A patient's unique number assigned by the provider agency during claim submission, which identifies the client or the client's episode of service within the provider's system to facilitate retrieval of individual financial and clinical records and posting of payment	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(20)	~~155~~106	~~896~~729	~~915~~748	1. Value must be 20 characters or less 2. Value must not contain a pipe or asterisk symbol 3. Conditional

CIP172	CIP.002.172	ELIGIBLE-LAST-NAME	Eligible Last Name	Conditional	The last name of the individual to whom the services were provided. (The patients name should be captured as it appears on the claim record, it does not need to be the same as it appears on the eligibility file. The MSIS Identification Number will be used to associate a claim record with the appropriate eligibility data.)	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(30)	~~156~~107	~~916~~749	~~945~~778	1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional
CIP173	CIP.002.173	ELIGIBLE-FIRST-NAME	Eligible First Name	Conditional	The first name of the individual to whom the services were provided. (The patients name should be captured as it appears on the claim record, it does not need to be the same as it appears on the eligibility file. The MSIS Identification Number will be used to associate a claim record with the appropriate eligibility data.)	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(30)	~~157~~108	~~946~~779	~~975~~808	1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional
CIP174	CIP.002.174	ELIGIBLE-MIDDLE-INIT	Eligible Middle Initial	Conditional	Individual's middle initial; middle initial component of full name (e.g. First Name, Middle Initial, Last Name).	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	~~158~~109	~~976~~809	~~976~~809	1. ~~Value may include any alphanumeric characters, digits or symbols~~ ~~2.~~ Value must be 1 character ~~3~~2. Value must not contain a pipe or asterisk symbols ~~4~~3. Conditional
CIP175	CIP.002.175	DATE-OF-BIRTH	Date of Birth	Mandatory	Date of birth of the individual to whom the services were provided. A patient's age should not be greater than 112 years.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~159~~110	~~977~~810	~~984~~817	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Mandatory

CIP176	CIP.002.176	HEALTH-HOME-PROV-IND	Health Home Provider Indicator	Conditional	Indicates whether the claim is submitted by a provider or provider group enrolled in the Health Home care model~~.~~ to provide services for the beneficiary on the claim. Health home providers provide service for patients with chronic illnesses. ~~States should not submit claim records for an eligible individual that indicate the claim was submitted by a provider or provider group enrolled in a health home model if the eligible individual is not enrolled in the health home program.~~ States that do not specify an eligible individual's health home provider number, if applicable, should not report claims that indicate the claim is submitted by a provider or provider group enrolled in the health home model.	HEALTH-HOME-PROV-IND	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	~~160~~111	~~985~~818	~~985~~818	1. Value must be in Health Home Provider Indicator List (VVL) 2. Value must be 1 character 3. If there is an associated Health Home Entity Name value, then value must be "1" ~~3. Value must be 1 character~~ ~~4.~~4. Conditional
CIP177	CIP.002.177	WAIVER-TYPE	Waiver Type	Conditional	A code for specifying waiver type under which the eligible individual is covered during the month and receiving services/under which claim is submitted.	WAIVER-TYPE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	16~~1~~2	~~986~~819	~~987~~820	~~1.~~1. Value must be 2 characters 2. Value must be in Waiver Type List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Value must ~~be in ['06', '07', '08', '09', '10', '11', '12', '13', '14', '15', '16', '17', '18', '19', '20', '33'] when associated Program~~ match Eligible Waiver Type ~~equals "07"~~ ~~4.~~(ELG.012.173) for the enrollee for the same time period (by date of service) 4. Value must have a corresponding value in Waiver ID (CIP.002.178) 5. Conditional

CIP178	CIP.002.178	WAIVER-ID	Waiver ID	Conditional	Field specifying the waiver or demonstration which authorized payment for a claim. These IDs must be the approved, full federal waiver ID number assigned during the state submission and CMS approval process. Waiver IDs should actually only be the "core" part of the waiver IDs, without including suffixes for renewals or amendments.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(20)	~~162~~113	~~988~~821	~~100~~784 0	~~1.~~1. Value must be 20 characters or less 2. Value must be associated with a populated Waiver Type ~~2. Value must be 20 characters or less~~ ~~3.~~3. (1115 demonstration ~~waivers~~) If value begins with "11-W-" or "21-W-", the associated Claim Waiver Type value must be 01 or in [21-30] 4. (1115 demonstration) If value begins with"11-W-" or "21-W-", then the value must include slash “/” in the 11th position followed by the last digit of the CMS Region [0-9] in the 12th position 5. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation followed by a period (.), the associated Claim Waiver Type value must be in [02-20,32,33] ~~5~~6. Conditional
CIP179	CIP.002.179	BILLING-PROV-NUM	Billing Provider Number	Conditional	A unique identification number assigned by the state to a provider or ~~capitation~~managed care plan. This data element should represent the entity billing for the service. For encounter records, if associated Type of Claim value equals 3, C, or W, then value must be the state identifier of the provider or entity (billing or reporting) to the managed care plan.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(30)	~~163~~114	~~100~~84 1	~~103~~787 0	1. Value must be 30 characters or less 2. ~~Value must be reported in Provider Identifier (PRV.005.080) with an associated Provider Identifier Type (PRV.005.081) equal to '1'~~ ~~3.~~ Conditional ~~4~~3. When Type of Claim not in ~~('2','3','C','W','2","B","V"," 4","D","X")~~[3,C,W] then value may match (PRV.002.019) Submitting State Provider ID or 4. When Type of Claim not in ~~('2','3','C','W','2","B","V"," 4","D","X")~~[3,C,W] then value may match (PRV.005.081) Provider Identifier where the Provider Identifier Type ~~=~~ ~~'1'~~(PRV.005.077) equals "1" 5. Discharge Date (CIP.002.096) may be between Provider Attributes Effective Date (PRV.002.020) and Provider Attributes End Date (PRV.002.021) or

													6. Discharge Date (CIP.002.096) may be between Provider Identifier Effective Date (PRV.005.079) and Provider Identifier End Date (PRV.005.080)
CIP180	CIP.002.180	BILLING-PROV-NPI-NUM	Billing Provider NPI Number	Conditional	~~A National Provider Identifier (NPI) is a unique 10-digit identification number issued to health care providers in the United States by CMS. Healthcare providers acquire their unique 10-digit NPIs to identify themselves in a standard way throughout their industry. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number).~~The National Provider ID (NPI) of the billing entity responsible for billing a patient for healthcare services. The billing provider can also be servicing, referring, or prescribing provider. Can be admitting provider except for Long Term Care.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(10)	~~164~~115	~~103~~871	~~104~~880	1. Value must be 10 digits~~, consisting of 9 numeric digits followed by one check digit calculated using the Luhn formula (algorithm) 2.~~ 2. Value must have an associated Provider Identifier Type equal to ~~'2'~~"2" 3. Value must exist in the NPPES NPI data file 4. Conditional 45. When populated, value must match Provider Identifier (PRV.005.081) and Facility Group Individual Code (PRV.002.028) must equal ~~'01'~~"01" 6. NPPES Entity Type Code associated with this NPI must equal "2" (Organization)
CIP181	CIP.002.181	BILLING-PROV-TAXONOMY	Billing Provider Taxonomy	Conditional	The taxonomy code for the institution billing for the beneficiary.	PROV-TAXONOMY	CIP00002	CLAIM-HEADER-RECORD-IP	X(12)	1165~~5~~	~~104~~8881	~~105~~8992	~~1.~~1. Value must be 12 characters or less 2. Value must be in Provider Taxonomy List (VVL) ~~2. Value must be 12 characters or less~~ ~~3.~~3. Conditional

CIP182	CIP.002.182	BILLING-PROV-TYPE	Billing Provider Type	Conditional	A code to describe the type of ~~entity billing for the service~~provider being reported.	PROV-TYPE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	~~166~~117	~~106~~089 3	~~106~~189 4	~~1.~~1. Value must be 2 characters 2. Value must be in Provider Type Code List (VVL~~).~~ ~~2. Value must be 2 characters~~) 3. Conditional
CIP183	CIP.002.183	BILLING-PROV-SPECIALTY	Billing Provider Specialty	Conditional	This code describes the area of specialty for the provider being reported.	PROV-SPECIALTY	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	~~167~~118	~~106~~289 5	~~106~~389 6	~~1.~~1. Value must be 2 characters 2. Value must be in Provider Specialty List (VVL~~).~~ ~~2. Value must be 2 characters~~) 3. Conditional
CIP184	CIP.002.184	ADMITTING-PROV-NPI-NUM	Admitting Provider NPI Number	~~Not Applicable~~Conditional	~~A National Provider Identifier (NPI) is a unique 10-digit identification number issued to health care providers in the United States by CMS. Healthcare providers acquire their unique 10-digit NPIs to identify themselves in a standard way throughout their industry. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number).~~The National Provider ID (NPI) of the doctor responsible for admitting a patient to a hospital or other inpatient health facility.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(10)	~~168~~119	~~106~~489 7	~~107~~390 6	1. Value must be 10 digits~~, consisting of 9 numeric digits followed by one check digit calculated using the Luhn formula (algorithm)~~ ~~2.~~ 2. Conditional 3. Value must have an associated Provider Identifier Type equal to ~~'2'~~"2" 4. Value must exist in the NPPES NPI File
CIP185	CIP.002.185	ADMITTING-PROV-NUM	Admitting Provider Number	Conditional	The Medicaid ID of the doctor responsible for admitting a patient to a hospital or other inpatient health facility.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(30)	~~169~~120	~~1~~907~~4~~	~~110~~393 6	1. Value must be 30 characters or less 2. ~~Value must be reported in Provider Identifier (PRV.005.080) with an associated Provider Identifier Type (PRV.005.081) equal to '1'~~ ~~3.~~ Conditional
CIP186	CIP.002.186	ADMITTING-PROV-SPECIALTY	Admitting Provider Specialty	Conditional	This code describes the area of specialty for the provider being reported.	PROV-SPECIALTY	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	~~170~~121	~~110~~493 7	~~110~~593 8	~~1.~~1. Value must be 2 characters 2. Value must be in Provider Specialty List (VVL~~).~~ ~~2. Value must be 2 characters~~) 3. Conditional

CIP187	CIP.002.187	ADMITTING-PROV-TAXONOMY	Admitting Provider Taxonomy	Conditional	Taxonomic classification (code) for a given healthcare provider, as defined by the National Uniform Claim Committee.	PROV-TAXONOMY	CIP00002	CLAIM-HEADER-RECORD-IP	X(12)	~~171~~122	~~110~~693 9	~~111~~795 0	~~1.~~1. Value must be 12 characters or less 2. Value must be in Provider Taxonomy List (VVL) ~~2. Value must be 12 characters or less~~ ~~3.~~3. Conditional
CIP188	CIP.002.188	ADMITTING-PROV-TYPE	Admitting Provider Type	Conditional	A code to describe the type of ~~entity billing for the service~~provider being reported.	PROV-TYPE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	1~~2~~23	~~111~~895 1	~~111~~995 2	1. Value must be 12 characters or less 2. Value must be in Provider ~~Type Code~~Taxonomy List (VVL~~).~~ ~~2. Value must be 2 characters~~) 3. Conditional
CIP189	CIP.002.189	REFERRING-PROV-NUM	Referring Provider Number	Conditional	A unique identification number assigned to a provider which identifies the physician or other provider who referred the patient. For physicians, this must be the individual's ID number, not a group identification number. If the referring provider number 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.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(30)	~~173~~124	~~112~~095 3	~~114~~998 2	1. Value must be 30 characters or less 2. ~~Value must be reported in Provider Identifier (PRV.005.080) with an associated Provider Identifier Type (PRV.005.081) equal to '1'~~ ~~3.~~Conditional
CIP190	CIP.002.190	REFERRING-PROV-NPI-NUM	Referring Provider NPI Number	Conditional	~~A National Provider Identifier (NPI) is a unique 10-digit identification number issued to health care providers in the United States by CMS. Healthcare providers acquire their unique 10-digit NPIs to identify themselves in a standard way throughout their industry. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number).~~The National Provider ID (NPI) of the provider who recommended the servicing provider to the patient.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(10)	~~174~~125	~~115~~098 3	~~115~~999 2	1. Value must be 10 digits~~, consisting of 9 numeric digits followed by one check digit calculated using the Luhn formula (algorithm)~~ ~~2.~~ 2. Value must have an associated Provider Identifier Type equal to ~~'2'~~"2" 3. Value must exist in the NPPES NPI data file 4. Conditional
~~CIP191~~	~~CIP.002.191~~	~~REFERRING-PROV-TAXONOMY~~	~~Referring Provider Taxonomy~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~CIP00002~~	~~CLAIM-HEADER-RECORD-IP~~	~~X(12)~~	~~175~~	~~1160~~	~~1171~~	~~1. Not Applicable~~

~~CIP192~~	~~CIP.002.192~~	~~REFERRING-PROV-TYPE~~	~~Referring Provider Type~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~CIP00002~~	~~CLAIM-HEADER-RECORD-IP~~	~~X(2)~~	~~176~~	~~1172~~	~~1173~~	~~1. Not Applicable~~
~~CIP193~~	~~CIP.002.193~~	~~REFERRING-PROV-SPECIALTY~~	~~Referring Provider Specialty~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~CIP00002~~	~~CLAIM-HEADER-RECORD-IP~~	~~X(2)~~	~~177~~	~~1174~~	~~1175~~	~~1. Not Applicable~~
CIP194	CIP.002.194	DRG-OUTLIER-AMT	DRG Outlier Amount	Conditional	The additional payment on a claim that is associated with either a cost outlier or length of stay outlier. Outlier payments compensate hospitals paid on a fixed amount per Medicare ~~"'~~diagnosis related group~~"'~~ discharge with extra dollars for patient stays that substantially exceed the typical requirements for patient stays in the same DRG category.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11) V99	~~178~~126	~~1176~~993	~~1188~~1005	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. ~~Conditional~~ ~~4.~~Value must ~~not~~ be populated when Outlier Code (CIP.002.197) is ~~'01','02' or '10'~~in [01,02,10] 4. Conditional
CIP195	CIP.002.195	DRG-REL-WEIGHT	DRG Relative Weight	Conditional	The relative weight for the DRG on the claim. Each year CMS assigns a relative weight to each DRG. These weights indicate the relative costs for treating patients during the prior year. The national average charge for each DRG is compared to the overall average. This ratio is published annually in the Federal Register for each DRG. A DRG with a weight of 2.0000 means that charges were historically twice the average; a DRG with a weight of 0.5000 was half the average. This data element in T-MSIS is expected to capture the relative weight of the DRG in the state's system regardless of which DRG system the state uses.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	~~X(8)~~S9(3)V99999	127~~9~~	~~1189~~1006	101~~96~~3	1. Value ~~must be 8 characters or less~~ ~~2.~~may include up to 3 digits to the left of the decimal point, and 5 digits to the right e.g. 123.45678 2. Conditional 3. When populated value must be zero or greater

CIP196	CIP.002.196	MEDICARE-HIC-NUM	Medicare HIC Number	Conditional	The Medicare HIC Number (HICN) is an identifier formerly used by SSA and CMS to identify all Medicare beneficiaries. For many beneficiaries, their SSN was a major component of their HICN. To prevent identify theft, among other reasons, HICN gradually were retired and replaced by the Medicare Beneficiary Identifier (MBI) over the course of 2018 and 2019. HICN continue to be used by Medicare for limited administrative purposes after 2019 but starting in 2020 the MBI became the primary identifier for Medicare beneficiaries. HICN consists of two components: SSN ~~&~~and alpha-suffix or (for Railroad IDs) prefix and ID (not always SSN based~~)~~).	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(12)	1280	101974	120825	1. ~~Conditional~~ ~~2.~~ Value must be 12 characters or less 2. Conditional 3. Value must not contain a pipe or asterisk symbols 4. (Not Dual Eligible) if Dual Eligible Code (ELG.DE.085) value ~~=~~equals "00", then value must not be populated~~.~~ 5. Value must be populated when Crossover Indicator (CIP.002.023) equals ~~'1'~~"1" and Medicare Beneficiary Identifier (CIP.002.222) is not populated~~.~~
CIP197	CIP.002.197	OUTLIER-CODE	Outlier Code	Conditional	This code indicates the Type of Outlier Code or DRG Source. The field identifies two mutually exclusive conditions. The first, for PPS providers (codes 0, 1, and 2), classifies stays of exceptional cost or length (outliers). The second, for non-PPS providers (codes 6, 7, 8, and 9), denotes the source for developing the DRG. https://www.resdac.org/cms-data/variables/medpar-drgoutlier-stay-code	OUTLIER-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	~~181~~129	120926	121027	~~1.~~1. Value must be 2 characters 2. Value must be in Outlier Code List (VVL) ~~2. (Day Outlier) If Outlier Code~~3. Value is ~~01, then~~ mandatory if either DRG Outlier Amount (CIP.002.194) or Outlier Days (CIP.002.198) ~~must be~~are populated~~.~~ ~~3. Value must be 2 characters~~ 4. Conditional ~~5. If value equals '00' or '09', then DRG Outlier Amount (CIP.002.194) must not be populated~~
CIP198	CIP.002.198	OUTLIER-DAYS	Outlier Days	Conditional	This field specifies the number of days paid as outliers under Prospective Payment System (PPS) and the days over the threshold for the DRG.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(5)	~~182~~130	102~~118~~	103~~215~~	1. Value must be 5 digits or less 2. Value must be numeric ~~2. The value may be up to 5 digits in length~~ 3. Value must be populated, if Outlier Code (CIP.002.197) equals "01" 4. Conditional

CIP199	CIP.002.199	PATIENT-STATUS	Patient Status	Mandatory	A code indicating the patient's status as of the last day the claim covers. Values used are from UB-04. This is also referred to as patient discharge status. A valid list of codes can be purchased at: https://www.nubc.org/license	PATIENT-STATUS	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	1~~8~~31	~~1216~~10 33	~~1217~~10 34	~~1.~~1. Value must be 2 characters 2. Value must be in Patient Status List (VVL~~).~~ ~~2. Value must be 2 characters~~) 3. Mandatory 4. When value in ~~[~~"[20",",40",",41",",42"~~],~~], then associated Discharge Date (CIP.002.096) must be less than or equal to Date of Death (ELG.002.025)
~~CIP201~~	~~CIP.002.201~~	~~BMI~~	~~Body Mass Index~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~CIP00002~~	~~CLAIM-HEADER-RECORD-IP~~	~~S9(5)V9~~	~~184~~	~~1218~~	~~1223~~	~~1. Not Applicable~~
CIP202	CIP.002.202	REMITTANCE-NUM	Remittance Number	Mandatory	The Remittance Advice Number is a sequential number that identifies the current Remittance Advice (RA) produced for a provider. The number is incremented by one each time a new RA is generated. ~~The first five (5) positions are Julian date following a YYDDD format.~~ The RA is the detailed explanation of the reason for the payment amount. ~~The RA number is not the check number.~~	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(30)	~~185~~132	~~1224~~10 35	~~1253~~10 64	1. Value must be 30 characters or less 2. ~~First five (5) characters of the value must be a Julian date express in the form YYDDD (e.g. 19095, 95th day of 20(19))~~ ~~3.~~ Value must not contain a pipe or asterisk symbols ~~4~~3. Mandatory
CIP203	CIP.002.203	SPLIT-CLAIM-IND	Split Claim Indicator	Conditional	An indicator that denotes that claims in excess of a pre-determined number of claim lines (threshold determined by the individual state) will be split during processing.	SPLIT-CLAIM-IND	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	~~186~~133	1~~2~~065~~4~~	1~~2~~065~~4~~	~~1.~~1. Value must be 1 character 2. Value must be in Split Claim Indicator List (VVL~~).~~ ~~2. Value must be 1 character~~) 3. Conditional
CIP204	CIP.002.204	BORDER-STATE-IND	Border State Indicator	Conditional	A code to indicate whether an individual received services or equipment across state borders. (The provider location is out of state, but for payment purposes the provider is treated as an in-state provider.)	BORDER-STATE-IND	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	~~187~~134	~~1255~~10 66	~~1255~~10 66	~~1.~~1. Value must be 1 character 2. Value must be in Border State Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Conditional

CIP206	CIP.002.206	TOT-BENEFICIARY-COINSURANCE-PAID-AMOUNT	Beneficiary Coinsurance Paid Amount	Conditional	The amount ~~of money~~ the beneficiary or his or her representative (e.g., their guardian) paid towards their coinsurance for the covered services on the claim. Do not include coinsurance payments made by a third party/s on behalf of the beneficiary.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11) V99	~~188~~135	1~~25~~067	~~1268~~1079	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. ~~Must have an associated Beneficiary Coinsurance Date Paid~~ ~~4.~~ Conditional
CIP207	CIP.002.207	BENEFICIARY-COINSURANCE-DATE-PAID	Beneficiary Coinsurance Date Paid	Conditional	The date the beneficiary paid the coinsurance amount.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~189~~136	~~1269~~1080	1~~20~~87~~6~~	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~in the form "CCYYMMDD" 2. When populated, value must have an associated Beneficiary Coinsurance Amount ~~4~~3. Conditional
CIP208	CIP.002.208	TOT-BENEFICIARY-COPAYMENT-PAID-AMOUNT	Total Beneficiary Copayment Paid Amount	Conditional	The amount ~~of money~~ the beneficiary or his or her representative (e.g., their guardian) paid towards their copayment for the covered services on the claim. Do not include copayment payments made by a ~~co-payment~~third party/s on behalf of the beneficiary.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11) V99	~~190~~137	~~1277~~1088	~~1289~~1100	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. ~~Must have an associated Beneficiary Copayment Date Paid~~ ~~4.~~ Conditional
CIP209	CIP.002.209	BENEFICIARY-COPAYMENT-DATE-PAID	Beneficiary Copayment Date Paid	Conditional	The date the beneficiary paid the copayment amount.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~191~~138	1~~29~~101	~~1297~~1108	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~in the form "CCYYMMDD" 2. When populated, value must have an associated Beneficiary Copayment Amount ~~4~~3. Conditional

CIP210	CIP.002.210	TOT-BENEFICIARY-DEDUCTIBLE-PAID-AMOUNT	Total Beneficiary Deductible Paid Amount	Conditional	The amount ~~of money~~ the beneficiary or his or her representative (e.g., their guardian) paid towards ~~an annual~~their deductible for the covered services on the claim. Do not include deductible payments made by a third party/s on behalf of the beneficiary.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11)V99	1392	121098	131021	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. ~~Must have an associated Beneficiary Deductible Date Paid~~ 4. Conditional
CIP211	CIP.002.211	BENEFICIARY-DEDUCTIBLE-DATE-PAID	Beneficiary Deductible Date Paid	Conditional	The date the beneficiary paid the deductible amount.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	193140	131122	131829	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~in the form "CCYYMMDD" 2. When populated, value must have an associated Beneficiary Deductible ~~Date Paid~~ 4Amount 3. Conditional
CIP212	CIP.002.212	CLAIM-DENIED-INDICATOR	Claim Denied Indicator	Mandatory	An indicator to identify a claim that the state refused pay in its entirety.	CLAIM-DENIED-INDICATOR	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	1941	131930	131930	~~1.~~1. Value must be 1 character 2. Value must be in Claim Denied Indicator List (VVL) ~~2~~3. If value ~~is '0',~~equals "0", then Claim Status Category must equal "F2" ~~3. Value must be 1 character~~ ~~4.~~4. Mandatory
CIP213	CIP.002.213	COPAY-WAIVED-IND	Copayment Waived Indicator	~~Op~~Situational	An indicator signifying that the copay was discounted or waived by the provider (e.g., physician or hospital). Do not use to indicate administrative-level, Medicaid State Agency or Medicaid MCO copayment waived decisions.	COPAY-WAIVED-IND	CIP00002	CLAIM-HEADER-RECORD-IP	X(1)	195142	113201	113201	~~1.~~1. Value must be 1 character 2. Value must be in Copay Waived Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3. Optional~~3. Situational

CIP214	CIP.002.214	HEALTH-HOME-ENTITY-NAME	Health Home Entity Name	Conditional	A free-form text field to indicate the health home program that authorized payment for the service on the claim~~.~~ or to identify the health home SPA in which an individual is enrolled. The name entered should be the name that the state uses to uniquely identify the team. A "Health Home Entity" can be a designated provider (e.g., physician, clinic, behavioral health organization), a health team which links to a designated provider, or a health team (physicians, nurses, behavioral health professionals). Because an identification numbering schema has not been established, the entities' names are being used instead.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(50)	~~196~~143	1132~~1~~	~~1370~~1181	~~1. Value must 50 characters or less~~ ~~2.~~1. Value must not contain a pipe or asterisk symbols 2. Value must 50 characters or less 3. Conditional
CIP216	CIP.002.216	THIRD-PARTY-COINSURANCE-AMOUNT-PAID	Third Party Coinsurance Amount Paid	~~Op~~Situational	The amount of money paid by a third party on behalf of the beneficiary towards coinsurance ~~on the claim or claim line item~~.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11)V99	~~197~~144	1~~37~~182	~~1383~~1194	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. ~~Op~~Situational
CIP217	CIP.002.217	THIRD-PARTY-COINSURANCE-DATE-PAID	Third Party Coinsurance Date Paid	Conditional	The date ~~a Third Party~~the third party paid the coinsurance amount ~~was paid on this claim or adjustment.~~	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~198~~145	~~1384~~1195	~~1391~~1202	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~in the form "CCYYMMDD" 2. When populated, value must have an associated Third Party Coinsurance Amount 3. Conditional
CIP218	CIP.002.218	THIRD-PARTY-COPAYMENT-AMOUNT-PAID	Third Party Copayment Amount Paid	~~Op~~Situational	The amount of money paid by a third ~~-~~party on behalf of the beneficiary ~~paid~~ towards ~~a~~ copayment.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11)V99	~~199~~146	1~~39~~203	~~1404~~1215	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. ~~Op~~Situational

CIP219	CIP.002.219	THIRD-PARTY-COPAYMENT-DATE-PAID	Third Party Copayment Date Paid	~~Op~~Situati onal	The date ~~a Third Party~~the third party paid the copayment amount ~~was paid on a claim or adjustment~~.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	~~200~~147	~~140~~512 16	1~~41~~223	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~in the form "CCYYMMDD" 2. When populated, value must have an associated Third Party Copayment Amount 3. ~~Op~~Situational
CIP220	CIP.002.220	MEDICAID-AMOUNT-PAID-DSH	Medicaid Amount Paid DSH	Conditional	The amount included in the Total Medicaid Amount (CIP.002.114) that is attributable to a Disproportionate Share Hospital (DSH) payment, when the state makes DSH payments by claim.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11) V99	~~201~~148	1224~~13~~	142~~5~~36	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CIP221	CIP.002.221	HEALTH-HOME-PROVIDER-NPI	Health Home Provider NPI Number	Conditional	~~A National Provider Identifier (NPI) is a unique 10-digit identification number issued to health care providers in the United States by CMS. Healthcare providers acquire their unique 10-digit NPIs to identify themselves in a standard way throughout their industry. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number).~~The National Provider ID (NPI) of the health home provider.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(10)	~~202~~149	142~~6~~37	124~~35~~6	1. Value must be 10 digits~~, consisting of 9 numeric digits followed by one check digit calculated using the Luhn formula (algorithm)~~ ~~2.~~ 2. Value must have an associated Provider Identifier, where Provider Identifier Type ~~equal to '2'~~(PRV.005.077) equals "2" 3. Value must exist in the NPPES NPI data file 4. Conditional

CIP222	CIP.002.222	MEDICARE-BENEFICIARY-IDENTIFIER	Medicare Beneficiary Identifier	Conditional	The Medicare Beneficiary Identifier (MBI) is a randomly generated identifier used to identify all Medicare beneficiaries. It replaced the previously-used SSN-based Medicare HIC Number (HICN). To prevent identify theft, among other reasons, HICN gradually were retired and replaced by the MBI over the course of 2018 and 2019. Starting in 2020, the MBI became the primary identifier for Medicare beneficiaries.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(12)	~~203~~150	124~~367~~	~~1447~~1258	1. Conditional 2. Value must be an 11-character string 3. Character 1 must be numeric values 1 thru 9 4. Character 2 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 5. Character 3 must be alphanumeric values 0 thru 9 or A thru Z (minus S,L,O,I,B,Z) 6. Character 4 must be numeric values 0 thru 9 7. Character 5 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 8. Character 6 must be alphanumeric values 0 thru 9 or A thru Z (minus S,L,O,I,B,Z) 9. Character 7 must be numeric values 0 thru 9 10. Character 8 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 11. Character 9 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 12. Character 10 must be numeric values 0 thru 9 13. Character 11 must be numeric values 0 thru 9 14. Value must not contain a pipe or asterisk symbols
CIP223	CIP.002.223	OPERATING-PROV-TAXONOMY	Operating Provider Taxonomy	Conditional	Taxonomic classification (code) for a given healthcare provider, as defined by the National Uniform Claim Committee.	PROV-TAXONOMY	CIP00002	CLAIM-HEADER-RECORD-IP	X(12)	~~204~~151	~~1448~~1259	~~1459~~1270	~~1.~~1. Value must be 12 characters or less 2. Value must be in Provider Taxonomy List (VVL) ~~2. Value must be 12 characters or less~~ ~~3.~~3. Conditional
~~CIP224~~	~~CIP.002.224~~	~~UNDER-DIRECTION-OF-PROV-NPI~~	~~Under Direction of Provider NPI~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for~~	~~N/A~~	~~CIP00002~~	~~CLAIM-HEADER-RECORD-IP~~	~~X(10)~~	~~205~~	~~1460~~	~~1469~~	~~1. Not Applicable~~

					~~specific definition and coding requirement description(s).]~~								
~~CIP225~~	~~CIP.002.225~~	~~UNDER-DIRECTION-OF-PROV-TAXONOMY~~	~~Under Direction of Provider Taxonomy~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~CIP00002~~	~~CLAIM-HEADER-RECORD-IP~~	~~X(12)~~	~~206~~	~~1470~~	~~1481~~	~~1. Not Applicable~~
~~CIP226~~	~~CIP.002.226~~	~~UNDER-SUPERVISION-OF-PROV-NPI~~	~~Under Supervision of Provider NPI~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~CIP00002~~	~~CLAIM-HEADER-RECORD-IP~~	~~X(10)~~	~~207~~	~~1482~~	~~1491~~	~~1. Not Applicable~~
~~CIP227~~	~~CIP.002.227~~	~~UNDER-SUPERVISION-OF-PROV-TAXONOMY~~	~~Under Supervision of Provider Taxonomy~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~CIP00002~~	~~CLAIM-HEADER-RECORD-IP~~	~~X(12)~~	~~208~~	~~1492~~	~~1503~~	~~1. Not Applicable~~
CIP228	CIP.002.228	MEDICARE-PAID-AMT	Medicare Paid Amount	Conditional	The amount paid by Medicare on this claim~~ or adjustment~~. For claims where Medicare payment is only available at the line level, report the sum of all the line level Medicare payment amounts at the header.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11) V99	~~209~~152	~~150~~412 71	~~151~~612 83	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Crossover Indicator value ~~is~~equals "0", then the ~~Medicare Paid Amount value~~ must not be populated~~.~~ 4. Conditional 5. If value is populated, Crossover Indicator must be equal to "1"
CIP229	CIP.002.229	STATE-NOTATION	State Notation	~~Op~~Situatio nal	A free text field for the submitting state to enter whatever information it chooses.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(500)	~~210~~177	1~~51~~789	~~201~~622 88	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational

CIP231	CIP.003.231	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	CIP00003	CLAIM-LINE-RECORD-IP	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "CIP00003"
CIP232	CIP.003.232	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	CIP00003	CLAIM-LINE-RECORD-IP	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (CIP.001.007)
CIP233	CIP.003.233	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	CIP00003	CLAIM-LINE-RECORD-IP	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory

CIP234	CIP.003.234	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual ~~(except on service tracking payments).~~ . Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47572~~reporting-shared-msis-identification-numbers-eligibility/	N/A	CIP00003	CLAIM-LINE-RECORD-IP	X(20)	4	22	41	~~1. Mandatory~~ ~~2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN~~ ~~3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN~~ ~~4. Value must be 20 characters or less~~ ~~5. When Type of Claim (CIP.002.100) = 4, D or X (lump sum payment) value must begin with an '&'~~1. Value must be 20 characters or less 2. Mandatory
CIP235	CIP.003.235	ICN-ORIG	Original ICN	Mandatory	A unique number assigned by the state's payment system that identifies an original or adjustment claim.	N/A	CIP00003	CLAIM-LINE-RECORD-IP	X(50)	5	42	91	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
CIP236	CIP.003.236	ICN-ADJ	Adjustment ICN	Conditional	A unique claim number assigned by the state's payment system that identifies the adjustment claim for an original transaction.	N/A	CIP00003	CLAIM-LINE-RECORD-IP	X(50)	6	92	141	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value ~~is~~ equals "0~~,~~", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated

CIP237	CIP.003.237	LINE-NUM-ORIG	Original Line Number	Mandatory	A unique number to identify the transaction line number that is being reported on the original claim.	N/A	CIP00003	CLAIM-LINE-RECORD-IP	X(3)	7	142	144	1. Value must be 3 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory 4. ~~When populated,~~ Value must be one or greater
CIP238	CIP.003.238	LINE-NUM-ADJ	Adjustment Line Number	Conditional	A unique number to identify the transaction line number that identifies the line number on the adjustment claim.	N/A	CIP00003	CLAIM-LINE-RECORD-IP	X(3)	8	145	147	1. Value must be 3 characters or less 2. If associated Line Adjustment Indicator value ~~is~~ equals "0~~,~~", then value must not be populated 3. If associated Line Adjustment Indicator value ~~is~~ equals "1~~,~~", then value is mandatory and must be provided 4. Conditional 5. When populated, value must be one or greater
CIP239	CIP.003.239	LINE-ADJUSTMENT-IND	Line Adjustment Indicator	Conditional	A code to indicate the type of adjustment record claim/encounter represents at claim detail level.	LINE-ADJUSTMENT-IND	CIP00003	CLAIM-LINE-RECORD-IP	X(1)	9	148	148	~~1.~~1. Value must be 1 character 2. Value must be in Line Adjustment Indicator List (VVL) ~~2. If associated Type of Claim value is in [1, 3, 5, A, C, E, U, W, Y], then value must be in [0, 1, 4]~~ ~~3. If associated Type of Claim value is in [4, D, X], then.~~ Value must be in [~~5, 6~~] ~~4. Value must be 1 character~~ ~~5.~~0,1,4] 4. Conditional ~~6~~5. If associated Line Adjustment Number is populated, then value must be populated
CIP240	CIP.003.240	LINE-ADJUSTMENT-REASON-CODE	Line Adjustment Reason Code	Conditional	Claim adjustment reason codes communicate why a service line was paid differently than it was billed.	LINE-ADJUSTMENT-REASON-CODE	CIP00003	CLAIM-LINE-RECORD-IP	X(3)	10	149	151	~~1.~~1. Value must be 3 characters or less 2. Value must be in Line Adjustment Reason Code List (VVL) ~~2. Value must be 3 characters or less~~ ~~3.~~3. Conditional 4. ~~When populated, Line Adjustment Indicator~~Value must be populated when the

													total paid amount is different from the total billed amount
CIP241	CIP.003.241	SUBMITTER-ID	Submitter ID	Mandatory	The Submitter Identification number is the value that identifies the provider/trading partner/clearing house organization to the state's claim adjudication system.	N/A	CIP00003	CLAIM-LINE-RECORD-IP	X(12)	11	152	163	1. Value must be 12 characters or less 2. Mandatory
CIP242	CIP.003.242	CLAIM-LINE-STATUS	Claim Line Status	Conditional	The claim line status ~~conveys~~codes from the 277 transaction set identify the status of a specific ~~service~~detail claim line ~~using~~rather than the ~~X12 Claim Status Codes from~~entire claim. Only report the claim ~~adjudication process~~line for the final, adjudicated claim.	CLAIM-STATUS	CIP00003	CLAIM-LINE-RECORD-IP	X(3)	12	164	166	~~1.~~1. Value must be 3 characters or less 2. Value must be in Claim Status List (VVL) ~~2. Value must be 3 characters or less~~ ~~3.~~3. Conditional 4. If value in [545,585,654], then Claim Denied Indicator must be "0" and Claim Status Category must be"F2"
CIP243	CIP.003.243	BEGINNING-DATE-OF-SERVICE	Beginning Date of Service	Mandatory	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, this would be 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. For financial transactions reported to the OT file, populate with the first day of the time period covered by this financial transaction.~~	N/A	CIP00003	CLAIM-LINE-RECORD-IP	9(8)	13	167	174	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3. When Type of Claim is not in ['2', '4', 'B', 'D', 'V'] in the form "CCYYMMDD"~~ 2. Value must be less than or equal to associated End of Time Period value ~~4~~3. Value must be less than or equal to associated Ending Date of Service value ~~5. When Type of Claim is not in ['2', '4', 'B', 'D', 'V']~~4. Value must be less than or equal to associated Adjudication Date value ~~6~~5. Value must be less than or equal to associated Date of Death (ELG.002.025) value when populated ~~7~~6. Value must be less than or equal to at

													least one of the eligible's Enrollment End Date (ELG.021.254) values ~~8~~7. Mandatory
CIP244	CIP.003.244	ENDING-DATE-OF-SERVICE	Ending Date of Service	Mandatory	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. For financial transactions reported to the OT file, populate with the first day of the time period covered by this financial transaction.~~	N/A	CIP00003	CLAIM-LINE-RECORD-IP	9(8)	14	175	182	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3. When Type of Claim is not in ['2', '4', 'B', 'D', 'V'] in the form "CCYYMMDD"~~ 2. Value must be less than or equal to associated End of Time Period value ~~4~~3. Value must be greater than or equal to associated Beginning Date of Service value ~~5. When Type of Claim is not in ['2', '4', 'B', 'D', 'V']~~4. Value must be less than or equal to associated Adjudication Date value ~~6~~5. Value must be less than or equal to associated Date of Death (ELG.002.025) value when populated ~~7~~6. Value must be equal to or greater than associated Date of Birth (ELG.002.024) value ~~8~~7. Mandatory

CIP245	CIP.003.245	REVENUE-CODE	Revenue Code	Mandatory	A code which identifies a specific accommodation, ancillary service or billing calculation (as defined by UB-04 Billing Manual). Revenue Code should be passed through to T-MSIS exactly as it was billed by the provider on the provider's 837I or UB-04 claim. It is only required on Inpatient, Long-Term Care and Other Fee for Service claims and managed care encounters that have a valid Type of Bill value. It's not required on financial transactions or non-institutional claims.	REVENUE-CODE	CIP00003	CLAIM-LINE-RECORD-IP	X(4)	15	183	186	~~1.~~1. Value must be 4 characters or less 2. Value must be in Revenue Code List (VVL) ~~2~~3. A Revenue Code value requires an associated Revenue Charge ~~3. Value must be 4 characters or less~~ ~~4.~~4. Mandatory
~~CIP248~~	~~CIP.003.248~~	~~IMMUNIZATION-TYPE~~	~~Immunization Type~~	~~Conditional~~	~~This field identifies the type of immunization provided in order to track additional detail not currently contained in Current Procedural Terminology codes.~~	~~IMMUNIZATION-TYPE~~	~~CIP00003~~	~~CLAIM-LINE-RECORD-IP~~	~~X(2)~~	~~16~~	~~187~~	~~188~~	~~1. Value must be in Immunization Type List (VVL)~~ ~~2. Value must be 2 characters~~ ~~3. Conditional~~
CIP249	CIP.003.249	~~IP LT~~REVENUE-CENTER-QUANTITY-~~OF-SERVICE~~ ACTUAL	~~IP LT~~Revenue Center Quantity ~~of Service~~ Actual	Mandatory	On facility ~~claim entries~~claims/encounters, this field is to capture the actual service quantity by revenue code category, e.g., number of days in a particular type of accommodation, pints of blood, etc. However, when HCPCS codes are required for services, the units are equal to the number of times the procedure/service being reported was performed. For CLAIMOT claims/encounters use Service Quantity Actual and CLAIMRX claims/encounters use the Prescription Quantity Actual field	N/A	CIP00003	CLAIM-LINE-RECORD-IP	S9(6)V999	~~17~~16	18~~97~~	19~~75~~	1. Value must be numeric 2. Value may include up to 6 digits to the left of the decimal point, and 3 digits to the right e.g. 123456.789 3. Mandatory

CIP250	CIP.003.250	~~IP LT~~REVENUE-CENTER-QUANTITY-~~OF SERVICE~~ ALLOWED	~~IP LT~~Revenue Center Quantity ~~of Service~~ Allowed	Conditional	On facility ~~claim entries~~claims/encounters, this field is to capture maximum allowable quantity by revenue code category, e.g., number of days in a particular type of accommodation, pints of blood, etc. However, when HCPCS codes are required for services, the units are equal to the number of times the procedure/service being reported was ~~performed~~allowed. 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 CLAIMOT claims/encounters use Service Quantity Allowed and CLAIMRX claims/encounters use the Prescription Quantity Allowed field.	N/A	CIP00003	CLAIM-LINE-RECORD-IP	S9(6)V999	~~18~~17	19~~8~~6	20~~6~~4	1. Value must be numeric 2. Value may include up to 6 digits to the left of the decimal point, and 3 digits to the right, e.g. 123456.789 3. Conditional
CIP251	CIP.003.251	REVENUE-CHARGE	Revenue Charge	Conditional	The total amount billed for the related Revenue Code. Total amount billed includes both covered and non-covered charges (as defined by UB-04 Billing Manual). For encounter records, Type of Claim = 3, C, or W, this field should be populated with the amount that the provider billed to the managed care plan. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the amount that the provider billed the sub-capitated entity at the claim line detail level. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.	N/A	CIP00003	CLAIM-LINE-RECORD-IP	S9(11)V99	~~19~~18	20~~7~~5	21~~9~~7	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Value must be less than or equal to associated Total Billed Amount value. 4. When populated, associated claim line Revenue Charge must be populated 5. Conditional

CIP252	CIP.003.252	ALLOWED-AMT	Allowed Amount	Conditional	The maximum amount displayed at the claim line level as determined by the payer as being "'allowable"' under the provisions of the contract prior to the determination of actual payment. On Fee for Service claims the Allowed Amount is determined by the state's MMIS (or PBM). On managed care encounters the Allowed Amount is determined by the managed care organization. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the amount that the sub-capitated entity allowed at the claim line detail level. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.	N/A	CIP00003	CLAIM-LINE-RECORD-IP	S9(11) V99	~~20~~19	~~220~~218	23~~2~~0	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
~~CIP253~~	~~CIP.003.253~~	~~TPL-AMT~~	~~Third Party Liability Amount~~	~~Conditional~~	~~Third-party liability refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a state plan. This is the total amount denoted at the claim detail level paid by the third party.~~	~~N/A~~	~~CIP00003~~	~~CLAIM-LINE-RECORD-IP~~	~~S9(11) V99~~	~~21~~	~~233~~	~~245~~	~~1. Value must be between -99999999999.99 and 99999999999.99~~ ~~2. Value must be expressed as a number with 2-digit precision (e.g. 100.50)~~ ~~3. Conditional~~

CIP254	CIP.003.254	MEDICAID-PAID-AMT	Medicaid Paid Amount	Conditional	The amount paid by Medicaid/CHIP agency or the managed care plan on this claim or adjustment at the claim detail level. ~~For claims where Medicaid payment is only available at the header level, report the entire payment amount on the T-MSIS record corresponding to the line item with the highest charge or the 1st detail. Zero fill Medicaid Amount Paid on all other MSIS records created from the original claim.~~For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the amount that the sub-capitated entity paid the provider at the claim line detail level. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.	N/A	CIP00003	CLAIM-LINE-RECORD-IP	S9(11) V99	~~22~~20	~~246~~231	~~258~~243	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50~~)~~ ~~3. Conditional~~) 3. Conditional 4. Value should not be populated or should be equal to zero, when associated Claim Line Status is in [542,585,654]
CIP255	CIP.003.255	MEDICAID-FFS-EQUIVALENT-AMT	Medicaid FFS Equivalent Amount	Conditional	The amount that would have been paid had the services been provided on a Fee for Service basis.	N/A	CIP00003	CLAIM-LINE-RECORD-IP	S9(11) V99	~~23~~21	~~259~~244	~~271~~256	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Type of Claim value ~~equals '3,~~ in [3,C,W~~']~~, then value is mandatory and must be provided 4. Conditional
CIP256	CIP.003.256	BILLING-UNIT	Billing Unit	Conditional	Unit of billing that is used for billing services by the facility.	BILLING-UNIT	CIP00003	CLAIM-LINE-RECORD-IP	X(2)	~~24~~22	25~~72~~	~~273~~258	~~1.~~1. Value must be 2 characters 2. Value must be in Billing Unit List (VVL~~).~~ ~~2. Value must be 2 characters~~ ~~)~~ 3. Conditional

CIP257	CIP.003.257	TYPE-OF-SERVICE	Type of Service	Mandatory	A code to categorize the services provided to a Medicaid or CHIP enrollee.	TYPE-OF-SERVICE-IP	CIP00003	CLAIM-LINE-RECORD-IP	X(3)	~~25~~23	~~274~~259	2~~7~~61	1. Value must be 3 characters 2. Mandatory 3. Value must ~~not equal '086'~~be in Type of Service IP List (VVL) 4. If Sex (ELG.002.023) equals ~~'M'~~ ~~4. Value must satisfy the requirements of Type of Service (Inpatient Claim) List (VVL)~~"M", then value must not equal "086"
CIP260	CIP.003.260	SERVICING-PROV-NUM	Servicing Provider Number	Conditional	A unique number to identify the provider who treated the recipient. The Servicing Provider Number should be for the individual doctor who rendered the service. If "Servicing" provider and the "Billing" provider such as a sole-practitioner are the same then use the same number in both fields. The value is conditional as its usage varies by state.	N/A	CIP00003	CLAIM-LINE-RECORD-IP	X(30)	~~26~~24	~~277~~262	~~306~~291	1. Value must be 30 characters or less 2. ~~Value must be reported in Provider Identifier (PRV.005.080) with an associated Provider Identifier Type (PRV.005.081) equal to '1'~~ ~~3.~~ Conditional ~~4~~3. When Type of Claim not in ~~('Z','3','C','W',"2","B","V"," 4","D","X")~~[3,C,W], then value may match (PRV.005.081) Provider Identifier or 4. When Type of Claim not in ~~('Z','3','C','W',"2","B","V"," 4","D","X")~~ [3,C,W], then value may match (PRV.002.019) Submitting State Provider ID
CIP261	CIP.003.261	SERVICING-PROV-NPI-NUM	Servicing Provider NPI Number	Conditional	The NPI of the health care professional who delivers or completes a particular medical service or non-surgical procedure. The Servicing Provider NPI Number is required when rendering provider is different than the attending provider and state or federal regulatory requirements call for a "combined claim" (i.e., a claim that includes both facility and professional components). Examples are Medicaid clinic bills or critical access hospital claims.	N/A	CIP00003	CLAIM-LINE-RECORD-IP	X(10)	~~27~~25	~~307~~292	30~~1~~6	1. Value must be 10 digits~~, consisting of 9 numeric digits followed by one check digit calculated using the Luhn formula (algorithm) 2.~~ 2. Value must have an associated Provider Identifier Type equal to ~~'2'~~"2" 3. Value must exist in the NPPES NPI data file 4. Conditional
~~CIP262~~	~~CIP.003.262~~	~~SERVICING-PROV-TAXONOMY~~	~~Servicing Provider Taxonomy~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for~~	~~N/A~~	~~CIP00003~~	~~CLAIM-LINE-RECORD-IP~~	~~X(12)~~	~~28~~	~~317~~	~~328~~	~~1. Not Applicable~~

					~~specific definition and coding requirement description(s).]~~								
CIP263	CIP.003.263	SERVICING-PROV-TYPE	Servicing Provider Type	Conditional	A code to describe the type of ~~entity billing for the service~~provider being reported.	PROV-TYPE	CIP00003	CLAIM-LINE-RECORD-IP	X(2)	~~29~~26	30~~2~~9	3~~3~~03	~~1.~~1. Value must be 2 characters 2. Value must be in Provider Type Code List (VVL~~).~~ ~~2. Value must be 2 characters~~) 3. Conditional
CIP264	CIP.003.264	SERVICING-PROV-SPECIALTY	Servicing Provider Specialty	Conditional	This code describes the area of specialty for the provider being reported.	PROV-SPECIALTY	CIP00003	CLAIM-LINE-RECORD-IP	X(2)	~~30~~27	~~331~~304	~~332~~305	~~1.~~1. Value must be 2 characters 2. Value must be in Provider Specialty List (VVL~~).~~ ~~2. Value must be 2 characters~~) 3. Conditional
CIP265	CIP.003.265	OPERATING-PROV-NPI-NUM	Operating Provider NPI Number	Conditional	~~A National Provider Identifier (NPI) is a unique 10-digit identification number issued to health care providers in the United States by CMS. Healthcare providers acquire their unique 10-digit NPIs to identify themselves in a standard way throughout their industry. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number).~~The National Provider ID (NPI) of the provider who performed the surgical procedures on the beneficiary.	N/A	CIP00003	CLAIM-LINE-RECORD-IP	X(10)	~~31~~28	~~333~~306	~~342~~315	1. Value must be 10 digits~~, consisting of 9 numeric digits followed by one check digit calculated using the Luhn formula (algorithm) 2.~~ 2. Value must have an associated Provider Identifier Type equal to ~~'2'~~"2" 3. Conditional 4. Value must exist in the NPPES NPI data file
CIP266	CIP.003.266	OTHER-TPL-COLLECTION	Other TPL Collection	~~Conditional~~ Mandatory	This data element indicates that the claim is for a beneficiary for whom other third party resource development and collection activities are in progress, when the liability is not another health insurance plan for which the eligible is a beneficiary.	OTHER-TPL-COLLECTION	CIP00003	CLAIM-LINE-RECORD-IP	X(3)	~~32~~29	~~343~~316	~~345~~318	~~1.~~1. Value must be 3 characters 2. Value must be in Other TPL Collection List (VVL) ~~2. Value must be 3 characters~~ ~~3. Conditional~~3. Mandatory
CIP267	CIP.003.267	PROV-FACILITY-TYPE	Provider Facility Type	Mandatory	The type of facility in which services on the claim were rendered. The Provider Facility Type code set is based on corresponding groups of HIPAA provider taxonomy codes.	PROV-FACILITY-TYPE	CIP00003	CLAIM-LINE-RECORD-IP	X(9)	~~33~~30	~~346~~319	~~354~~327	~~1.~~1. Value must be 9 characters or less 2. Value must be in Provider Facility Type List (VVL)

													2. Value must be 9 characters or less 3.3. Mandatory
CIP268	CIP.003.268	BENEFIT-TYPE	Benefit Type	Mandatory	The benefit category corresponding to the service reported on the claim or encounter record. Note: The code definitions in the valid value list originate from the Medicaid and CHIP Program Data System (MACPro) benefit type list. See Appendix H: Benefit Types	BENEFIT-TYPE	CIP00003	CLAIM-LINE-RECORD-IP	X(3)	34	355	357	1. Value must be in Benefit Type Code List (VVL) 2. Value must be 3 characters 3. Mandatory
CIP269	CIP.003.269	CMS-64-CATEGORY-FOR-FEDERAL-REIMBURSEMENT	CMS-64 Category for Federal Reimbursement	Conditional	A code to indicate the Federal funding source for the payment.	CMS-64-CATEGORY-FOR-FEDERAL-REIMBURSEMENT	CIP00003	CLAIM-LINE-RECORD-IP	X(2)	3531	3528	3529	1. Value must be 2 characters 2. Value must be in CMS-64 Category for Federal Reimbursement List (VVL) 2. Value must be 2 characters 3.3. (Federal Funding under Title XXI) if value equals '02', then the eligible's CHIP Code (ELG.003.054) must be in ['2', '3'2,3] 4. (Federal Funding under Title XIX) if value equals '01' then the eligible's CHIP Code (ELG.003.054) must be '1'"1" 5. Conditional 6. If Type of Claim is in ['1','2','5','A','B','E','U','V','Y'1,A,U] and the Total Medicaid Paid Amount is populated on the corresponding claim header, then value must be reported. 7. If Type of Claim is in ['4','D'] and the Service Tracking Payment Amount on the relevant record is populated, then value must be reported.
CIP270	CIP.003.270	XIX-MBESCBES-CATEGORY-OF-SERVICE	XIX MBESCBES Category of Service	Conditional	A code indicating the category of service for the paid claim. The category of service is the line item from the CMS-64 form that states use to report their expenditures and request federal financial participation.	XIX-MBESCBES-CATEGORY-OF-SERVICE	CIP00003	CLAIM-LINE-RECORD-IP	X(4)	36	360	363	1. Value must be in XIX MBESCBES Category of Service List (VVL) 2. Value must be 4 characters or less 3. Conditional 4. (Medicaid Claim) if the associated CMS-64 Category for Federal Reimbursement value is '1', then a valid value is mandatory and must be reported 5. If value is in ['14', '35', '42' or '44'], then Sex

													~~(ELG.002.023) must not equals 'M'~~ ~~6. If XXI MBESCBES Category of Service is populated then must not be populated~~
~~CIP271~~	~~CIP.003.271~~	~~XXI-MBESCBES-CATEGORY-OF-SERVICE~~	~~XXI MBESCBES Category of Service~~	~~Conditional~~	~~A code to indicate the category of service for the paid claim. The category of service is the line item from the CMS-21 form that states use to report their expenditures and request federal financial participation.~~	~~XXI-MBESCBES-CATEGORY-OF-SERVICE~~	~~CIP00003~~	~~CLAIM-LINE-RECORD-IP~~	~~X(3)~~	~~37~~	~~364~~	~~366~~	~~1. Value must be in XXI MBESCBES Category of Service List (VVL)~~ ~~2. Conditional~~ ~~3. (CHIP Claim) if the associated CMS-64 Category for Federal Reimbursement value is '2', then a valid value is mandatory and must be reported~~ ~~4. If XIX MBESCBES Category of Service is populated then value must not be populated~~ ~~5. Value must be 3 characters or less~~
CIP272	CIP.003.272	OTHER-INSURANCE-AMT	Other Insurance Amount	Conditional	The amount paid by insurance other than Medicare or Medicaid on this claim.	N/A	CIP00003	CLAIM-LINE-RECORD-IP	S9(11)V99	~~38~~32	~~367~~330	~~379~~342	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CIP273	CIP.003.273	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	CIP00003	CLAIM-LINE-RECORD-IP	X(500)	~~39~~49	~~380~~616	~~879~~1115	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
CIP275	CIP.001.275	SEQUENCE-NUMBER	Sequence Number	Mandatory	To enable states to sequentially number files, when related, follow-on files are necessary (i.e. update files, replace files). This should begin with 1 for the original Create submission type and be incremented by one for each Replacement or Update submission for the same reporting period and file type (subject area).	N/A	CIP00001	FILE-HEADER-RECORD-IP	X(4)	14	79	82	~~1.~~1. Value must be 4 characters or less 2. Value must between 1 and 9999 ~~2~~3. Value must be equal to the largest of any prior values for the same reporting period and file type, plus 1 (i.e. incremented by 1) ~~3~~4. Value must not contain a pipe symbol ~~4. Value must be 4 characters or less~~ 5. Mandatory
CIP278	CIP.003.278	NDC-QUANTITY	NDC Quantity	Conditional	This field is to capture the actual quantity of the National Drug Code being prescribed on the claim/encounter.	N/A	CIP00003	CLAIM-LINE-RECORD-IP	S9(~~6~~)V9~~99~~9)V(9)	~~43~~33	~~908~~343	~~916~~360	1. Value may include up to ~~6~~9 digits to the left of the decimal point, and ~~3~~9 digits to the right e.g. ~~123456.789~~123456789.123456789 2. Conditional

~~CIP279~~	~~CIP.003.279~~	~~HCPCS-RATE~~	~~HCPCS Rate~~	~~Conditional~~	~~This data element is expected to capture data from the HIPAA 837I claim loop 2400 SV206 or UB-04 FL 44. (NOTE: This element varies slightly by claim file time, and claim-file-specific requirements will be specified at in the file specification for each claim type.)~~	~~HCPCS-RATE~~	~~CIP00003~~	~~CLAIM-LINE-RECORD-IP~~	~~X(14)~~	~~40~~	~~880~~	~~893~~	~~1. Value must be in HCPCS Rate List (VVL).~~ ~~2. Value must be 14 characters or less~~ ~~3. Value must not contain a pipe or asterisk symbols~~ ~~4. Conditional~~
CIP284	CIP.003.284	NATIONAL-DRUG-CODE	National Drug Code	Conditional	A code following the National Drug Code format indicating the drug, device, or medical supply covered by this claim.	N/A	CIP00003	CLAIM-LINE-RECORD-IP	X(12)	~~41~~34	~~894~~361	~~905~~372	~~1. Characters 1-5 of value must be numeric~~ ~~2. Characters 6-9 of value must be numeric~~ ~~3. Characters 10-12 of value must be numeric or blank~~ ~~4.~~1. Value must be 12 digits or less ~~5~~2. Value must be a valid National Drug Code ~~6~~3. Conditional
CIP285	CIP.003.285	NDC-UNIT-OF-MEASURE	NDC Unit of Measure	Conditional	A code to indicate the basis by which the quantity of the National Drug Code is expressed.	NDC-UNIT-OF-MEASURE	CIP00003	CLAIM-LINE-RECORD-IP	X(2)	~~42~~35	~~906~~373	~~907~~374	~~1.~~1. Value must be 2 characters 2. Value must be in NDC Unit of Measure List (VVL~~).~~ ~~2. Value must be 2 characters~~ ~~)~~ 3. Conditional
CIP286	CIP.003.286	ADJUDICATION-DATE	Adjudication Date	Mandatory	The date on which the payment status of the claim was finally adjudicated by the state. For Encounter Records (Type of Claim = 3, C, W), use date the encounter was processed by the state.	N/A	CIP00003	CLAIM-LINE-RECORD-IP	9(8)	~~44~~36	~~917~~375	~~924~~382	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value should be on or before End of Time Period ~~value found in associated T-MSIS File Header Record~~ ~~4.~~ (CRX.001.010) 3. Mandatory ~~5~~4. Value should be on or after associated Admission Date value
CIP287	CIP.003.287	SELF-DIRECTION-TYPE	Self Direction Type	~~Conditional~~ Mandatory	This data element is not applicable to this file type.	SELF-DIRECTION-TYPE	CIP00003	CLAIM-LINE-RECORD-IP	X(3)	~~45~~37	~~925~~383	~~927~~385	~~1.~~1. Value must be 3 characters 2. Value must be in Self Direction Type List (VVL)

													~~2. Value must be 3 characters~~ ~~3. Conditional~~3. Mandatory
CIP288	CIP.003.288	PRE-AUTHORIZATION-NUM	Preauthorization Number	Conditional	A number, code or other value that indicates the services provided on this claim have been authorized by the payee or other service organization, or that a referral for services has been approved. (Also referred to as a Prior Authorization or Referral Number).	N/A	CIP00003	CLAIM-LINE-RECORD-IP	X(18)	~~46~~38	~~928~~386	~~945~~403	1. Value must be 18 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional
CIP289	CIP.002.289	PROV-LOCATION-ID	Provider Location ID	Mandatory	A code to uniquely identify the geographic location where the provider's services were performed. The Provider Location Identifier values reported on Inpatient, Long-Term Care, Other, and Pharmacy Claim Header Segments must correspond to an active Provider Location Identifier value on a Provider Location ~~&~~and Contact Info (~~PRV00003~~PRV.003) segment. If a particular license (e.g., a physician's medical license) or provider identifier (e.g., an individual provider's NPI or SSN) is applicable to all of their servicing locations, value "000" (a string of exactly three zeros) can be used in the ~~PRV00004~~PRV.004 or ~~PRV00005~~PRV.005, respectively, to represent all locations, however that location identifier must not be attributed to claims or provider bed type info.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(5)	~~211~~153	~~2017~~1284	~~2021~~1288	~~1.~~1. Value must be 5 characters or less 2. Value must not contain a pipe or asterisk symbols ~~2. Value must be 5 characters or less~~ ~~3.~~3. Mandatory

CIP290	CIP.002.290	BEGINNING-DATE-OF-SERVICE	Beginning Date of Service	Mandatory	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, this would be the date on which the service covered by this claim began.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	154	1289	1296	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be less than or equal to associated End of Time Period value 3. Value must be less than or equal to associated Ending Date of Service value 4. Value must be less than or equal to associated Adjudication Date value 5. Value must be less than or equal to associated Date of Death (ELG.002.025) value when populated 6. Value must be less than or equal to at least one of the eligible's Enrollment End Date (ELG.021.254) values 7. Mandatory
CIP291	CIP.002.291	ENDING-DATE-OF-SERVICE	Ending Date of Service	Mandatory	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.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	9(8)	155	1297	1304	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be less than or equal to associated End of Time Period value 3. Value must be greater than or equal to associated Beginning Date of Service value 4. Value must be less than or equal to associated Adjudication Date value 5. Value must be less than or equal to associated Date of Death (ELG.002.025) value when populated 6. Value must be equal to or greater than associated Date of Birth (ELG.002.024) value 7. Mandatory
CIP292	CIP.002.292	TOT-BENEFICIARY-COPAYMENT-LIABLE-AMOUNT	Total Beneficiary Copayment Liable Amount	Conditional	The total copayment amount on a claim that the beneficiary is obligated to pay for covered services. This is the total Medicaid or contract negotiated beneficiary copayment liability for	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11)V99	156	1305	1317	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional

					covered service on the claim. Do not subtract out any payments made toward the copayment.								
CIP293	CIP.002.293	TOT-BENEFICIARY-COINSURANCE-LIABLE-AMOUNT	Total Beneficiary Coinsurance Liable Amount	Conditional	The total coinsurance amount on a claim the beneficiary is obligated to pay for covered services. This amount is the total Medicaid or contract negotiated beneficiary coinsurance liability for covered services on the claim. Do not subtract out any payments made toward the coinsurance.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11) V99	157	1318	1330	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CIP294	CIP.002.294	TOT-BENEFICIARY-DEDUCTIBLE-LIABLE-AMOUNT	Total Beneficiary Deductible Liable Amount	Conditional	The total deductible amount on a claim the beneficiary is obligated to pay for covered services. This amount is the total Medicaid or contract negotiated beneficiary deductible liability minus previous beneficiary payments that went toward their deductible. Do not subtract out any payments for the given claim that went toward the deductible.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11) V99	158	1331	1343	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CIP295	CIP.002.295	COMBINED-BENE-COST-SHARING-PAID-AMOUNT	Combined Beneficiary Cost Sharing Paid Amount	Conditional	The combined amounts the beneficiary or his or her representative (e.g., their guardian) paid towards their copayment, coinsurance, and/or deductible for the covered services on the claim. Only report this data element when the claim does not differentiate among copayment, coinsurance, and/or deductible payments made by the beneficiary. Do not include beneficiary cost sharing payments made by a third party/ies on behalf of the beneficiary.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11) V99	159	1344	1356	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional

CIP296	CIP.003.296	IHS-SERVICE-IND	IHS Service Indicator	Mandatory	To indicate Services received by Medicaid-eligible individuals who are American Indian or Alaska Native (AI/AN) through facilities of the Indian Health Service (IHS), whether operated by IHS or by Tribes.	IHS-SERVICE-IND	CIP00003	CLAIM-LINE-RECORD-IP	X(1)	39	404	404	1. Value must be 1 character 2. Value must be in the IHS Service Indicator List (VVL) 3. Mandatory
CIP297	CIP.002.297	LTC-RCP-LIAB-AMT	LTC RCP Liability Amount	Conditional	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.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11)V99	160	1357	1369	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CIP298	CIP.002.298	BILLING-PROV-ADDR-LN-1	Billing Provider Address Line 1	Mandatory	Billing provider address line 1 from X12 837I loop 2010AA.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(60)	161	1370	1429	1. Value must not be more than 60 characters long 2. Mandatory 3. Value must not contain a pipe or asterisk symbols
CIP299	CIP.002.299	BILLING-PROV-ADDR-LN-2	Billing Provider Address Line 2	Conditional	Billing provider address line 2 from X12 837I loop 2010AA.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(60)	162	1430	1489	1. Value must not be more than 60 characters long 2. Conditional 3. Value must not be equal to associated Address Line 1 4. Value must not contain a pipe or asterisk symbols 5. There must be an Address Line 1 in order to have an Address Line 2
CIP300	CIP.002.300	BILLING-PROV-CITY	Billing Provider City	Mandatory	Billing provider address city name from X12 837I loop 2010AA.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(28)	163	1490	1517	1. Value must not be more than 28 characters long 2. Mandatory
CIP301	CIP.002.301	BILLING-PROV-STATE	Billing Provider State Code	Mandatory	Billing provider address state code from X12 837I loop 2010AA.	STATE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	164	1518	1519	1. Value must not be more than 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory

CIP302	CIP.002.302	BILLING-PROV-ZIP-CODE	Billing Provider ZIP Code	Mandatory	Billing provider address ZIP code from X12 837I loop 2010AA.	ZIP-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(9)	165	1520	1528	1. Value may only be 5 digits (0-9) (Example: 91320) or 9 digits (0-9) (Example: 913200011) 2. Value must be in ZIP Code List (VVL) 3. Mandatory
CIP303	CIP.002.303	SERVICE-FACILITY-LOCATION-ORG-NPI	Service Facility Location Organization NPI	Conditional	Service facility location organization NPI from X12 837I loop 2310E.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(10)	166	1529	1538	1.Value must be 10 digits 2. Value must have an associated Provider Identifier Type equal to "2" 3. Value must exist in the NPPES NPI data file 4. Conditional 5. When populated, value must match Provider Identifier (PRV.005.081) and Facility Group Individual Code (PRV.002.028) must equal "01" 6. NPPES Entity Type Code associated with this NPI must equal "2" (Organization)
CIP304	CIP.002.304	SERVICE-FACILITY-LOCATION-ADDR-LN-1	Service Facility Location Address Line 1	Conditional	Service facility location address line 1 from X12 837I loop 2310E.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(60)	167	1539	1598	1. Value must not be more than 60 characters long 2. Conditional 3. Value must not contain a pipe or asterisk symbols
CIP305	CIP.002.305	SERVICE-FACILITY-LOCATION-ADDR-LN-2	Service Facility Location Address Line 2	Conditional	Service facility location address line 2 from X12 837I loop 2310E.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(60)	168	1599	1658	1. Value must not be more than 60 characters long 2. Conditional 3. Value must not be equal to associated Address Line 1 4. There must be an Address Line 1 in order to have an Address Line 2 5. Value must not contain a pipe or asterisk symbols
CIP306	CIP.002.306	SERVICE-FACILITY-LOCATION-CITY	Service Facility Location City	Conditional	Service facility location address city name from X12 837I loop 2310E.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(28)	169	1659	1686	1. Value must not be more than 28 characters long 2. Conditional

CIP307	CIP.002.307	SERVICE-FACILITY-LOCATION-STATE	Service Facility Location State	Conditional	Service facility location address state code from X12 837I loop 2310E.	STATE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	170	1687	1688	1. Value must not be more than 2 characters 2. Value must be in State Code List (VVL) 3. Conditional
CIP308	CIP.002.308	SERVICE-FACILITY-LOCATION-ZIP-CODE	Service Facility Location ZIP Code	Conditional	Service facility location address ZIP code from X12 837I loop 2310E.	ZIP-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(9)	171	1689	1697	1. Value may only be 5 digits (0-9) (Example: 91320) or 9 digits (0-9) (Example: 913200011) 2. Value must be in ZIP Code List (VVL) 3. Conditional
CIP309	CIP.002.309	PROVIDER-CLAIM-FORM-CODE	Provider Claim Form Code	Mandatory	A code indicating the format in which the provider submitted their claim. Very few if any claims should be classified as "Other".	PROVIDER-CLAIM-FORM-CODE	CIP00002	CLAIM-HEADER-RECORD-IP	X(2)	172	1698	1699	1. Value must not be more than 2 characters 2. Value must be in Provider Claim Form Code List (VVL) 3. Mandatory
CIP310	CIP.002.310	PROVIDER-CLAIM-FORM-OTHER-TEXT	Provider Claim Form Other Text	Conditional	A free-form text field where a state can identify the "other" claim form used by the provider to submit their claim. Required when "Other" is reported to Provider Claim Form Code.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	X(50)	173	1700	1749	1. Value must not be more than 50 characters long 2. Conditional 3. Value must be provided when corresponding Provider Claim Form Code is "Other"
CIP311	CIP.002.311	TOT-GME-AMOUNT-PAID	Total GME Amount Paid	Conditional	The amount included in the Total Medicaid Amount (CIP.002.114) that is attributable to a Graduate Medical Education (GME) payment, when the state makes GME payments by claim.	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11)V99	174	1750	1762	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CIP314	CIP.003.314	UNIQUE-DEVICE-IDENTIFIER	Unique Device Identifier	Conditional	An unique identifier assigned to every medical device that meets the requirements of 21 CFR 801 and 830.	N/A	CIP00003	CLAIM-LINE-RECORD-IP	X(76)	40	405	480	1. Value must not be more than 76 characters long 2. Conditional

CIP315	CIP.003.315	MBESCBES-CATEGORY-OF-SERVICE	MBESCBES Category of Service	Conditional	A code indicating the category of service for the paid claim. The category of service is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.) that states use to report their expenditures and request federal financial participation.	21.P-FORM, 21BASE-FORM, 64.21U-FORM, 64.10BASE-FORM, 64.9P-FORM, 64.9A-FORM, 64.9BASE-FORM, 64.21UP-FORM	CIP00003	CLAIM-LINE-RECORD-IP	X(5)	43	532	536	1. Value must be 5 characters or less 2. When MBESCBES Form equals "21.P", value must be in 21.P Form List (VVL) 3. When MBESCBES Form equals "21BASE", value must be in 21BASE Form List (VVL) 4. When MBESCBES Form equals "64.21U", value must be in 64.21U Form List (VVL) 5. When MBESCBES Form equals "64.10BASE", value must be in 64.10BASE Form List (VVL) 6. When MBESCBES Form equals "64.9P", value must be in 64.9P Form List (VVL) 7. When MBESCBES Form equals "64.9A", value must be in 64.9A Form List (VVL) 8. When MBESCBES Form equals "64.9BASE", value must be in 64.9BASE Form List (VVL) 9. When MBESCBES Form equals "64.21UP", value must be in 64.21UP Form List (VVL) 10. Conditional 11. If Type of Claim in [1,A,U], then value must be populated on all claim lines with a Medicaid Paid Amount greater than $0 12. When populated, an associated MBESCBES Form Group and MBESCBES Form must be populated

CIP316	CIP.003.316	MBESCBES-FORM	MBESCBES Form	Conditional	The MBES or CBES form to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.). This should be determined by the state's MBES/CBES reporting process. The MBES or CBES form reported here will determine what the meaning of the corresponding MBES/CBES category of service value is.	MBESCBES-FORMGP-1, MBESCBES-FORMGP-2, MBESCBES-FORMGP-3	CIP00003	CLAIM-LINE-RECORD-IP	X(50)	42	482	531	1. Value must be 50 characters or less 2. When MBESCBES Form Group equals "1", value must be in MBESCBES Form Group 1 List (VVL) 3. When MBESCBES Form Group equals "2", value must be in MBESCBES Form Group 2 List (VVL) 4. When MBESCBES Form Group equals "3", value must be in MBESCBES Form Group 3 List (VVL) 5. Conditional 6. If Type of Claim in [1,A,U], then value must be populated on all claim lines with a Medicaid Paid Amount greater than $0
CIP317	CIP.003.317	GME-AMOUNT-PAID	GME Amount Paid	Conditional	The amount included in the Medicaid Amount (CIP.003.254) that is attributable to a Graduate Medical Education (GME) payment, when the state makes GME payments by claim.	N/A	CIP00003	CLAIM-LINE-RECORD-IP	S9(11)V99	44	537	549	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CIP318	CIP.003.318	REFERRING-PROV-NUM	Referring Provider Number	Conditional	A unique identification number assigned to a provider which identifies the physician or other provider who referred the patient. For physicians, this must be the individual's ID number, not a group identification number. If the referring provider number 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.	N/A	CIP00003	CLAIM-LINE-RECORD-IP	X(30)	45	550	579	1. Value must be 30 characters or less 2. Conditional
CIP319	CIP.003.319	REFERRING-PROV-NPI-NUM	Referring Provider NPI Number	Conditional	The National Provider ID (NPI) of the provider who recommended the servicing provider to the patient.	N/A	CIP00003	CLAIM-LINE-RECORD-IP	X(10)	46	580	589	1. Value must be 10 digits 2. Value must have an associated Provider Identifier Type equal to "2" 3. Value must exist in the NPPES NPI data file 4. Conditional

CIP322	CIP.004.322	RECORD-ID	Record ID	Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	CIP00004	CLAIM-DX-IP	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "CIP00004"
CIP323	CIP.004.323	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	CIP00004	CLAIM-DX-IP	X(2)	2	9	10	1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (CIP.001.007)
CIP324	CIP.004.324	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	CIP00004	CLAIM-DX-IP	9(11)	3	11	21	1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
CIP325	CIP.004.325	ICN-ORIG	Original ICN	Mandatory	A unique number assigned by the state's payment system that identifies an original or adjustment claim.	N/A	CIP00004	CLAIM-DX-IP	X(50)	4	22	71	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory

CIP326	CIP.004.326	ICN-ADJ	Adjustment ICN	Conditional	A unique claim number assigned by the state's payment system that identifies the adjustment claim for an original transaction.	N/A	CIP00004	CLAIM-DX-IP	X(50)	5	72	121	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
CIP327	CIP.004.327	ADJUSTMENT-IND	Adjustment Indicator	Mandatory	Indicates the type of adjustment record.	ADJUSTMENT-IND	CIP00004	CLAIM-DX-IP	X(1)	6	122	122	1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Value must be in [0,1,4] 4. Mandatory 5. If value equals "0", then associated Adjustment ICN must not be populated 6. Value must equal "1", when associated Claim Status equals "686" 7. Value must match the adjustment indicator in the header (CIP.002.026)
CIP328	CIP.004.328	ADJUDICATION-DATE	Adjudication Date	Mandatory	The date on which the payment status of the claim was finally adjudicated by the state. For Encounter Records (Type of Claim = 3, C, W), use date the encounter was processed by the state.	N/A	CIP00004	CLAIM-DX-IP	9(8)	7	123	130	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value should be on or before End of Time Period (CIP.001.010) 3. Mandatory 4. Value should be on or after associated Admission Date value

CIP329	CIP.004.329	DIAGNOSIS-TYPE	Diagnosis Type	Mandatory	Indicates the context of the diagnosis code from the provider's claim (i.e., an 837I claim can have one principal diagnosis code, one admitting diagnosis code, up to 12 external cause of injury diagnosis codes, and up to 24 other diagnosis codes; a UB-04 claim can have one principal diagnosis code, one admitting diagnosis code, and up to 17 other diagnosis codes). The type of diagnosis code (e.g., principal, admitting, external cause of injury, or other) is captured here. The order in which the diagnosis code was reported is captured in the Diagnosis Sequence Number.	DIAGNOSIS-TYPE	CIP00004	CLAIM-DX-IP	X(1)	8	131	131	1. Value must be 1 character 2. Value must be in Diagnosis Type Code List (VVL) 3. Value must be in [P,A,E,O] 4. Mandatory
CIP330	CIP.004.330	DIAGNOSIS-SEQUENCE-NUMBER	Diagnosis Sequence Number	Mandatory	The order in which the diagnosis occurred on the provider's claim for a given type of diagnosis code (e.g., an 837I claim can have up to 12 external cause of injury diagnosis codes and up to 24 other diagnosis codes).	N/A	CIP00004	CLAIM-DX-IP	9(2)	9	132	133	1. Value must be in [01-24] 2. Mandatory
CIP331	CIP.004.331	DIAGNOSIS-CODE-FLAG	Diagnosis Code Flag	Mandatory	Flag used to identify wither the associated Diagnosis Code value is a ICD-9 or ICD-10 code.	DIAGNOSIS-CODE-FLAG	CIP00004	CLAIM-DX-IP	X(1)	10	134	134	1. Value must be 1 character 2. Value must be in Diagnosis Code Flag List (VVL) 3. Mandatory
CIP332	CIP.004.332	DIAGNOSIS-CODE	Diagnosis Code	Mandatory	ICD-9 or ICD-10 diagnosis codes used as a tool to group and identify diseases, disorders, symptoms, poisonings, adverse effects of drugs and chemicals, injuries and other reasons for patient encounters. Diagnosis codes should be passed through to T-MSIS exactly as they were submitted by the provider on their claim (with the exception of removing the decimal). For example: 210.5 is coded as '21051'.	DIAGNOSIS-CODE	CIP00004	CLAIM-DX-IP	X(7)	11	135	141	1. Value must be a minimum of 3 characters 2. If associated Diagnosis Code Flag value equals "1" (ICD-9), then value must be in ICD-9 Diagnosis Code List (VVL) 3. If associated Diagnosis Code Flag value equals "2" (ICD-10), then value must be in ICD-10 Diagnosis Code List (VVL) 4. Value must not contain a decimal point 5. Mandatory

CIP333	CIP.004.333	DIAGNOSIS-POA-FLAG	Diagnosis POA Flag	Conditional	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator is used to identify certain preventable conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. *States that do not use the grouper methodology may use CMS-approved methodology that is prospective in nature.	DIAGNOSIS-POA-FLAG	CIP00004	CLAIM-DX-IP	X(1)	12	142	142	1. Value must be 1 character 2. Value must be in Diagnosis POA Flag List (VVL) 3. Conditional
CIP334	CIP.004.334	STATE-NOTATION	State Notation	Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	CIP00004	CLAIM-DX-IP	X(500)	13	143	642	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
CIP336	CIP.003.336	SDP-ALLOWED-AMT	State Directed Payment Allowed Amount	Conditional	The component (in dollar and cents) of the allowed amount that represents the difference between what would have been the managed care plan's typical contractual allowed amount and the enhanced allowed amount for this specific claim as defined by the State's SPA, waiver, or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).	N/A	CIP00003	CLAIM-LINE-RECORD-IP	S9(11)V99	47	590	602	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional

CIP337	CIP.003.337	SDP-PAID-AMT	State Directed Payment Paid Amount	Conditional	The component (in dollar and cents) of the paid amount that represents the difference between what would have been the managed care plan's typical contractual paid amount and the enhanced paid amount for this specific claim as defined by the State's SPA, waiver, or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).	N/A	CIP00003	CLAIM-LINE-RECORD-IP	S9(11)V99	48	603	615	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CIP338	CIP.002.338	TOT-SDP-ALLOWED-AMT	Total State Directed Payment Allowed Amount	Conditional	The component (in dollar and cents) of the total allowed amount that represents the difference between what would have been the managed care plan's typical contractual allowed amount and the enhanced allowed amount for this specific claim as defined by the State's SPA, waiver, or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11)V99	175	1763	1775	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CIP339	CIP.002.339	TOT-SDP-PAID-AMT	Total State Directed Payment Paid Amount	Conditional	The component (in dollar and cents) of the total paid amount that represents the difference between what would have been the managed care plan's typical contractual paid amount and the enhanced paid amount for this specific claim as defined by the State's SPA, waiver, or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).	N/A	CIP00002	CLAIM-HEADER-RECORD-IP	S9(11)V99	176	1776	1788	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CIP340	CIP.003.340	MBESCBES-FORM-GROUP	MBESCBES Form Group	Conditional	Indicates group of MBES/CBES forms that this payment applies to (e.g., the CMS-64.9 Base form is for Title XIX-funded Medicaid, the CMS-64.21 form is for Title XXI-funded Medicaid-expansion CHIP (M-CHIP), and the CMS-21 Base form is for Title XXI-funded separate CHIP (S-CHIP)).	MBESCBES-FORM-GROUP	CIP00003	CLAIM-LINE-RECORD-IP	X(1)	41	481	481	1. Value must be 1 character 2. Value must be in MBESCBES Form Group List (VVL) 3. Conditional 4. If Type of Claim in [1,A,U], then value must be populated on all claim lines with a Medicaid Paid Amount greater than $0

T-MSIS Data Dictionary – CLT File Changes Between Versions 2.4.0 and 4.0.0

CLT001	CLT.001.001	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	CLT00001	FILE-HEADER-RECORD-LT	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "CLT00001"
CLT002	CLT.001.002	DATA-DICTIONARY-VERSION	Data Dictionary Version	Mandatory	A data element to capture the version of the T-MSIS data dictionary that was used to build the file. ~~Use the version number specified on the Cover Sheet of the data dictionary" to V2.4.~~	DATA-DICTIONARY-VERSION	CLT00001	FILE-HEADER-RECORD-LT	X(10)	2	9	18	1. Value must be 10 characters or less 2. Value must be in Data Dictionary Version List (VVL) 3. Value must not include the pipe ("|") symbol ~~3~~4. Mandatory
CLT003	CLT.001.003	SUBMISSION-TRANSACTION-TYPE	Submission Transaction Type	Mandatory	A data element to identify the whether the transactions in the file are original submissions of the data, a resubmission of a previously submitted file, or corrections of edit rejects.	SUBMISSION-TRANSACTION-TYPE	CLT00001	FILE-HEADER-RECORD-LT	X(1)	3	19	19	1. Value must be 1 character 2. Value must be in ~~Submission Transaction Type~~Subcaptitation Indicator List (VVL) ~~2. Value must be 1 character~~ 3. Mandatory
CLT004	CLT.001.004	FILE-ENCODING-SPECIFICATION	File Encoding Specification	Mandatory	Denotes which supported file encoding standard was used to create the file.	FILE-ENCODING-SPECIFICATION	CLT00001	FILE-HEADER-RECORD-LT	X(3)	4	20	22	~~1.~~1. Value must be 3 characters 2. Value must be in File Encoding Specification List (VVL) ~~2. Value must be 3 characters~~ ~~3.~~3. Mandatory
CLT005	CLT.001.005	DATA-MAPPING-DOCUMENT-VERSION	Data Mapping Document Version	Mandatory	Identifies the version of the T-MSIS data mapping document used to build a state	N/A	CLT00001	FILE-HEADER-RECORD-LT	X(9)	5	23	31	1. Value must be 9 characters or less 2. Mandatory

					submission file. ~~Use the version number specified on the title page of the data mapping document~~								
CLT006	CLT.001.006	FILE-NAME	File Name	~~Not Applicable~~ Mandatory	A code to identify the subject area to which the records in its file relate. Each T-MSIS submission file should only contain records for one subject area (i.e., Eligible, Third-party liability, Provider, Managed Care Plan Information, Inpatient, Long-Term Care, Other, ~~and~~ Pharmacy Claim, and Financial Transactions).	N/A	CLT00001	FILE-HEADER-RECORD-LT	X(8)	6	32	39	1. Value must equal ~~'CLAIM-LT'~~"CLAIM-LT" 2. Mandatory
CLT007	CLT.001.007	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	CLT00001	FILE-HEADER-RECORD-LT	X(2)	7	40	41	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ 3. Mandatory
CLT008	CLT.001.008	DATE-FILE-CREATED	Date File Created	Mandatory	The date on which the file was created.	N/A	CLT00001	FILE-HEADER-RECORD-LT	9(8)	8	42	49	~~1.~~1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" ~~2~~3. Value must be ~~8 characters in the form "CCYYMMDD"~~ ~~3. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~4.~~less than current date 4. Value must be equal to or after the value of associated End of Time Period 5. Mandatory
CLT009	CLT.001.009	START-OF-TIME-PERIOD	Start of Time Period	Mandatory	This value must be the first day of the reporting month, regardless of the actual date span of the data in the file.	N/A	CLT00001	FILE-HEADER-RECORD-LT	9(8)	9	50	57	~~1. Value of the CC component must be "20"~~ ~~2. Value must be 8 characters in the form "CCYYMMDD"~~ ~~3.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~4. Value must be less than current date~~ ~~5.~~in the form "CCYYMMDD" 2. Value must be equal to or earlier than

													associated Date File Created ~~6~~3. Value must be before associated End of Time Period ~~7~~4. Mandatory 5. Value of the CC component must be "20"
CLT010	CLT.001.010	END-OF-TIME-PERIOD	End of Time Period	Mandatory	This value must be the last day of the reporting month, regardless of the actual date span.	N/A	CLT00001	FILE-HEADER-RECORD-LT	9(8)	10	58	65	1. ~~Value~~The date must be ~~8 characters~~a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" 3. ~~The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~4.~~ Value must be equal to or earlier than associated Date File Created ~~5~~4. Value must be equal to or after associated Start of Time Period ~~6~~5. Mandatory
CLT011	CLT.001.011	FILE-STATUS-INDICATOR	File Status Indicator	Mandatory	A code to indicate whether the records in the file are test or production records.	FILE-STATUS-INDICATOR	CLT00001	FILE-HEADER-RECORD-LT	X(1)	11	66	66	~~1.~~1. Value must be 1 character 2. For production files, value must be equal to ~~'P'~~ ~~2. Value must be 1 character~~ "P" 3. Value must be in File Status Indicator List (VVL) 4. Mandatory
CLT012	CLT.001.012	SSN-INDICATOR	SSN Indicator	Mandatory	Indicates whether the state uses the eligible person's social security number instead of an MSIS Identification Number as the unique, unchanging eligible person identifier. A state's SSN/Non-SSN designation on the eligibility file should match on the claims and third party liability files.	SSN-INDICATOR	CLT00001	FILE-HEADER-RECORD-LT	X(1)	12	67	67	~~1.~~1. Value must be 1 character 2. Value must be in SSN Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory

CLT013	CLT.001.013	TOT-REC-CNT	Total Record Count	Mandatory	A count of all records in the file except for the file header record. This count will be used as a control total to help assure that the file did not become corrupted during transmission.	N/A	CLT00001	FILE-HEADER-RECORD-LT	9(11)	13	68	78	~~1.~~1. Value must be 11 digits or less 2. Value must be a positive integer ~~2~~3. Value must be between 0:99999999999 (inclusive) ~~3. Value must be 11 digits or less~~ ~~4.~~4. Value must equal the number of records included in the file submission except for the file header record. 5. Mandatory
CLT014	CLT.001.014	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	CLT00001	FILE-HEADER-RECORD-LT	X(500)	15	83	582	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
CLT016	CLT.002.016	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	CLT00002	CLAIM-HEADER-RECORD-LT	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~ 3. Value must be in Record ID List (VVL) 4. Value must equal "CLT00002"

CLT017	CLT.002.017	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (CLT.001.007)
CLT018	CLT.002.018	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory
CLT019	CLT.002.019	ICN-ORIG	Original ICN	Mandatory	A unique number assigned by the state's payment system that identifies an original or adjustment claim.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(50)	4	22	71	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
CLT020	CLT.002.020	ICN-ADJ	Adjustment ICN	Conditional	A unique claim number assigned by the state's payment system that identifies the adjustment claim for an original transaction.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(50)	5	72	121	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value ~~is~~ equals "0~~,~~", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
CLT021	CLT.002.021	SUBMITTER-ID	Submitter ID	Mandatory	The Submitter Identification number is the value that identifies the provider/trading partner/clearing house organization to the state's claim adjudication system.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(12)	6	122	133	1. Value must be 12 characters or less 2. Mandatory

CLT022	CLT.002.022	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual ~~(except on service tracking payments).~~ . Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47572~~reporting-shared-msis-identification-numbers-eligibility/	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(20)	7	134	153	1. Mandatory 2. ~~For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN~~ ~~3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN~~ ~~4.~~ Value must be 20 characters or less ~~5. Populated value must begin with an '&', when TYPE-OF-CLAIM = 4, D or X (lump sum payment)~~ ~~6.~~. 3. The Beginning Date of Service on the claim must fall between (ELG.021.253) enrollment effective and (ELG.021.253) end date
CLT023	CLT.002.023	CROSSOVER-INDICATOR	Crossover Indicator	~~Conditional~~ Mandatory	An indicator specifying whether the claim is a crossover claim where a portion is paid by Medicare.	CROSSOVER-INDICATOR	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	8	154	154	~~1.~~1. Value must be 1 character 2. Value must be in Crossover Indicator List (VVL) ~~2~~3. If Crossover Indicator value ~~is~~equals "1", then associated Dual Eligible Code (ELG.005.085) value must be in "[01~~",~~ ",02~~",~~ ",04~~",~~ ",08~~",~~ ",09~~", or ~~",10"] for the same time period (by date of service) ~~3. Value must be 1 character~~ ~~4. Conditional~~ ~~5. If the TYPE-OF-CLAIM value is in ["1", "3", "A", "C"], then value is mandatory and must be reported.~~4. Mandatory

CLT024	CLT.002.024	1115A-DEMONSTRATION-IND	1115A Demonstration Indicator	Conditional	~~Indicates that~~In the claims files this data element indicates whether the claim or encounter was covered under the authority of an ~~1115(A)~~1115A demonstration. ~~1115(A) is a Center for Medicare and Medicaid Innovation~~In the Eligibility file, this data element indicates whether the individual participates in an 1115A demonstration.	1115A-DEMONSTRATION-IND	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	9	155	155	~~1.~~1. Value must be 1 character 2. Value must be in 1115A Demonstration Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Conditional 4. When value equals ~~'~~"0~~'~~", is invalid or not populated, then the associated 1115A Demonstration Indicator (ELG.018.2~~2~~33) must equal ~~'~~"0~~'~~", is invalid or not populated
CLT025	CLT.002.025	ADJUSTMENT-IND	Adjustment Indicator	Mandatory	Indicates the type of adjustment record.	ADJUSTMENT-IND	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	10	156	156	~~1.~~1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) ~~2. If associated Type of Claim value is in [1,~~ 3~~, 5, A, C, E, U, W, Y], then value must be in [0, 1, 4]~~ ~~3. If associated Type of Claim value is '4, D, X',~~ ~~then value~~. Value must be in [~~ 5, 6~~0,1,4] 4. ~~Value must be 1 character~~ ~~5.~~Mandatory 5. If value equals "0", then associated Adjustment ICN must not be populated 6. Value must equal "1", when associated Claim Status equals "686" 7. Value must match the adjustment indicator in the header (CIP.002.026)
CLT026	CLT.002.026	ADJUSTMENT-REASON-CODE	Adjustment Reason Code	Conditional	Claim adjustment reason codes communicate why a claim was paid differently than it was billed.~~ If the amount paid is different from the amount billed you need an adjustment reason code.~~	ADJUSTMENT-REASON-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(3)	11	157	159	~~1.~~1. Value must be 3 characters or less 2. Value must be in Adjustment Reason Code List (VVL) ~~2. Value must be 3 characters or less~~ ~~3.~~3. Conditional 4. Value must ~~not~~ be populated when ~~associated Adjustment Indicator equals "0"~~the total paid amount is different from the total billed amount

CLT027	CLT.002.027	ADMITTING-DIAGNOSIS-CODE	Admitting Diagnosis Code	Conditional	ICD-9 or ICD-10 diagnosis codes used as a tool to group and identify diseases, disorders, symptoms, poisonings, adverse effects of drugs and chemicals, injuries and other reasons for patient encounters. Diagnosis codes should be passed through to T-MSIS exactly as they were submitted by the provider on their claim (with the exception of removing the decimal). For example: 210.5 is coded as "2105".	ADMITTING-DIAGNOSIS-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(7)	12	160	166	1. When populated, a Diagnosis Code Flag is required 2. If associated Diagnosis Code Flag value is "1" (ICD-9), then value must be in ICD-9 Diagnosis Codes List (VVL) 3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Codes List (VVL) 4. Value must be a minimum of 3 characters 5. Value must not contain a decimal point 6. If associated Diagnosis Code Flag value is '"1" (ICD-9), value must not exceed 5 characters 7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 characters 8. When there is more than one diagnosis code on a claim, each value must be unique 9. Conditional
CLT028	CLT.002.028	ADMITTING-DIAGNOSIS-CODE-FLAG	Admitting Diagnosis Code Flag	Mandatory	A flag that identifies the coding system used for the Admitting Diagnosis Code.	ADMITTING-DIAGNOSIS-CODE-FLAG	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	13	167	167	1. Value must be in Diagnosis Code Flag(VVL) 2. Value must be 1 character 3. Mandatory
CLT029	CLT.002.029	DIAGNOSIS-CODE-1	Diagnosis Code 1	Conditional	ICD-9 or ICD-10 diagnosis codes used as a tool to group and identify diseases, disorders, symptoms, poisonings, adverse effects of drugs and chemicals, injuries and other reasons for patient encounters. Diagnosis codes should be passed through to T-MSIS exactly as they were submitted by the provider on their claim (with the exception of removing the decimal). For example: 210.5 is coded as "2105".	DIAGNOSIS-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(7)	14	168	174	1. When populated, a Diagnosis Code Flag is required 2. If associated Diagnosis Code Flag value is "1" (ICD-9), then value must be in ICD-9 Diagnosis Codes List (VVL) 3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Codes List (VVL) 4. Value must be a minimum of 3 characters 5. Value must not contain a decimal point 6. If associated Diagnosis Code Flag value is '"1" (ICD-9), value must not exceed 5 characters 7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 characters 8. When there is more than one diagnosis code on a claim, each value must be unique 9. Conditional 10. If Type of Claim (CLT.002.100) in ("1", "3", "A",

													"C", "U", "W") then Diagnosis Code 1 (CLT.002.032) must be populated.
CLT030	CLT.002.030	DIAGNOSIS CODE FLAG 1	Diagnosis Code Flag 1	Conditional	Flag used to identify if associated Diagnosis Code field is reported with ICD-9 or ICD-10 code. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.	DIAGNOSIS CODE FLAG	CLT00002	CLAIM HEADER RECORD LT	X(1)	15	175	175	1. Value must be in Diagnosis Code Flag List (VVL) 2. Value must be 1 character 3. Conditional 4. Value should not be populated, if the associated diagnosis code is not populated
CLT031	CLT.002.031	DIAGNOSIS POA FLAG 1	Diagnosis POA Flag 1	Conditional	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator is used to identify certain preventable conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. *States that do not use the grouper methodology may use CMS-approved methodology that is prospective in nature. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.	DIAGNOSIS POA FLAG	CLT00002	CLAIM HEADER RECORD LT	X(1)	16	176	176	1. Value must be in Diagnosis POA Flag List (VVL) 2. Value must be 1 character 3. Conditional
CLT032	CLT.002.032	DIAGNOSIS CODE 2	Diagnosis Code 2	Conditional	ICD-9 or ICD-10 diagnosis codes used as a tool to group and identify diseases, disorders, symptoms, poisonings, adverse effects of drugs and chemicals, injuries and other reasons for patient encounters. Diagnosis codes should be passed through to T-MSIS exactly as they were submitted by the provider on	DIAGNOSIS CODE	CLT00002	CLAIM HEADER RECORD LT	X(7)	17	177	183	1. When populated, a Diagnosis Code Flag is required 2. If associated Diagnosis Code Flag value is "1" (ICD-9), then value must be in ICD-9 Diagnosis Codes List (VVL) 3. If associated Diagnosis Code Flag value is "2"

					their claim (with the exception of removing the decimal). For example: 210.5 is coded as "2105".								(ICD-10), then value must be in ICD-10 Diagnosis Codes List (VVL) 4. Value must be a minimum of 3 characters 5. Value must not contain a decimal point 6. If associated Diagnosis Code Flag value is '"1" (ICD-9), value must not exceed 5 characters 7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 characters 8. When there is more than one diagnosis code on a claim, each value must be unique 9. Conditional 10. Value must not be populated when Diagnosis Code 1 (CLT.002.029) is not populated
CLT033	CLT.002.033	DIAGNOSIS CODE FLAG 2	Diagnosis Code Flag 2	Conditional	Flag used to identify if associated Diagnosis Code field is reported with ICD-9 or ICD-10 code. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.	DIAGNOSIS CODE FLAG	CLT00002	CLAIM HEADER RECORD LT	X(1)	18	184	184	1. Value must be in Diagnosis Code Flag List (VVL) 2. Value must be 1 character 3. Conditional 4. Value should not be populated, if the associated diagnosis code is not populated
CLT034	CLT.002.034	DIAGNOSIS POA FLAG 2	Diagnosis POA Flag 2	Conditional	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator is used to identify certain preventable conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. *States that do not use the grouper methodology may use CMS-approved methodology that is prospective in nature. Each Diagnosis Code Flag is associated with one, and	DIAGNOSIS POA FLAG	CLT00002	CLAIM HEADER RECORD LT	X(1)	19	185	185	1. Value must be in Diagnosis POA Flag List (VVL) 2. Value must be 1 character 3. Conditional

					only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.								
CLT035	CLT.002.035	DIAGNOSIS-CODE-3	Diagnosis Code 3	Conditional	ICD-9 or ICD-10 diagnosis codes used as a tool to group and identify diseases, disorders, symptoms, poisonings, adverse effects of drugs and chemicals, injuries and other reasons for patient encounters. Diagnosis codes should be passed through to T-MSIS exactly as they were submitted by the provider on their claim (with the exception of removing the decimal). For example: 210.5 is coded as "2105".	DIAGNOSIS-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(7)	20	186	192	1. When populated, a Diagnosis Code Flag is required 2. If associated Diagnosis Code Flag value is "1" (ICD-9), then value must be in ICD-9 Diagnosis Codes List (VVL) 3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Codes List (VVL) 4. Value must be a minimum of 3 characters 5. Value must not contain a decimal point 6. If associated Diagnosis Code Flag value is '"1" (ICD-9), value must not exceed 5 characters 7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 characters 8. When there is more than one diagnosis code on a claim, each value must be unique 9. Conditional 10. Value must not be populated when Diagnosis Code 2 (CLT.002.032) is not populated
CLT036	CLT.002.036	DIAGNOSIS-CODE-FLAG-3	Diagnosis Code Flag 3	Conditional	Flag used to identify if associated Diagnosis Code field is reported with ICD-9 or ICD-10 code. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.	DIAGNOSIS-CODE-FLAG	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	21	193	193	1. Value must be in Diagnosis Code Flag List (VVL) 2. Value must be 1 character 3. Conditional 4. Value should not be populated, if the associated diagnosis code is not populated
CLT037	CLT.002.037	DIAGNOSIS-POA-FLAG-3	Diagnosis POA Flag 3	Conditional	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator is used to identify certain preventable conditions that are: (a) high cost or high volume or	DIAGNOSIS-POA-FLAG	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	22	194	194	1. Value must be in Diagnosis POA Flag List (VVL) 2. Value must be 1 character 3. Conditional

					~~both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines.~~ ~~*States that do not use the grouper methodology may use CMS-approved methodology that is prospective in nature.~~ ~~Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.~~								
~~CLT038~~	~~CLT.002.038~~	~~DIAGNOSIS-CODE-4~~	~~Diagnosis Code 4~~	~~Conditional~~	~~ICD-9 or ICD-10 diagnosis codes used as a tool to group and identify diseases, disorders, symptoms, poisonings, adverse effects of drugs and chemicals, injuries and other reasons for patient encounters. Diagnosis codes should be passed through to T-MSIS exactly as they were submitted by the provider on their claim (with the exception of removing the decimal). For example: 210.5 is coded as "2105".~~	~~DIAGNOSIS-CODE~~	~~CLT00002~~	~~CLAIM-HEADER-RECORD-LT~~	~~X(7)~~	~~23~~	~~195~~	~~201~~	~~1. When populated, a Diagnosis Code Flag is required 2. If associated Diagnosis Code Flag value is "1" (ICD-9), then value must be in ICD-9 Diagnosis Codes List (VVL) 3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Codes List (VVL) 4. Value must be a minimum of 3 characters 5. Value must not contain a decimal point 6. If associated Diagnosis Code Flag value is '"1" (ICD-9), value must not exceed 5 characters 7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 characters 8. When there is more than one diagnosis code on a claim, each value must be unique 9. Conditional 10. Value must not be populated when Diagnosis Code 3 (CLT.002.035) is not populated~~
~~CLT039~~	~~CLT.002.039~~	~~DIAGNOSIS-CODE-FLAG-4~~	~~Diagnosis Code Flag 4~~	~~Conditional~~	~~Flag used to identify if associated Diagnosis Code field is reported with ICD-9 or ICD-10 code. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with~~	~~DIAGNOSIS-CODE-FLAG~~	~~CLT00002~~	~~CLAIM-HEADER-RECORD-LT~~	~~X(1)~~	~~24~~	~~202~~	~~202~~	~~1. Value must be in Diagnosis Code Flag List (VVL) 2. Value must be 1 character 3. Conditional~~

					Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.								4. Value should not be populated, if the associated diagnosis code is not populated
CLT040	CLT.002.040	DIAGNOSIS POA FLAG 4	Diagnosis POA Flag 4	Conditional	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator is used to identify certain preventable conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. *States that do not use the grouper methodology may use CMS-approved methodology that is prospective in nature. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.	DIAGNOSIS POA FLAG	CLT00002	CLAIM HEADER RECORD LT	X(1)	25	203	203	1. Value must be in Diagnosis POA Flag List (VVL) 2. Value must be 1 character 3. Conditional
CLT041	CLT.002.041	DIAGNOSIS CODE 5	Diagnosis Code 5	Conditional	ICD-9 or ICD-10 diagnosis codes used as a tool to group and identify diseases, disorders, symptoms, poisonings, adverse effects of drugs and chemicals, injuries and other reasons for patient encounters. Diagnosis codes should be passed through to T-MSIS exactly as they were submitted by the provider on their claim (with the exception of removing the decimal). For example: 210.5 is coded as "2105".	DIAGNOSIS CODE	CLT00002	CLAIM HEADER RECORD LT	X(7)	26	204	210	1. When populated, a Diagnosis Code Flag is required 2. If associated Diagnosis Code Flag value is "1" (ICD-9), then value must be in ICD-9 Diagnosis Codes List (VVL) 3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Codes List (VVL) 4. Value must be a minimum of 3 characters 5. Value must not contain a decimal point 6. If associated Diagnosis Code Flag value is '"1" (ICD-9), value must not exceed 5 characters 7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 characters

													8. When there is more than one diagnosis code on a claim, each value must be unique 9. Conditional 10. Value must not be populated when Diagnosis Code 4 (CLT.002.038) is not populated
CLT042	CLT.002.042	DIAGNOSIS CODE FLAG 5	Diagnosis Code Flag 5	Conditional	Flag used to identify if associated Diagnosis Code field is reported with ICD-9 or ICD-10 code. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.	DIAGNOSIS CODE FLAG	CLT00002	CLAIM HEADER RECORD LT	X(1)	27	211	211	1. Value must be in Diagnosis Code Flag List (VVL) 2. Value must be 1 character 3. Conditional 4. Value should not be populated, if the associated diagnosis code is not populated
CLT043	CLT.002.043	DIAGNOSIS POA FLAG 5	Diagnosis POA Flag 5	Conditional	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator is used to identify certain preventable conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. *States that do not use the grouper methodology may use CMS-approved methodology that is prospective in nature. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.	DIAGNOSIS POA FLAG	CLT00002	CLAIM HEADER RECORD LT	X(1)	28	212	212	1. Value must be in Diagnosis POA Flag List (VVL) 2. Value must be 1 character 3. Conditional

CLT044	CLT.002.044	ADMISSION-DATE	Admission Date	Mandatory	The date on which the recipient was admitted to a psychiatric or long-term care facility.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	~~29~~12	~~213~~160	~~220~~167	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be less than or equal to associated Discharge Date value in the claim header~~.~~ ~~4~~ 3. Value must be greater than or equal to associated eligible Date of Birth value~~.~~ ~~5~~ 4. Value must be less than or equal to associated eligible Date of Death value~~.~~ ~~6~~ 5. Mandatory ~~7. When associated Type of Claim (CLT.002.052) is not '2','B' or 'V' (capitated payment) value must be~~ 6. Value must be before Adjudication Date (CLT.002.050) ~~8. When associated Type of Claim (CLT.002.052) is not '2','B' or 'V' (capitated payment) and Type of Service (CLT.003.211) is not '119, '120', '121', 122' value must be before Adjudication Date (CLT.003.233)~~
CLT045	CLT.002.045	ADMISSION-HOUR	Admission Hour	Conditional	The time of admission to a psychiatric or long-term care facility.	HOUR	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	~~30~~13	~~221~~168	~~222~~169	~~1.~~1. Value must be 2 characters 2. Value must be in Hour List (VVL) ~~2. Value must be 2 characters~~ 3. Conditional

CLT046	CLT.002.046	DISCHARGE-DATE	Discharge Date	Conditional	The date on which the recipient was discharged from a psychiatric or long-term care facility.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	~~31~~14	~~223~~170	~~230~~177	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be less than or equal to associated Adjudication Date value. ~~4~~3. Value must be greater than or equal to associated Admission Date value. ~~5~~4. Value must be greater than or equal to associated eligible Date of Birth value. ~~6~~5. Value must be less than or equal to associated eligible Date of Death value. ~~7~~6. Conditional 7. When populated, Discharge Hour (CLT.002.047) must be populated
CLT047	CLT.002.047	DISCHARGE-HOUR	Discharge Hour	Conditional	The time of discharge from a psychiatric or long-term care facility.	HOUR	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	~~32~~15	~~231~~178	~~232~~179	~~1.~~1. Value must be 2 characters 2. Value must be in Hour List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional 4. When populated, Discharge Date (CLT.002.046) must be populated

CLT048	CLT.002.048	BEGINNING-DATE-OF-SERVICE	Beginning Date of Service	Mandatory	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, this would be 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. For financial transactions reported to the OT file, populate with the first day of the time period covered by this financial transaction.~~covered by this claim began.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	~~33~~16	~~233~~180	~~240~~187	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3. When Type of Claim is not in ['2', '4', 'B', 'D', 'V'] value must be~~ in the form "CCYYMMDD" 2. Value must be less than or equal to associated End of Time Period value ~~4~~3. Value must be less than or equal to associated Ending Date of Service value ~~5. When Type of Claim is not in ['2', '4', 'B', 'D', 'V'] value~~4. Value must be less than or equal to associated Adjudication Date value ~~6~~5. Value must be less than or equal to associated Date of Death (ELG.002.025) value when populated ~~7~~6. Value must be less than or equal to at least one of the eligible's Enrollment End Date (ELG.021.254) values ~~8~~7. Mandatory
CLT049	CLT.002.049	ENDING-DATE-OF-SERVICE	Ending Date of Service	Mandatory	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. For financial transactions reported to the OT file, populate with the first day of the time period covered by this financial transaction.~~	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	~~34~~17	~~241~~188	~~248~~195	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3. When Type of Claim is not in ['2', '4', 'B', 'D', 'V'] value must be~~ in the form "CCYYMMDD" 2. Value must be less than or equal to associated End of Time Period value ~~4~~3. Value must be greater than or equal to associated Beginning Date of Service value ~~5. When Type of Claim is not in ['2', '4', 'B', 'D', 'V'] value~~4. Value must be less than or equal to associated Adjudication Date value ~~6~~5. Value must be less than or equal to associated Date of Death (ELG.002.025) value

													when populated ~~7~~6. Value must be equal to or greater than associated Date of Birth (ELG.002.024) value ~~8~~7. Mandatory
CLT050	CLT.002.050	ADJUDICATION-DATE	Adjudication Date	Mandatory	The date on which the payment status of the claim was finally adjudicated by the state. For Encounter Records (Type of Claim = 3, C, W), use date the encounter was processed by the state.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	~~35~~18	~~249~~196	~~256~~203	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value should be on or before End of Time Period ~~value found in associated T-MSIS File Header Record~~ ~~4.~~ (CIP.001.010) 3. Mandatory ~~5~~4. Value should be on or after associated Admission Date value
CLT051	CLT.002.051	MEDICAID-PAID-DATE	Medicaid Paid Date	Mandatory	The date Medicaid paid this claim or adjustment. For Encounter Records (Type of Claim = 3, C, W), the date the managed care organization paid the provider for the claim or adjustment.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	~~36~~19	~~257~~204	~~264~~211	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Total Medicaid

													Paid Amount ~~4~~3. Mandatory
CLT052	CLT.002.052	TYPE-OF-CLAIM	Type of Claim	Mandatory	A code to indicate what type of payment is covered in this claim. For sub-capitated encounters from a sub-capitated entity or sub-capitated network provider, report TYPE-OF-CLAIM = '3' for a Medicaid sub-capitated encounter record or "C" for an S-CHIP sub-capitated encounter record.	TYPE-OF-CLAIM	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	~~37~~20	~~265~~212	~~265~~212	~~1.~~1. Value must be 1 character 2. Value must be in Type of Claim List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory ~~4. When value equals 'Z', claim denied indicator must equal '0'~~
CLT053	CLT.002.053	TYPE-OF-BILL	Type of Bill	Mandatory	A data element corresponding with UB-04 form locator FL4 that classifies the claim as to the type of facility (2nd digit), type of care (3rd digit) and the billing record's sequence in the episode of care (4th digit). (Note that the 1st digit is always zero.)	TYPE-OF-BILL	CLT00002	CLAIM-HEADER-RECORD-LT	X(4)	~~38~~21	~~266~~213	216~~9~~	~~1.~~1. Value must be 4 characters 2. Value must be in Type of Bill List (VVL) ~~2. Value must be 4 characters~~ ~~3.~~3. First character must be a ~~'0'~~"0" 4. Mandatory
CLT054	CLT.002.054	CLAIM-STATUS	Claim Status	Conditional	The health care claim status codes convey the status of an entire claim~~.~~ status codes from the 277 transaction set. Only report the claim status for the final, adjudicated claim.	CLAIM-STATUS	CLT00002	CLAIM-HEADER-RECORD-LT	X(3)	~~39~~22	217~~0~~	~~272~~219	~~1.~~1. Value must be 3 characters or less 2. Value must be in Claim Status List (VVL) ~~2. Value must be 3 characters or less~~ ~~3.~~3. Conditional 4. If value in [~~ 26, 87,~~542,585,654~~],~~], then Claim Denied Indicator must be ~~'0'~~"0" and Claim Status Category must be "F2"
CLT055	CLT.002.055	CLAIM-STATUS-CATEGORY	Claim Status Category	Mandatory	The ~~Claim Status Category conveys the status~~ general category of the ~~entire~~ claim ~~using the X12 Claim Status Category Codes~~status (accepted, rejected, pended, finalized, additional information requested, etc.) from the 277 transaction set which is then further detailed in the companion data element claim ~~adjudication process~~status.	CLAIM-STATUS-CATEGORY	CLT00002	CLAIM-HEADER-RECORD-LT	X(3)	~~40~~23	~~273~~220	~~275~~222	~~1.~~1. Value must be 3 characters or less 2. Value must be in Claim Status Category List (VVL) ~~2~~3. (Denied Claim) if associated Claim Denied Indicator indicates the claim was denied, then value must be "F2" ~~3~~4. (Denied Claim) if associated ~~Type of Claim equals Z or associated~~ Claim Status is in [~~ 26, 87,~~ 542,~~ 8~~585,654], then value must be "F2"

													~~4. Value must be 3 characters or less~~ 5. Mandatory
CLT056	CLT.002.056	SOURCE-LOCATION	Source Location	Mandatory	~~The field denotes the claims payment system from which the claim was extracted.~~The field denotes the claims payment system from which the claim was extracted. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report a SOURCE-LOCATION = '22' to indicate that the sub-capitated entity paid a provider for the service to the enrollee on a FFS basis. For sub-capitated encounters from a sub-capitated network provider that were submitted to sub-capitated entity, report a SOURCE-LOCATION = '23' to indicate that the sub-capitated network provider provided the service directly to the enrollee. For sub-capitated encounters from a sub-capitated network provider, report a SOURCE-LOCATION = “23” to indicate that the sub-capitated network provider provided the service directly to the enrollee.	SOURCE-LOCATION	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	~~41~~24	~~276~~223	~~277~~224	~~1.~~1. Value must be 2 characters 2. Value must be in Source Location List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory

CLT057	CLT.002.057	CHECK-NUM	Check Number	Conditional	The check or electronic funds transfer number.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(15)	~~42~~25	~~278~~225	23~~9~~~~2~~	1. Value must be 15 characters or less 2. Value must have an associated Check Effective Date 3. Value must not contain a pipe or asterisk symbols 4. Conditional
CLT058	CLT.002.058	CHECK-EFF-DATE	Check Effective Date	Conditional	The date a check is issued to the payee. In the case of electronic funds transfer, it is the date the transfer is made.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	~~43~~26	~~293~~240	~~300~~247	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3. Value may be the same as associated Remittance Date~~ ~~4.~~ in the form "CCYYMMDD" 2. Must have an associated Check Number ~~5~~3. Conditional
CLT059	CLT.002.059	CLAIM-PYMT-REM-CODE-1	~~Claim Payment~~Remittance Advice Remark Code 1	Conditional	Remittance Advice Remark Codes are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Each Remittance Advice Remark Code identifies a specific message as shown in the Remittance Advice Remark Code List. It is a code set used by the health care industry to convey non-financial information critical to understanding the adjudication of a health care claim for payment. It is an external code set whose use is as mandated by the Administrative Simplification provisions of the Health Insurance Portability and Accountably Act of 1996 (P.L.104-191, commonly referred to as HIPAA).	CLAIM-PYMT-REM-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(5)	~~44~~27	~~301~~248	~~305~~252	~~1.~~1. Value must be 5 characters or less 2. Value must be in Claim Payment Remittance Code List (VVL) ~~2. Value must be 5 characters or less~~ ~~3.~~3. Conditional 4. When more than one ~~code~~occurrence of Claim Payment Remark Code 1 through Claim Payment Remark Code 4 is populated on a claim, all values must be unique

CLT060	CLT.002.060	CLAIM-PYMT-REM-CODE-2	~~Claim Payment~~Remittance Advice Remark Code 2	Conditional	Remittance Advice Remark Codes are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Each Remittance Advice Remark Code identifies a specific message as shown in the Remittance Advice Remark Code List. It is a code set used by the health care industry to convey non-financial information critical to understanding the adjudication of a health care claim for payment. It is an external code set whose use is as mandated by the Administrative Simplification provisions of the Health Insurance Portability and Accountably Act of 1996 (P.L.104-191, commonly referred to as HIPAA).	CLAIM-PYMT-REM-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(5)	~~45~~28	~~306~~253	~~310~~257	~~1.~~1. Value must be 5 characters or less 2. Value must be in Claim Payment Remittance Code List (VVL) ~~2. Value must be 5 characters or less~~ ~~3.~~3. Conditional 4. When more than one ~~code~~occurrence of Claim Payment Remark Code 1 through Claim Payment Remark Code 4 is populated on a claim, all values must be unique 5. Value must not be populated when ~~Claim Payment~~Remittance Advice Remark Code 1 (CLT.002.059) is not populated
CLT061	CLT.002.061	CLAIM-PYMT-REM-CODE-3	~~Claim Payment~~Remittance Advice Remark Code 3	Conditional	Remittance Advice Remark Codes are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Each Remittance Advice Remark Code identifies a specific message as shown in the Remittance Advice Remark Code List. It is a code set used by the health care industry to convey non-financial information critical to understanding the adjudication of a health care claim for payment. It is an external code set whose use is as mandated by the Administrative Simplification provisions of the Health Insurance Portability and Accountably Act of 1996 (P.L.104-191, commonly referred to as HIPAA).	CLAIM-PYMT-REM-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(5)	~~46~~29	~~311~~258	~~315~~262	1. Value must be in Claim Payment Remittance Code List (VVL) 2. Value must be 5 characters or less 3. Conditional 4. When more than one ~~code~~occurrence of Claim Payment Remark Code 1 through Claim Payment Remark Code 4 is populated on a claim, all values must be unique 5. Value must not be populated when ~~Claim Payment~~Remittance Advice Remark Code 2 (CLT.002.060) is not populated

CLT062	CLT.002.062	CLAIM-PYMT-REM-CODE-4	~~Claim Payment~~Remittance Advice Remark Code 4	Conditional	Remittance Advice Remark Codes are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Each Remittance Advice Remark Code identifies a specific message as shown in the Remittance Advice Remark Code List. It is a code set used by the health care industry to convey non-financial information critical to understanding the adjudication of a health care claim for payment. It is an external code set whose use is as mandated by the Administrative Simplification provisions of the Health Insurance Portability and Accountably Act of 1996 (P.L.104-191, commonly referred to as HIPAA).	CLAIM-PYMT-REM-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(5)	~~47~~30	~~316~~263	~~320~~267	1. Value must be in Claim Payment Remittance Code List (VVL) 2. Value must be 5 characters or less 3. Conditional 4. When more than one ~~code~~occurrence of Claim Payment Remark Code 1 through Claim Payment Remark Code 4 is populated on a claim, all values must be unique 5. Value must not be populated when ~~Claim Payment~~Remittance Advice Remark Code 3 (CLT.002.061) is not populated
CLT063	CLT.002.063	TOT-BILLED-AMT	Total Billed Amount	Conditional	The total amount billed for this claim at the claim header level as submitted by the provider. For encounter records, when Type of Claim value is ~~[~~in [3, C, ~~or~~ W], then value must equal amount the provider billed to the managed care plan. ~~Total Billed Amount~~For sub-capitated encounters from a sub-capitated entity that is not ~~expected on financial transactions~~a sub-capitated network provider, report the total amount that the provider billed the sub-capitated entity for the service. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11) V99	~~48~~31	~~321~~268	~~333~~280	1. Value must be between -99999999999.99 and 99999999999.99. 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50 ~~)~~). 3. Value must equal the sum of all Billed Amount instances for the associated claim. 4. Conditional 5. ~~Value should not be populated when associated Type of Claim is in [2, 4, 5, B, D E or X]~~ ~~6. Value should not be populated when associated Type of Claim (CIP.002.100) is equal to '4', 'D' or 'X'~~ ~~7.~~ (individual line item payments) when populated and Payment Level Indicator (CLT.002.082) equals = '2' value must be greater than or equal to the sum of all claim line Revenue Charges (CLT.003.204~~)~~).

CLT064	CLT.002.064	TOT-ALLOWED-AMT	Total Allowed Amount	Conditional	The claim header level maximum amount determined by the payer as being 'allowable' under the provisions of the contract prior to the determination of actual payment. On FFS claims the Allowed Amount is determined by the state's MMIS. On managed care encounters the Allowed Amount is determined by the managed care organization. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the total amount that the sub-capitated entity allowed for the service. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11) V99	~~49~~32	~~334~~281	~~346~~293	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. When populated and Payment Level Indicator ~~= '2'~~equals "2", then value must equal the sum of all claim line Allowed Amount values 4. Conditional

CLT065	CLT.002.065	TOT-MEDICAID-PAID-AMT	Total Medicaid Paid Amount	Conditional	The total amount paid by Medicaid/CHIP or the managed care plan on this claim or adjustment at the claim header level, which is the sum of the amounts paid by Medicaid or the managed care plan at the detail level for the claim. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the total amount that the sub-capitated entity paid the provider for the service. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11) V99	~~50~~33	~~347~~294	~~359~~306	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Must have an associated Medicaid Paid Date 4. If Total Medicare Coinsurance Amount and Total Medicare Deductible Amount is reported it must equal Total Medicaid Paid Amount 5. When Payment Level Indicator equals '"2"', value must equal the sum of line level Medicaid Paid Amounts. 6. Conditional 7. Value must not be populated or equal to "0.00" when associated Claim Status is in [542,585,654] 8. Value must not be greater than Total Allowed Amount (CLT.002.064)
~~CLT066~~	~~CLT.002.066~~	~~TOT-COPAY-AMT~~	~~Total Copayment Amount~~	~~Conditional~~	~~The total amount paid by Medicaid/CHIP enrollee for each office or emergency department visit or purchase of prescription drugs in addition to the amount paid by Medicaid/CHIP.~~	~~N/A~~	~~CLT00002~~	~~CLAIM-HEADER-RECORD-LT~~	~~S9(11) V99~~	~~51~~	~~360~~	~~372~~	~~1. Value must be between -99999999999.99 and 99999999999.99~~ ~~2. Value must be expressed as a number with 2-digit precision (e.g. 100.50)~~ ~~3. Conditional~~

CLT067	CLT.002.067	TOT-MEDICARE-DEDUCTIBLE-AMT	Total Medicare Deductible Amount	Conditional	The amount paid by Medicaid/CHIP, on this claim at the claim header level, toward the beneficiary's Medicare deductible. 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, code Medicare Combined Indicator a "1"'1' and leave Total Medicare Coinsurance Amount unpopulated.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11) V99	52 34	307 3	385 319	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Crossover Indicator value is '0' equals "0" (not a crossover claim), then value should not be populated. 4. (Medicare Enrolled) if associated Dual Eligible Code (ELG.005.085) value is in ["[01", "¿02", "¿03", "¿04", "¿05", "¿06", "¿08", "¿09", or "¿10"],, then value is mandatory and must be provided 5. Conditional 6. When populated, value must be less than or equal to Total Billed Amount
CLT068	CLT.002.068	TOT-MEDICARE-COINS-AMT	Total Medicare Coinsurance Amount	Conditional	The total amount paid by the Medicaid/CHIP agency or a managed care plan towards the portion of the Medicare allowed charges that Medicare applied to coinsurance.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11) V99	53 35	386 320	398 332	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Crossover Indicator value is '0' equals "0" (not a crossover claim), then value should not be populated. 4. Conditional 5. If associated Medicare Combined Deductible Indicator is '1', equals "1", then value must not be populated 6. When populated, value must be less than or equal to Total Billed Amount

CLT069	CLT.002.069	TOT-TPL-AMT	Total ~~Third Party Liability~~TPL Amount	Conditional	Third-party liability refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a state plan. This is the total amount denoted at the claim header level paid by the third party.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11) V99	~~54~~36	~~399~~333	~~411~~345	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Value must be less than associated Total Billed Amount - (Total Medicare Coinsurance Amount + Total Medicare Deductible Amount) 4. Conditional
CLT070	CLT.002.070	TOT-OTHER-INSURANCE-AMT	Total Other Insurance Amount	Conditional	The amount paid by insurance other than Medicare or Medicaid on this claim.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11) V99	~~55~~37	~~412~~346	~~424~~358	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CLT071	CLT.002.071	OTHER-INSURANCE-IND	Other Insurance Indicator	Conditional	The field denotes whether the insured party is covered under an other insurance plan other than Medicare or Medicaid.	OTHER-INSURANCE-IND	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	~~56~~38	~~425~~359	~~425~~359	~~1.~~1. Value must be 1 character 2. Value must be in Other Insurance Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Conditional
CLT072	CLT.002.072	OTHER-TPL-COLLECTION	Other TPL Collection	~~Conditional~~ Mandatory	This data element indicates that the claim is for a beneficiary for whom other third party resource development and collection activities are in progress, when the liability is not another health insurance plan for which the eligible is a beneficiary.	OTHER-TPL-COLLECTION	CLT00002	CLAIM-HEADER-RECORD-LT	X(3)	~~57~~39	~~426~~360	~~428~~362	1. Value must be in Other TPL Collection List (VVL) 2. Value must be 3 characters 3. ~~Conditional~~Mandatory
~~CLT073~~	~~CLT.002.073~~	~~SERVICE-TRACKING-TYPE~~	~~Service Tracking Type~~	~~Conditional~~	~~A code to categorize service tracking claims. A "service tracking claim" is used to report lump sum payments that cannot be attributed to a single enrollee.~~	~~SERVICE-TRACKING-TYPE~~	~~CLT00002~~	~~CLAIM-HEADER-RECORD-LT~~	~~X(2)~~	~~58~~	~~429~~	~~430~~	~~1. Value must be in Service Tracking Type List (VVL)~~ ~~2. (Service Tracking Claim) if associated Type of Claim is in ['4','D', 'X'] then value is mandatory and must be reported~~ ~~3. Value must be 2 characters~~ ~~4. Conditional~~

~~CLT074~~	~~CLT.002.074~~	~~SERVICE-TRACKING-PAYMENT-AMT~~	~~Service Tracking Payment Amount~~	~~Conditional~~	~~On service tracking claims, the payment amount is the lump sum that cannot be attributed to any one beneficiary paid to the provider.~~	~~N/A~~	~~CLT00002~~	~~CLAIM-HEADER-RECORD-LT~~	~~S9(11) V99~~	~~59~~	~~431~~	~~443~~	~~1. Value must be between -99999999999.99 and 99999999999.99~~ ~~2. Value must be expressed as a number with 2-digit precision (e.g. 100.50)~~ ~~3. If associated Type of Claim value is in [4, D, or X], then value is mandatory and must be provided~~ ~~4. Conditional~~ ~~5. When populated, Service Tracking Type must be populated~~ ~~6. When populated, Total Medicaid Amount must not be populated~~
CLT075	CLT.002.075	FIXED-PAYMENT-IND	Fixed Payment Indicator	Conditional	This indicator indicates that the reimbursement amount included on the claim is for a fixed payment. Fixed payments are made by the state to insurers or providers for premiums or eligible coverage, not for a particular service. For example, some states have Primary Care Case Management programs where the state pays providers a monthly patient management fee of $3.50 for each eligible participant under their care. This fee is considered a fixed payment. It is very important for states to correctly identify fixed payments. Fixed payments do not have a defined ~~"medical record"~~'medical record' associated with the payment; therefore, fixed payments are not subject to medical record request and medical record review.	FIXED-PAYMENT-IND	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	~~60~~40	~~444~~363	~~444~~363	~~1.~~1. Value must be 1 character 2. Value must be in Fixed Payment Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Conditional
CLT076	CLT.002.076	FUNDING-CODE	Funding Code	~~Mandatory~~Conditional	A code to indicate the source of non-federal share funds.	FUNDING-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	~~61~~41	~~445~~364	~~446~~365	~~1.~~1. Value must be 1 character 2. Value must be in Funding Code List (VVL) ~~2. Value must be 1 character~~ ~~3. Mandatory~~3. If Type of Claim is not in [3,C,W], then value must be populated 4. Conditional

CLT077	CLT.002.077	FUNDING-SOURCE-NONFEDERAL-SHARE	Funding Source Non-Federal Share	~~Not Applicable~~Conditional	A code to indicate the type of non-federal share used by the state to finance its expenditure to the provider. In the event of two sources, states are to report the portion which represents the largest proportion not funded by the Federal government.	FUNDING-SOURCE-NONFEDERAL-SHARE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	~~62~~42	~~447~~366	~~448~~367	~~1.~~1. Value must be 2 characters 2. Value must be in Funding Source Non-Federal Share List (VVL) ~~2. Value must be 2 characters~~ ~~3. Required~~3. If Type of Claim is in [3,C,W], then value must be populated 4. Conditional
CLT078	CLT.002.078	MEDICARE-COMB-DED-IND	Medicare Combined Deductible Indicator	Conditional	Code indicating that the amount paid by Medicaid/CHIP on this claim toward the recipient's Medicare deductible was combined with their coinsurance amount because the amounts could not be separated.	MEDICARE-COMB-DED-IND	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	~~63~~43	~~449~~368	~~449~~368	~~1.~~1. Value must be 1 character 2. Value must be in Medicare Combined Deductible Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. If value equals '1', then Total Medicare Coinsurance amount ~~is~~must not be populated~~.~~ 4. ~~Value must equal '0' if associated Type of Claim is '3', 'C' or 'W'~~If value equals "0", then Crossover Indicator must equals "0" 5. If value equals "1", then Crossover Indicator must equals "1" 6. Conditional
CLT079	CLT.002.079	PROGRAM-TYPE	Program Type	Mandatory	A code to indicate special Medicaid program under which the service was provided.	PROGRAM-TYPE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	~~64~~44	~~450~~369	~~451~~370	~~1.~~1. Value must be 2 characters 2. Value must be in Program Type List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. (Community First Choice) If value equals '11', then State Plan Option Type (ELG.011.163) must equal '01' for the same time period 5. If value equals '13', then State Plan Option Type (ELG.011.163) must equal '02' for the same time period

CLT080	CLT.002.080	PLAN-ID-NUMBER	Plan ID Number	Conditional	A unique number assigned by the state which represents a distinct comprehensive managed care plan, prepaid health plan, primary care case management program, a program for all-inclusive care for the elderly entity, or other approved plans.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(12)	~~65~~45	~~452~~371	~~463~~382	1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional 4. Value must match Managed Care Plan ID (ELG.014.192~~)~~). 5. Value must match State Plan ID Number (MCR.002.019~~)~~). 6. Value should not be populated when Type of Claim is not ~~equal to '3', 'C' or 'W'~~in [3,C,W] 7. When Type of Claim in ~~(~~[3,C,W~~, 2, B, V)~~] value must have a managed care enrollment (ELG.014) for the beneficiary where the Beginning DOS (CLT.002.048) occurs between the managed care plan enrollment eff/end dates (ELG.014.197/198) 8. When Type of Claim in ~~(~~[3,C,W~~, 2, B, V)~~] value must have a managed care main record (MCR.002) for the plan where the Beginning DOS (CLT.002.048) occurs between the managed care contract eff/end dates (MCR.002.020/021)
~~CLT081~~	~~CLT.002.081~~	~~NATIONAL-HEALTH-CARE-ENTITY-ID~~	~~National Health Care Entity ID~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~CLT00002~~	~~CLAIM-HEADER-RECORD-LT~~	~~X(10)~~	~~66~~	~~464~~	~~473~~	~~1. Not Applicable~~

CLT082	CLT.002.082	PAYMENT-LEVEL-IND	Payment Level Indicator	Mandatory	~~The field denotes whether the payment amount was determined at the claim header or line/detail level.~~The field denotes whether the payment amount was determined at the claim header or line/detail level. For claims where payment is NOT determined at the individual line level (PAYMENT-LEVEL-IND = 1), the claim lines' associated allowed (ALLOWED-AMT) and paid (MEDICAID-PAID-AMT) amounts are left blank and the total allowed (TOT-ALLOWED-AMT) and total paid (TOT-MEDICAID-PAID-AMT) amount is reported at the header level only. For claims where payment/allowed amount is determined at the individual lines and when applicable, cost-sharing and/or coordination of benefits were deducted from one or more specific line-level payment/allowed amounts (PAYMENT-LEVEL-IND = 2), the allowed (ALLOWED-AMT) and paid (MEDICAID-PAID-AMT) amounts on the associated claim lines should sum to the total allowed (TOT-ALLOWED-AMT) and total paid (TOT-MEDICAID-PAID-AMT) amounts reported on the claim header. For claims where payment/allowed amount is determined at the individual lines but then cost sharing or coordination of benefits was deducted from the total paid/allowed amount at the header only (PAYMENT-LEVEL-IND = 3), then the line-level paid amount (MEDICAID-PAID-AMT) would be blank and line-level allowed (ALLOWED-AMT) and header level total allowed (TOT-ALLOWED-AMT) and total paid (TOT-MEDICAID-PAID-AMT) amounts must all be populated but the line level allowed amounts are not expected to sum exactly to the header level total allowed.	PAYMENT-LEVEL-IND	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	~~67~~46	~~474~~383	~~474~~383	~~1.~~1. Value must be 1 character 2. Value must be in Payment Level Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory

					For example, if a claim for an office visit and a procedure is assigned a separate line-level allowed amount for each line, but then at the header level a copay is deducted from the header-level total allowed and/or total paid amounts, then the sum of line-level allowed amounts may not be equal to the header-level total allowed amounts or correspond directly to the total paid amount. If the state cannot distinguish between the scenarios for value 1 and value 3, then value 1 can be used for all claims with only header-level total allowed/paid amounts.								
CLT083	CLT.002.083	MEDICARE-REIM-TYPE	Medicare Reimbursement Type	Conditional	A code to indicate the type of Medicare reimbursement.	MEDICARE-REIM-TYPE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	~~68~~47	~~475~~384	~~476~~385	~~1.~~1. Value must be 2 characters 2. Value must be in Medicare Reimbursement Type List (VVL) ~~2. (Crossover Claim) if associated Crossover Indicator value indicates a crossover claim, value~~3. Value is mandatory and must be provided ~~3. Value must be 2 characters~~ , when Crossover Indicator is equal to "1"

													(Crossover Claim) 4. Conditional
CLT084	CLT.002.084	NON-COV-DAYS	Non-Covered Days	Conditional	The number of days of institutional long-term care not covered by the payer for this sequence as qualified by the payer organization. The number of non-covered days does not refer to days not covered for any other service.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(5)	~~69~~48	~~477~~386	~~481~~390	~~1. Value must be a positive integer~~ ~~2. Value must be between 0:99999999999 (inclusive)~~ ~~3. Conditional~~ ~~4.~~1. Value must be 5 digits or less 2. Conditional
CLT085	CLT.002.085	NON-COV-CHARGES	Non-Covered Charges	Conditional	The charges for institutional long-term care, which are not reimbursable by the primary payer. The non-covered charges do not refer to charges not covered for any other service.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11) V99	~~70~~49	~~482~~391	~~494~~403	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CLT086	CLT.002.086	MEDICAID-COV-INPATIENT-DAYS	Medicaid Covered Inpatient Days	Conditional	The number of inpatient psychiatric days covered by Medicaid on this claim.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(5)	~~71~~50	~~495~~404	~~499~~408	1. Value must be a positive integer 2. Value must be between ~~0:99999999999~~00000:99999 (inclusive) 3. Conditional 4. Value must be less than or equal to double the number of days between Admission Date (CLT.002.044) and Discharge Date (CLT.002.046) plus one day 5. Value must be 5 digits or less 6. (inpatient mental health/psychiatric services) when associated Type of Service (CLT.003.211) in [044,048,050], this field must be populated

CLT087	CLT.002.087	CLAIM-LINE-COUNT	Claim Line Count	Mandatory	The total number of lines on the claim.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(4)	~~72~~51	~~500~~409	~~503~~412	1. Value must be 4 characters or less 2. Value must be a positive integer ~~2~~3. Value must be between ~~0~~0000:9999 (inclusive) ~~3~~4. Value must not include commas or other non-numeric characters ~~4~~5. Value must be equal to the number of claim lines (e.g. Original Claim Line Number or Adjustment Claim Line Number instances) reported in the associated claim record being reported ~~5. Value must be 4 characters or less~~ 6. Mandatory
CLT090	CLT.002.090	FORCED-CLAIM-IND	Forced Claim Indicator	Conditional	Indicates if the claim was processed by forcing it through a manual override process.	FORCED-CLAIM-IND	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	~~73~~52	~~504~~413	~~504~~413	~~1.~~1. Value must be 1 character 2. Value must be in Forced Claim Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Conditional
CLT091	CLT.002.091	HEALTH-CARE-ACQUIRED-CONDITION-IND	Healthcare Acquired Condition Indicator	Conditional	This code indicates whether the claim has a Health Care Acquired Condition. For additional coding information refer to the following site: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html?redirect=/hospitalacqcond/05_Coding.asp#TopOfPage	HEALTH-CARE-ACQUIRED-CONDITION-IND	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	~~74~~53	~~505~~414	~~505~~414	~~1.~~1. Value must be 1 character 2. Value must be in Healthcare Acquired Condition Indicator List (VVL~~).~~ ~~2. Value must be 1 character~~) 3. Conditional
CLT092	CLT.002.092	OCCURRENCE-CODE-01	Occurrence Code 1	Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are ~~FLs~~Form Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.	OCCURRENCE-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	~~75~~54	~~506~~415	~~507~~416	~~1.~~1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional

CLT093	CLT.002.093	OCCURRENCE-CODE-02	Occurrence Code 2	Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are ~~FLs~~Form Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.	OCCURRENCE-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	~~76~~55	~~508~~417	~~509~~418	~~1.~~1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional
CLT094	CLT.002.094	OCCURRENCE-CODE-03	Occurrence Code 3	Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are ~~FLs~~Form Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.	OCCURRENCE-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	~~77~~56	~~510~~419	~~511~~420	~~1.~~1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional
CLT095	CLT.002.095	OCCURRENCE-CODE-04	Occurrence Code 4	Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are ~~FLs~~Form Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.	OCCURRENCE-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	~~78~~57	~~512~~421	~~513~~422	~~1.~~1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional
CLT096	CLT.002.096	OCCURRENCE-CODE-05	Occurrence Code 5	Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are ~~FLs~~Form Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.	OCCURRENCE-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	~~79~~58	~~514~~423	~~515~~424	~~1.~~1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional
CLT097	CLT.002.097	OCCURRENCE-CODE-06	Occurrence Code 6	Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are ~~FLs~~Form Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.	OCCURRENCE-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	~~80~~59	~~516~~425	~~517~~426	~~1.~~1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional

CLT098	CLT.002.098	OCCURRENCE-CODE-07	Occurrence Code 7	Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are ~~FLs~~Form Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.	OCCURRENCE-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	~~81~~60	~~518~~427	~~519~~428	~~1.~~1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional
CLT099	CLT.002.099	OCCURRENCE-CODE-08	Occurrence Code 8	Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are ~~FLs~~Form Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.	OCCURRENCE-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	~~82~~61	~~520~~429	~~521~~430	~~1.~~1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional
CLT100	CLT.002.100	OCCURRENCE-CODE-09	Occurrence Code 9	Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are ~~FLs~~Form Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.	OCCURRENCE-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	~~83~~62	~~522~~431	~~523~~432	~~1.~~1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional
CLT101	CLT.002.101	OCCURRENCE-CODE-10	Occurrence Code 10	Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are ~~FLs~~Form Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.	OCCURRENCE-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	~~84~~63	~~524~~433	~~525~~434	~~1.~~1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional
CLT102	CLT.002.102	OCCURRENCE-CODE-EFF-DATE-01	Occurrence Code Effective Date 1	Conditional	The start date of the corresponding occurrence code or occurrence span codes.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	~~85~~64	~~526~~435	~~533~~442	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code ~~4~~3. Conditional

													~~5~~4. Value must be less than or equal to Occurrence Code End Date
CLT103	CLT.002.103	OCCURRENCE-CODE-EFF-DATE-02	Occurrence Code Effective Date 2	Conditional	The start date of the corresponding occurrence code or occurrence span codes.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	~~86~~65	~~534~~443	~~541~~450	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code ~~4~~3. Conditional ~~5~~4. Value must be less than or equal to Occurrence Code End Date
CLT104	CLT.002.104	OCCURRENCE-CODE-EFF-DATE-03	Occurrence Code Effective Date 3	Conditional	The start date of the corresponding occurrence code or occurrence span codes.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	~~87~~66	~~542~~451	~~549~~458	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code ~~4~~3. Conditional ~~5~~4. Value must be less than or equal to Occurrence Code End Date

CLT105	CLT.002.105	OCCURRENCE-CODE-EFF-DATE-04	Occurrence Code Effective Date 4	Conditional	The start date of the corresponding occurrence code or occurrence span codes.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	~~88~~67	~~550~~459	~~557~~466	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code ~~4~~3. Conditional ~~5~~4. Value must be less than or equal to Occurrence Code End Date
CLT106	CLT.002.106	OCCURRENCE-CODE-EFF-DATE-05	Occurrence Code Effective Date 5	Conditional	The start date of the corresponding occurrence code or occurrence span codes.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	~~89~~68	~~558~~467	~~565~~474	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code ~~4~~3. Conditional ~~5~~4. Value must be less than or equal to Occurrence Code End Date
CLT107	CLT.002.107	OCCURRENCE-CODE-EFF-DATE-06	Occurrence Code Effective Date 6	Conditional	The start date of the corresponding occurrence code or occurrence span codes.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	~~90~~69	~~566~~475	~~573~~482	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code ~~4~~3. Conditional ~~5~~4. Value must be less than or equal to Occurrence Code End Date

CLT108	CLT.002.108	OCCURRENCE-CODE-EFF-DATE-07	Occurrence Code Effective Date 7	Conditional	The start date of the corresponding occurrence code or occurrence span codes.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	~~91~~70	~~574~~483	~~581~~490	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code ~~4~~3. Conditional ~~5~~4. Value must be less than or equal to Occurrence Code End Date
CLT109	CLT.002.109	OCCURRENCE-CODE-EFF-DATE-08	Occurrence Code Effective Date 8	Conditional	The start date of the corresponding occurrence code or occurrence span codes.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	~~92~~71	~~582~~491	~~589~~498	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code ~~4~~3. Conditional ~~5~~4. Value must be less than or equal to Occurrence Code End Date
CLT110	CLT.002.110	OCCURRENCE-CODE-EFF-DATE-09	Occurrence Code Effective Date 9	Conditional	The start date of the corresponding occurrence code or occurrence span codes.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	~~93~~72	~~590~~499	~~597~~506	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code ~~4~~3. Conditional ~~5~~4. Value must be less than or equal to Occurrence Code End Date

CLT111	CLT.002.111	OCCURRENCE-CODE-EFF-DATE-10	Occurrence Code Effective Date 10	Conditional	The start date of the corresponding occurrence code or occurrence span codes.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	~~94~~73	~~598~~507	~~605~~514	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code ~~4~~3. Conditional ~~5~~4. Value must be less than or equal to Occurrence Code End Date
CLT112	CLT.002.112	OCCURRENCE-CODE-END-DATE-01	Occurrence Code End Date 1	Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	~~95~~74	~~606~~515	~~613~~522	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional
CLT113	CLT.002.113	OCCURRENCE-CODE-END-DATE-02	Occurrence Code End Date 2	Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	~~96~~75	~~614~~523	~~621~~530	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional

CLT114	CLT.002.114	OCCURRENCE-CODE-END-DATE-03	Occurrence Code End Date 3	Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	~~97~~76	~~622~~531	~~629~~538	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional
CLT115	CLT.002.115	OCCURRENCE-CODE-END-DATE-04	Occurrence Code End Date 4	Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	~~98~~77	~~630~~539	~~637~~546	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional
CLT116	CLT.002.116	OCCURRENCE-CODE-END-DATE-05	Occurrence Code End Date 5	Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	~~99~~78	~~638~~547	~~645~~554	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional

CLT117	CLT.002.117	OCCURRENCE-CODE-END-DATE-06	Occurrence Code End Date 6	Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	~~100~~79	~~646~~555	~~653~~562	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional
CLT118	CLT.002.118	OCCURRENCE-CODE-END-DATE-07	Occurrence Code End Date 7	Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	~~101~~80	~~654~~563	~~661~~570	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional
CLT119	CLT.002.119	OCCURRENCE-CODE-END-DATE-08	Occurrence Code End Date 8	Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	~~102~~81	~~662~~571	~~669~~578	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional

CLT120	CLT.002.120	OCCURRENCE-CODE-END-DATE-09	Occurrence Code End Date 9	Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	~~103~~82	~~670~~579	~~677~~586	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional
CLT121	CLT.002.121	OCCURRENCE-CODE-END-DATE-10	Occurrence Code End Date 10	Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	~~104~~83	~~678~~587	~~685~~594	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional
CLT122	CLT.002.122	PATIENT-CONTROL-NUM	Patient Control Number	Conditional	A patient's unique number assigned by the provider agency during claim submission, which identifies the client or the client's episode of service within the provider's system to facilitate retrieval of individual financial and clinical records and posting of payment	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(20)	~~105~~84	~~686~~595	~~705~~614	1. Value must be 20 characters or less 2. Value must not contain a pipe or asterisk symbol 3. Conditional
CLT123	CLT.002.123	ELIGIBLE-LAST-NAME	Eligible Last Name	Conditional	The last name of the individual to whom the services were provided. (The patients name should be captured as it appears on the claim record, it does not need to be the same as it appears on the eligibility file. The MSIS Identification Number will be used to associate a claim record with the appropriate eligibility data.)	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(30)	~~106~~85	~~706~~615	~~735~~644	1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional

CLT124	CLT.002.124	ELIGIBLE-FIRST-NAME	Eligible First Name	Conditional	The first name of the individual to whom the services were provided. (The patients name should be captured as it appears on the claim record, it does not need to be the same as it appears on the eligibility file. The MSIS Identification Number will be used to associate a claim record with the appropriate eligibility data.)	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(30)	~~107~~86	~~736~~645	~~765~~674	1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional
CLT125	CLT.002.125	ELIGIBLE-MIDDLE-INIT	Eligible Middle Initial	Conditional	Individual's middle initial; middle initial component of full name (e.g. First Name, Middle Initial, Last Name).	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	~~108~~87	~~766~~675	~~766~~675	1. ~~Value may include any alphanumeric characters, digits or symbols~~ ~~2.~~ Value must be 1 character ~~3~~2. Value must not contain a pipe or asterisk symbols ~~4~~3. Conditional
CLT126	CLT.002.126	DATE-OF-BIRTH	Date of Birth	Mandatory	An individual's date of birth.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	~~109~~88	~~7~~676	~~774~~683	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3. Mandatory~~ ~~4. Value must equal Date of Birth (ELG.002.024) when Conception to Birth Indicator (ELG.005.094) does not equal '1' and Eligibility Group (ELG.005.087) does not equal '64'~~1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Mandatory

CLT127	CLT.002.127	HEALTH-HOME-PROV-IND	Health Home Provider Indicator	Conditional	Indicates whether the claim is submitted by a provider or provider group enrolled in the Health Home care model~~.~~ to provide services for the beneficiary on the claim. Health home providers provide service for patients with chronic illnesses. ~~States should not submit claim records for an eligible individual that indicate the claim was submitted by a provider or provider group enrolled in a health home model if the eligible individual is not enrolled in the health home program.~~ States that do not specify an eligible individual's health home provider number, if applicable, should not report claims that indicate the claim is submitted by a provider or provider group enrolled in the health home model.	HEALTH-HOME-PROV-IND	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	~~110~~89	~~775~~684	~~775~~684	1. Value must be in Health Home Provider Indicator List (VVL) 2. Value must be 1 character 3. If there is an associated Health Home Entity Name value, then value must be "1" ~~3. Value must be 1 character~~ ~~4.~~4. Conditional
CLT128	CLT.002.128	WAIVER-TYPE	Waiver Type	Conditional	A code for specifying waiver type under which the eligible individual is covered during the month and receiving services/under which claim is submitted.	WAIVER-TYPE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	~~111~~90	~~776~~685	~~777~~686	~~1.~~1. Value must be 2 characters 2. Value must be in Waiver Type List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Value must ~~be in ['06', '07', '08', '09', '10', '11', '12', '13', '14', '15', '16', '17', '18', '19', '20', '33'] when associated Program~~ match Eligible Waiver Type ~~equals "07"~~ ~~4.~~(ELG.012.173) for the enrollee for the same time period (by date of service) 4. Value must have a corresponding value in Waiver ID (CLT.002.129) 5. Conditional

CLT129	CLT.002.129	WAIVER-ID	Waiver ID	Conditional	Field specifying the waiver or demonstration which authorized payment for a claim. These IDs must be the approved, full federal waiver ID number assigned during the state submission and CMS approval process. Waiver IDs should actually only be the "core" part of the waiver IDs, without including suffixes for renewals or amendments.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(20)	~~112~~91	~~778~~687	~~797~~706	~~1.~~1. Value must be 20 characters or less 2. Value must be associated with a populated Waiver Type ~~2. Value must be 20 characters or less~~ ~~3.~~3. (1115 demonstration ~~waivers~~) If value begins with "11-W-" or "21-W-", the associated Claim Waiver Type value must be 01 or in [21-30] 4. (1115 demonstration) If value begins with"11-W-" or "21-W-", then the value must include slash "/" in the 11th position followed by the last digit of the CMS Region [0-9] in the 12th position 5. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation followed by a period (.), the associated Claim Waiver Type value must be in [02-20,32,33] ~~5~~6. Conditional
CLT130	CLT.002.130	BILLING-PROV-NUM	Billing Provider Number	Conditional	A unique identification number assigned by the state to a provider or ~~capitation~~managed care plan. This data element should represent the entity billing for the service. For encounter records, if associated Type of Claim value equals 3, C, or W, then value must be the state identifier of the provider or entity (billing or reporting) to the managed care plan.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(30)	~~113~~92	~~798~~707	~~827~~736	1. Value must be 30 characters or less 2. ~~Value must be reported in Provider Identifier (PRV.005.080) with an associated Provider Identifier Type (PRV.005.081) equal to '1'~~ ~~3.~~ Conditional ~~4~~3. When Type of Claim not in ~~('2','3','C','W','2","B","V"," 4","D","X")~~[3,C,W] then value may match (PRV.002.019) Submitting State Provider ID or 4. When Type of Claim not in ~~('2','3','C','W','2","B","V"," 4","D","X")~~[3,C,W] then value may match (PRV.005.081) Provider Identifier where the Provider Identifier Type ~~=~~ ~~'1'~~(PRV.005.077) equals "1" 5. ~~Ending~~Discharge Date ~~of Service~~ ~~(CLT~~(CIP.002.0~~4~~96) may be between Provider Attributes Effective Date (PRV.002.020) and Provider Attributes End Date (PRV.002.021) or

													~~Ending~~6. Discharge Date ~~of Service (CLT~~(CIP.002.0~~4~~96) may be between Provider Identifier Effective Date (PRV.005.079) and Provider Identifier End Date (PRV.005.080)
CLT131	CLT.002.131	BILLING-PROV-NPI-NUM	Billing Provider NPI Number	Conditional	~~A National Provider Identifier (NPI) is a unique 10-digit identification number issued to health care providers in the United States by CMS. Healthcare providers acquire their unique 10-digit NPIs to identify themselves in a standard way throughout their industry. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number).~~The National Provider ID (NPI) of the billing entity responsible for billing a patient for healthcare services. The billing provider can also be servicing, referring, or prescribing provider. Can be admitting provider except for Long Term Care.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(10)	~~114~~93	~~828~~737	~~837~~746	1. Value must be 10 digits~~, consisting of 9 numeric digits followed by one check digit calculated using the Luhn formula (algorithm) 2.~~ 2. Value must have an associated Provider Identifier Type equal to ~~'2'~~"2" 3. Value must exist in the NPPES NPI data file 4. Conditional ~~4~~5. When ~~Type of Claim (CLT.002.052) not in ('3','C','W') then~~populated, value must match Provider Identifier (PRV.00~~2~~5.081) and Facility Group Individual Code (PRV.002.028) must equal "01" 6. NPPES Entity Type Code associated with this NPI must equal "2" (Organization)
CLT132	CLT.002.132	BILLING-PROV-TAXONOMY	Billing Provider Taxonomy	Conditional	The taxonomy code for the institution billing for the beneficiary.	PROV-TAXONOMY	CLT00002	CLAIM-HEADER-RECORD-LT	X(12)	~~115~~94	~~838~~747	~~849~~758	~~1.~~1. Value must be 12 characters or less 2. Value must be in Provider Taxonomy List (VVL)

													~~2. Value must be 12 characters or less~~ ~~3.~~3. Conditional
CLT133	CLT.002.133	BILLING-PROV-TYPE	Billing Provider Type	Conditional	A code to describe the type of ~~entity billing for the service~~provider being reported.	PROV-TYPE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	~~116~~95	~~850~~759	~~851~~760	~~1.~~1. Value must be 2 characters 2. Value must be in Provider Type Code List (VVL~~).~~ ~~2. Value must be 2 characters~~ ~~)~~ 3. Conditional
CLT134	CLT.002.134	BILLING-PROV-SPECIALTY	Billing Provider Specialty	Conditional	This code describes the area of specialty for the provider being reported.	PROV-SPECIALTY	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	~~117~~96	~~852~~761	~~853~~762	~~1.~~1. Value must be 2 characters 2. Value must be in Provider Specialty List (VVL~~).~~ ~~2. Value must be 2 characters~~ ~~)~~ 3. Conditional
CLT135	CLT.002.135	REFERRING-PROV-NUM	Referring Provider Number	Conditional	A unique identification number assigned to a provider which identifies the physician or other provider who referred the patient. For physicians, this must be the individual's ID number, not a group identification number. If the referring provider number 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.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(30)	~~118~~97	~~854~~763	~~883~~792	1. Value must be 30 characters or less 2. ~~Value must be reported in Provider Identifier (PRV.005.080) with an associated Provider Identifier Type (PRV.005.081) equal to '1'~~ ~~3.~~ Conditional
CLT136	CLT.002.136	REFERRING-PROV-NPI-NUM	Referring Provider NPI Number	Conditional	~~A National Provider Identifier (NPI) is a unique 10-digit identification number issued to health care providers in the United States by CMS. Healthcare providers acquire their unique 10-digit NPIs to identify themselves in a standard way throughout their industry. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number).~~The National Provider ID (NPI) of the provider who	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(10)	~~119~~98	~~884~~793	~~893~~802	1. Value must be 10 digits~~, consisting of 9 numeric digits followed by one check digit calculated using the Luhn formula (algorithm)~~ ~~2.~~ 2. Value must have an associated Provider Identifier Type equal to ~~'2'~~"2" 3. Value must exist in the NPPES NPI data file 4. Conditional

					recommended the servicing provider to the patient.								
~~CLT137~~	~~CLT.002.137~~	~~REFERRING-PROV-TAXONOMY~~	~~Referring Provider Taxonomy~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~CLT00002~~	~~CLAIM-HEADER-RECORD-LT~~	~~X(12)~~	~~120~~	~~894~~	~~905~~	~~1. Not Applicable~~
~~CLT138~~	~~CLT.002.138~~	~~REFERRING-PROV-TYPE~~	~~Referring Provider Type~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~CLT00002~~	~~CLAIM-HEADER-RECORD-LT~~	~~X(2)~~	~~121~~	~~906~~	~~907~~	~~1. Not Applicable~~
~~CLT139~~	~~CLT.002.139~~	~~REFERRING-PROV-SPECIALTY~~	~~Referring Provider Specialty~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~CLT00002~~	~~CLAIM-HEADER-RECORD-LT~~	~~X(2)~~	~~122~~	~~908~~	~~909~~	~~1. Not Applicable~~
CLT140	CLT.002.140	MEDICARE-HIC-NUM	Medicare HIC Number	Conditional	The Medicare HIC Number (HICN) is an identifier formerly used by SSA and CMS to identify all Medicare beneficiaries. For many beneficiaries, their SSN was a major component of their HICN. To prevent identify theft, among other reasons, HICN gradually were retired and replaced by the Medicare Beneficiary Identifier (MBI) over the course of 2018 and 2019. HICN continue to be used by Medicare for limited administrative purposes after 2019 but starting in 2020 the MBI became the primary identifier for Medicare beneficiaries. HICN consists of two components: SSN ~~&~~and alpha-suffix or (for Railroad IDs) prefix and ID (not always SSN based~~)~~).	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(12)	~~123~~99	~~910~~803	~~921~~814	1. ~~Conditional~~ ~~2.~~ Value must be 12 characters or less 2. Conditional 3. Value must not contain a pipe or asterisk symbols 4. (Not Dual Eligible) if Dual Eligible Code (ELG.DE.085) value ~~=~~equals "00", then value must not be populated~~.~~ 5. Value must be populated when Crossover Indicator (CLT.002.023) equals ~~'1'~~"1" and Medicare Beneficiary Identifier (CLT.002.168) is not populated~~.~~

CLT141	CLT.002.141	PATIENT-STATUS	Patient Status	Mandatory	A code indicating the patient's status as of the last day the claim covers. Values used are from UB-04. This is also referred to as patient discharge status. A valid list of codes can be purchased at: https://www.nubc.org/license	PATIENT-STATUS	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	~~124~~100	~~922~~815	~~923~~816	~~1.~~1. Value must be 2 characters 2. Value must be in Patient Status List (VVL~~).~~ ~~2. Value must be 2 characters~~) 3. Mandatory
~~CLT143~~	~~CLT.002.143~~	~~BMI~~	~~Body Mass Index~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~CLT00002~~	~~CLAIM-HEADER-RECORD-LT~~	~~S9(5)V9~~	~~125~~	~~924~~	~~929~~	~~1. Not Applicable~~
CLT144	CLT.002.144	REMITTANCE-NUM	Remittance Number	Mandatory	The Remittance Advice Number is a sequential number that identifies the current Remittance Advice (RA) produced for a provider. The number is incremented by one each time a new RA is generated. ~~The first five (5) positions are Julian date following a YYDDD format.~~ The RA is the detailed explanation of the reason for the payment amount. ~~The RA number is not the check number.~~	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(30)	~~126~~101	~~930~~817	~~959~~846	1. Value must be 30 characters or less 2. ~~First five (5) characters of the value must be a Julian date express in the form YYDDD (e.g. 19095, 95th day of 20(19))~~ ~~3.~~ Value must not contain a pipe or asterisk symbols ~~4~~3. Mandatory
CLT145	CLT.002.145	LTC-RCP-LIAB-AMT	LTC RCP Liability Amount	Conditional	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.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11)V99	102~~7~~	~~960~~847	~~972~~859	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
~~CLT146~~	~~CLT.002.146~~	~~DAILY-RATE~~	~~Daily Rate~~	~~Conditional~~	~~The amount a policy will pay per day for a covered service.~~	~~N/A~~	~~CLT00002~~	~~CLAIM-HEADER-RECORD-LT~~	~~S9(5)V99~~	~~128~~	~~973~~	~~979~~	~~1. Value must be between 0.00 and 99999.99~~ ~~2. Conditional~~ ~~3. Value must be expressed as a number with 2-digit precision (e.g. 100.50)~~

CLT147	CLT.002.147	ICF-IID-DAYS	ICF IID Days	Conditional	The number of days of intermediate care for individuals with an intellectual disability that were paid for in whole or in part by Medicaid. If value exceeds 99998 days, code as 99998. (e.g., code 100023 as 99998).	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(5)	~~129~~103	~~9~~860	~~9~~864	1. Value must be 5 digits or less 2. Conditional 3. Value is mandatory when associated Type of Service (CLT.003.211) ~~= '046'~~equals "046" 4. Value must be less than or equal to the number of days between (ending date of service minus beginning date of service) plus one day 5. When populated, if value is greater than 0 and less than 99998, then Level of Care Status (ELG.005.088) for the associated MSIS Identification Number (CLT.002.022) must equal ~~'~~"004~~'~~" (ICF/IID) for the same month as the begin and end date of service
CLT148	CLT.002.148	LEAVE-DAYS	Leave Days	Conditional	The number of days, during the period covered by Medicaid, on which the patient did not reside in the long term care facility.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(5)	1~~3~~04	~~9~~865	~~9~~869	1. Value must be numeric 2. Value must be 5 digits or less 3. Conditional 4. (Intermediate Care Facility for Individuals with Intellectual Disabilities) value is required when Type of Service (CLT.003.211) in [009,045,046,047,059]

CLT149	CLT.002.149	NURSING-FACILITY-DAYS	Nursing Facility Days	Conditional	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. If value exceeds 99998 days, code as 99998.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(5)	~~131~~105	~~990~~870	~~994~~874	~~1. Value must be numeric~~ ~~2.~~1. Value must be 5 digits or less 2. Value must be numeric 3. Conditional 4. When populated, value must be less than or equal to the number of days between (ending date of service minus beginning date of service) plus one day 5. (nursing facility) value is required when the Type of Service in [009,045,047,059] 6. When populated, if value is greater than zero, then Level of Care Status (ELG.005.088) for the associated MSIS Identification Number (CLT.002.022) must equal '~~'~~003'~~'~~ (Nursing Facility) for the same month as the beginning and ending date of service
CLT150	CLT.002.150	SPLIT-CLAIM-IND	Split Claim Indicator	Conditional	An indicator that denotes that claims in excess of a pre-determined number of claim lines (threshold determined by the individual state) will be split during processing.	SPLIT-CLAIM-IND	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	~~132~~106	~~995~~875	~~995~~875	~~1.~~1. Value must be 1 character 2. Value must be in Split Claim Indicator List (VVL~~).~~ ~~2. Value must be 1 character~~ ~~)~~ 3. Conditional
CLT151	CLT.002.151	BORDER-STATE-IND	Border State Indicator	Conditional	A code to indicate whether an individual received services or equipment across state borders. (The provider location is out of state, but for payment purposes the provider is treated as an in-state provider.)	BORDER-STATE-IND	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	~~133~~107	~~996~~876	~~996~~876	~~1.~~1. Value must be 1 character 2. Value must be in Border State Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Conditional
CLT153	CLT.002.153	TOT-BENEFICIARY-COINSURANCE-PAID-AMOUNT	Total Beneficiary Coinsurance Paid Amount	Conditional	The amount ~~of money~~ the beneficiary or his or her representative (e.g., their guardian) paid towards their coinsurance for the covered services on the claim. Do not include coinsurance payments made by a third party/s on behalf of the beneficiary.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11) V99	~~134~~108	~~997~~877	~~100~~988 9	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. ~~Must have an associated Beneficiary Coinsurance Date Paid~~ ~~4.~~ Conditional

CLT154	CLT.002.154	BENEFICIARY-COINSURANCE-DATE-PAID	Beneficiary Coinsurance Date Paid	Conditional	The date the beneficiary paid the coinsurance amount.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	~~135~~109	~~101~~0890	~~101~~7897	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3. Must~~ in the form "CCYYMMDD" 2. When populated, value must have an associated Beneficiary Coinsurance Amount ~~4~~3. Conditional
CLT155	CLT.002.155	TOT-BENEFICIARY-COPAYMENT-PAID-AMOUNT	Total Beneficiary Copayment Paid Amount	Conditional	The amount ~~of money~~ the beneficiary or his or her representative (e.g., their guardian) paid towards their copayment for the covered services on the claim. Do not include copayment payments made by a ~~co-payment.~~third party/s on behalf of the beneficiary..	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11) V99	~~136~~110	~~101~~898	910~~30~~	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. ~~Must have an associated Beneficiary Copayment Date Paid~~ ~~4.~~Conditional
CLT156	CLT.002.156	BENEFICIARY-COPAYMENT-DATE-PAID	Beneficiary Copayment Date Paid	Conditional	The date the beneficiary paid the copayment amount.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	~~137~~111	910~~3~~1	910~~3~~8	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3. Must~~ in the form "CCYYMMDD" 2. When populated, value must have an associated Beneficiary Copayment Amount ~~4~~3. Conditional
CLT157	CLT.002.157	TOT-BENEFICIARY-DEDUCTIBLE-PAID-AMOUNT	Total Beneficiary Deductible Paid Amount	Conditional	The amount ~~of money~~ the beneficiary or his or her representative (e.g., their guardian) paid towards ~~an annual deductible~~their copayment for the covered services on the claim. Do not include copayment payments made by a third party/s on behalf of the beneficiary.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11) V99	~~138~~112	910~~3~~9	~~105~~1931	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. ~~Must have an associated Beneficiary Deductible Date Paid~~ ~~4.~~Conditional

CLT158	CLT.002.158	BENEFICIARY-DEDUCTIBLE-DATE-PAID	Beneficiary Deductible Date Paid	Conditional	The date the beneficiary paid the deductible amount.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	1139	1052932	1059939	1. Value must be 8 characters in the form "CCYYMMDD" 2. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st) 3. Must in the form "CCYYMMDD" 2. When populated, value must have an associated Beneficiary Deductible Date Paid 4Amount 3. Conditional
CLT159	CLT.002.159	CLAIM-DENIED-INDICATOR	Claim Denied Indicator	Mandatory	An indicator to identify a claim that the state refused pay in its entirety.	CLAIM-DENIED-INDICATOR	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	1140	1060940	1060940	1.1. Value must be 1 character 2. Value must be in Claim Denied Indicator List (VVL) 23. If value is '0',equals "0", then Claim Status Category must equal "F2" 3. Value must be 1 character 4.4. Mandatory
CLT160	CLT.002.160	COPAY-WAIVED-IND	Copayment Waived Indicator	OpSituational	An indicator signifying that the copay was discounted or waived by the provider (e.g., physician or hospital). Do not use to indicate administrative-level, Medicaid State Agency or Medicaid MCO copayment waived decisions.	COPAY-WAIVED-IND	CLT00002	CLAIM-HEADER-RECORD-LT	X(1)	1415	1061941	1061941	1.1. Value must be 1 character 2. Value must be in Copay Waived Indicator List (VVL) 2. Value must be 1 character 3. Optional3. Situational
CLT161	CLT.002.161	HEALTH-HOME-ENTITY-NAME	Health Home Entity Name	Conditional	A free-form text field to indicate the health home program that authorized payment for the service on the claim. or to identify the health home SPA in which an individual is enrolled. The name entered should be the name that the state uses to uniquely identify the team. A "Health Home Entity" can be a designated provider (e.g., physician, clinic, behavioral health organization), a health team which links to a designated provider, or a health team (physicians, nurses, behavioral health professionals). Because an identification	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(50)	142116	1062942	1111991	1. Value must 50 characters or less 2.1. Value must not contain a pipe or asterisk symbols 2. Value must 50 characters or less 3. Conditional

					numbering schema has not been established, the entities' names are being used instead.								
CLT163	CLT.002.163	THIRD-PARTY-COINSURANCE-AMOUNT-PAID	Third Party Coinsurance Amount Paid	~~Op~~Situati~~o~~nal	The amount of money paid by a third party on behalf of the beneficiary towards coinsurance ~~on the claim or claim line item~~.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11) V99	~~143~~117	~~111~~2992	1~~12~~004	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. ~~Op~~Situational
CLT164	CLT.002.164	THIRD-PARTY-COINSURANCE-DATE-PAID	Third Party Coinsurance Date Paid	Conditional	The date ~~a Third Party Coinsurance~~the third party paid the coinsurance amount ~~was paid on this claim or adjustment.~~	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	~~144~~118	1~~12~~005	101~~3~~2	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~in the form "CCYYMMDD" 2. When populated, value must have an associated Third Party Coinsurance Amount 3. Conditional
CLT165	CLT.002.165	THIRD-PARTY-COPAYMENT-AMOUNT-PAID	Third Party Copayment Amount Paid	~~Op~~Situati~~o~~nal	The amount of money paid by a third ~~-~~party on behalf of the beneficiary ~~paid~~ towards ~~a~~ copayment.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11) V99	~~145~~119	10133	1~~14~~025	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. ~~Op~~Situational

CLT166	CLT.002.166	THIRD-PARTY-COPAYMENT-DATE-PAID	Third Party Copayment Date Paid	~~Op~~Situati onal	The date ~~a Third Party~~the third party paid the copayment amount ~~was paid on a claim or adjustment~~.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	9(8)	~~146~~120	1~~14~~026	1~~150~~33	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~in the form "CCYYMMDD" 2. When populated, value must have an associated Third Party Copayment Amount 3. ~~Op~~Situational
CLT167	CLT.002.167	HEALTH-HOME-PROVIDER-NPI	Health Home Provider NPI Number	Conditional	~~A National Provider Identifier (NPI) is a unique 10-digit identification number issued to health care providers in the United States by CMS. Healthcare providers acquire their unique 10-digit NPIs to identify themselves in a standard way throughout their industry. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number).~~The National Provider ID (NPI) of the health home provider.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(12)	~~147~~121	1~~15~~034	1~~16~~045	1. Value must be ~~10~~12 digits~~, consisting of 9 numeric digits followed by one check digit calculated using the Luhn formula (algorithm)~~ ~~2.~~ 2. Value must have an associated Provider Identifier, where Provider Identifier Type ~~equal to '2'~~(PRV.005.077) equals "2" 3. Value must exist in the NPPES NPI data file 4. Conditional

CLT168	CLT.002.168	MEDICARE-BENEFICIARY-IDENTIFIER	Medicare Beneficiary Identifier	Conditional	The Medicare Beneficiary Identifier (MBI) is a randomly generated identifier used to identify all Medicare beneficiaries. It replaced the previously-used SSN-based Medicare HIC Number (HICN). To prevent identify theft, among other reasons, HICN gradually were retired and replaced by the MBI over the course of 2018 and 2019. Starting in 2020, the MBI became the primary identifier for Medicare beneficiaries.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(12)	~~148~~122	1~~1~~04~~6~~6	1~~1~~05~~7~~7	1. Conditional 2. Value must be an 11-character string 3. Character 1 must be numeric values 1 thru 9 4. Character 2 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 5. Character 3 must be alphanumeric values 0 thru 9 or A thru Z (minus S,L,O,I,B,Z) 6. Character 4 must be numeric values 0 thru 9 7. Character 5 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 8. Character 6 must be alphanumeric values 0 thru 9 or A thru Z (minus S,L,O,I,B,Z) 9. Character 7 must be numeric values 0 thru 9 10. Character 8 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 11. Character 9 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 12. Character 10 must be numeric values 0 thru 9 13. Character 11 must be numeric values 0 thru 9 14. Value must not contain a pipe or asterisk symbols ~~15. Not Applicable~~
~~CLT169~~	~~CLT.002.169~~	~~UNDER-DIRECTION-OF-PROV-NPI~~	~~Under Direction of Provider NPI~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~CLT00002~~	~~CLAIM-HEADER-RECORD-LT~~	~~X(12)~~	~~149~~	~~1178~~	~~1189~~	~~1. Not Applicable~~
~~CLT170~~	~~CLT.002.170~~	~~UNDER-DIRECTION-OF-PROV-TAXONOMY~~	~~Under Direction of Provider Taxonomy~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for~~	~~N/A~~	~~CLT00002~~	~~CLAIM-HEADER-RECORD-LT~~	~~X(12)~~	~~150~~	~~1190~~	~~1201~~	~~1. Not Applicable~~

					~~specific definition and coding requirement description(s).]~~								
~~CLT171~~	~~CLT.002.171~~	~~UNDER-SUPERVISION-OF-PROV-NPI~~	~~Under Supervision of Provider NPI~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~CLT00002~~	~~CLAIM-HEADER-RECORD-LT~~	~~X(12)~~	~~151~~	~~1202~~	~~1213~~	~~1. Not Applicable~~
~~CLT172~~	~~CLT.002.172~~	~~UNDER-SUPERVISION-OF-PROV-TAXONOMY~~	~~Under Supervision of Provider Taxonomy~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~CLT00002~~	~~CLAIM-HEADER-RECORD-LT~~	~~X(12)~~	~~152~~	~~1214~~	~~1225~~	~~1. Not Applicable~~
CLT173	CLT.002.173	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(500)	15~~9~~0	~~1295~~16 03	~~1794~~21 02	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
CLT174	CLT.002.174	ADMITTING-PROV-NPI-NUM	Admitting Provider NPI Number	Conditional	~~A National Provider Identifier (NPI) is a unique 10-digit identification number issued to health care providers in the United States by CMS. Healthcare providers acquire their unique 10-digit NPIs to identify themselves in a standard way throughout their industry. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number).~~The National Provider ID (NPI) of the doctor responsible for admitting a patient to a hospital or other inpatient health facility.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(10)	1~~5~~23	~~1226~~10 58	~~1235~~10 67	1. Value must be 10 digits~~, consisting of 9 numeric digits followed by one check digit calculated using the Luhn formula (algorithm) 2.~~ 2. Conditional 3. Value must have an associated Provider Identifier Type equal to ~~'2'~~ ~~3. Conditional~~"2" 4. Value must exist in the NPPES NPI File
CLT175	CLT.002.175	ADMITTING-PROV-NUM	Admitting Provider Number	Conditional	The Medicaid ID of the doctor responsible for admitting a patient to a hospital or other inpatient health facility.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(30)	1~~5~~24	1~~23~~06~~8~~	~~1265~~10 97	1. Value must be 30 characters or less 2. ~~Value must be reported in Provider Identifier (PRV.005.080) with an associated Provider Identifier Type (PRV.005.081) equal to '1'~~ ~~3.~~ Conditional

CLT176	CLT.002.176	ADMITTING-PROV-SPECIALTY	Admitting Provider Specialty	Conditional	This code describes the area of specialty for the provider being reported.	PROV-SPECIALTY	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	1255	12661098	12671099	1. 1. Value must be 2 characters 2. Value must be in Provider Specialty List (VVL). 2. Value must be 2 characters) 3. Conditional
CLT177	CLT.002.177	ADMITTING-PROV-TAXONOMY	Admitting Provider Taxonomy	Conditional	Taxonomic classification (code) for a given healthcare provider, as defined by the National Uniform Claim Committee.	PROV-TAXONOMY	CLT00002	CLAIM-HEADER-RECORD-LT	X(12)	1526	12681100	12791111	1. 1. Value must be 12 characters or less 2. Value must be in Provider Taxonomy List (VVL) 2. Value must be 12 characters or less 3. 3. Conditional
CLT178	CLT.002.178	ADMITTING-PROV-TYPE	Admitting Provider Type	Conditional	A code to describe the type of entity billing for the serviceprovider being reported.	PROV-TYPE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	1527	111280	128113	1. Value must be 12 characters or less 2. Value must be in Provider Type CodeTaxonomy List (VVL). 2. Value must be 2 characters) 3. Conditional
CLT179	CLT.002.179	MEDICARE-PAID-AMT	Medicare Paid Amount	Conditional	The amount paid by Medicare on this claim or adjustment. For claims where Medicare payment is only available at the line level, report the sum of all the line level Medicare payment amounts at the header.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11)V99	1528	12811114	112946	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Crossover Indicator value isequals "0", then the Medicare Paid Amount value must not be populated. 4. Conditional 5. If value is populated, Crossover Indicator must be equal to "1"

CLT184	CLT.003.184	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	CLT00003	CLAIM-LINE-RECORD-LT	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "CLT00003"
CLT185	CLT.003.185	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	CLT00003	CLAIM-LINE-RECORD-LT	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (CLT.001.007)
CLT186	CLT.003.186	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	CLT00003	CLAIM-LINE-RECORD-LT	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory

CLT187	CLT.003.187	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual ~~(except on service tracking payments).~~ . Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47572~~reporting-shared-msis-identification-numbers-eligibility/	N/A	CLT00003	CLAIM-LINE-RECORD-LT	X(20)	4	22	41	~~1. Mandatory~~ ~~2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN~~ ~~3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN~~ ~~4. Value must be 20 characters or less~~ ~~5. When Type of Claim (CLT.002.052) equals 4, D or X (lump sum payment) value must begin with an '&'~~1. Value must be 20 characters or less 2. Mandatory
CLT188	CLT.003.188	ICN-ORIG	Original ICN	Mandatory	A unique number assigned by the state's payment system that identifies an original or adjustment claim.	N/A	CLT00003	CLAIM-LINE-RECORD-LT	X(50)	5	42	91	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
CLT189	CLT.003.189	ICN-ADJ	Adjustment ICN	Conditional	A unique claim number assigned by the state's payment system that identifies the adjustment claim for an original transaction.	N/A	CLT00003	CLAIM-LINE-RECORD-LT	X(50)	6	92	141	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value ~~is~~ equals "0~~,~~", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated

CLT190	CLT.003.190	LINE-NUM-ORIG	Original Line Number	Mandatory	A unique number to identify the transaction line number that is being reported on the original claim.	N/A	CLT00003	CLAIM-LINE-RECORD-LT	X(3)	7	142	144	1. Value must be 3 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory 4. ~~When populated, value~~Value must be one or greater
CLT191	CLT.003.191	LINE-NUM-ADJ	Adjustment Line Number	Conditional	A unique number to identify the transaction line number that identifies the line number on the adjustment claim.	N/A	CLT00003	CLAIM-LINE-RECORD-LT	X(3)	8	145	147	1. Value must be 3 characters or less 2. If associated Line Adjustment Indicator value ~~is~~ equals "0~~,~~", then value must not be populated 3. If associated Line Adjustment Indicator value ~~is~~ equals "1~~,~~", then value is mandatory and must be provided 4. Conditional 5. When populated, value must be one or greater
CLT192	CLT.003.192	LINE-ADJUSTMENT-IND	Line Adjustment Indicator	Conditional	A code to indicate the type of adjustment record claim/encounter represents at claim detail level.	LINE-ADJUSTMENT-IND	CLT00003	CLAIM-LINE-RECORD-LT	X(1)	9	148	148	~~1.~~1. Value must be 1 character 2. Value must be in Line Adjustment Indicator List (VVL) ~~2. If associated Type of Claim value is in [1,~~ 3~~, 5, A, C, E, U, W, Y], then value must be in [0, 1, 4]~~ ~~3. If associated Type of Claim value is in [4, D, X], then value~~. Value must be in [~~5, 6~~] ~~4. Value must be 1 character~~ ~~5.~~0,1,4] 4. Conditional ~~6~~5. If associated Line Adjustment Number is populated, then value must be populated
CLT193	CLT.003.193	LINE-ADJUSTMENT-REASON-CODE	Line Adjustment Reason Code	Conditional	Claim adjustment reason codes communicate why a service line was paid differently than it was billed.	LINE-ADJUSTMENT-REASON-CODE	CLT00003	CLAIM-LINE-RECORD-LT	X(3)	10	149	151	~~1.~~1. Value must be 3 characters or less 2. Value must be in Line Adjustment Reason Code List (VVL) ~~2. Value must be 3 characters or less~~ ~~3.~~3. Conditional 4. ~~When populated, Line Adjustment Indicator~~Value must be populated when the

													total paid amount is different from the total billed amount
CLT194	CLT.003.194	SUBMITTER-ID	Submitter ID	Mandatory	The Submitter Identification number is the value that identifies the provider/trading partner/clearing house organization to the state's claim adjudication system.	N/A	CLT00003	CLAIM-LINE-RECORD-LT	X(12)	11	152	163	1. Value must be 12 characters or less 2. Mandatory
CLT195	CLT.003.195	CLAIM-LINE-STATUS	Claim Line Status	Conditional	The ~~Claim Line Status conveys~~claim line status codes from the 277 transaction set identify the status of a specific ~~service~~detail claim line ~~using~~rather than the ~~X12 Claim Status Codes from~~entire claim. Only report the claim ~~adjudication process~~line for the final, adjudicated claim.	CLAIM-STATUS	CLT00003	CLAIM-LINE-RECORD-LT	X(3)	12	164	166	~~1.~~1. Value must be 3 characters or less 2. Value must be in Claim Status List (VVL) ~~2. Value must be 3 characters or less~~ ~~3.~~3. Conditional 4. If value in [545,585,654], then Claim Denied Indicator must be "0" and Claim Status Category must be"F2"
CLT196	CLT.003.196	BEGINNING-DATE-OF-SERVICE	Beginning Date of Service	Mandatory	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, this would be 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. For financial transactions reported to the OT file, populate with the first day of the time period covered by this financial transaction.~~	N/A	CLT00003	CLAIM-LINE-RECORD-LT	9(8)	13	167	174	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3. When Type of Claim is not in ['2', '4', 'B', 'D', 'V'] value must be~~ in the form "CCYYMMDD" 2. Value must be less than or equal to associated End of Time Period value ~~4~~3. Value must be less than or equal to associated Ending Date of Service value ~~5. When Type of Claim is not in ['2', '4', 'B', 'D', 'V'] value~~4. Value must be less than or equal to associated Adjudication Date value ~~6~~5. Value must be less than or equal to associated Date of Death (ELG.002.025) value when populated ~~7~~6. Value must be less than or equal to at

													least one of the eligible's Enrollment End Date (ELG.021.254) values ~~8~~7. Mandatory
CLT197	CLT.003.197	ENDING-DATE-OF-SERVICE	Ending Date of Service	Mandatory	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. For financial transactions reported to the OT file, populate with the first day of the time period covered by this financial transaction.~~	N/A	CLT00003	CLAIM-LINE-RECORD-LT	9(8)	14	175	182	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3. When Type of Claim is not in ['2', '4', 'B', 'D', 'V'] value must be~~ in the form "CCYYMMDD" 2. Value must be less than or equal to associated End of Time Period value ~~4~~3. Value must be greater than or equal to associated Beginning Date of Service value ~~5. When Type of Claim is not in ['2', '4', 'B', 'D', 'V'] value~~4. Value must be less than or equal to associated Adjudication Date value ~~6~~5. Value must be less than or equal to associated Date of Death (ELG.002.025) value when populated ~~7~~6. Value must be equal to or greater than associated Date of Birth (ELG.002.024) value ~~8~~7. Mandatory

CLT198	CLT.003.198	REVENUE-CODE	Revenue Code	Mandatory	A code which identifies a specific accommodation, ancillary service or billing calculation (as defined by UB-04 Billing Manual). Revenue Code should be passed through to T-MSIS exactly as it was billed by the provider on the provider's 837I or UB-04 claim. It is only required on Inpatient, Long-Term Care and Other Fee for Service claims and managed care encounters that have a valid Type of Bill value. It's not required on financial transactions or non-institutional claims.	REVENUE-CODE	CLT00003	CLAIM-LINE-RECORD-LT	X(4)	15	183	186	~~1.~~1. Value must be 4 characters or less 2. Value must be in Revenue Code List (VVL) ~~2~~3. A Revenue Code value requires an associated Revenue Charge ~~3. Value must be 4 characters or less~~ ~~4.~~4. Mandatory
~~CLT201~~	~~CLT.003.201~~	~~IMMUNIZATION-TYPE~~	~~Immunization Type~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~CLT00003~~	~~CLAIM-LINE-RECORD-LT~~	~~X(2)~~	~~16~~	~~187~~	~~188~~	~~1. Not Applicable~~
CLT202	CLT.003.202	~~IP-LT~~REVENUE-CENTER-QUANTITY-~~OF-SERVICE~~ ACTUAL	~~IP-LT~~Revenue Center Quantity ~~of Service~~ Actual	~~Not Applicable~~ Mandatory	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~On facility claims/encounters, this field is to capture the actual service quantity by revenue code category, e.g., number of days in a particular type of accommodation, pints of blood, etc. However, when HCPCS codes are required for services, the units are equal to the number of times the procedure/service being reported was performed. For CLAIMOT claims/encounter records use Service Quantity Actual and CLAIMRX claims/encounter records use the Prescription Quantity Actual field	N/A	CLT00003	CLAIM-LINE-RECORD-LT	S9(6)V999	~~17~~16	18~~9~~7	19~~7~~5	~~1. Not Applicable~~1. Value must be numeric 2. Value may include up to 6 digits to the left of the decimal point, and 3 digits to the right e.g. 123456.789 3. Mandatory

CLT203	CLT.003.203	~~IP LT~~REVENUE-CENTER-QUANTITY-~~OF SERVICE~~ ALLOWED	~~IP LT~~Revenue Center Quantity ~~of Service~~ Allowed	~~Not Applicable~~Conditional	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~On facility claims/encounters, this field is to capture maximum allowable quantity by revenue code category, e.g., number of days in a particular type of accommodation, pints of blood, etc. However, when HCPCS codes are required for services, the units are equal to the number of times the procedure/service being reported was allowed. 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 CLAIMOT claims/encounters use Service Quantity Allowed and CLAIMRX claims/encounters use the Prescription Quantity Allowed field.	N/A	CLT00003	CLAIM-LINE-RECORD-LT	S9(6)V999	~~18~~17	19~~8~~6	20~~6~~4	~~1. Not Applicable~~1. Value must be numeric 2. Value may include up to 6 digits to the left of the decimal point, and 3 digits to the right, e.g. 123456.789 3. Conditional

CLT204	CLT.003.204	REVENUE-CHARGE	Revenue Charge	Conditional	The total amount billed for the related Revenue Code. Total amount billed includes both covered and non-covered charges (as defined by UB-04 Billing Manual). For encounter records, Type of Claim = 3, C, or W, this field should be populated with the amount that the provider billed to the managed care plan. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the amount that the provider billed the sub-capitated entity at the claim line detail level. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.	N/A	CLT00003	CLAIM-LINE-RECORD-LT	S9(11) V99	~~19~~18	20~~7~~5	21~~9~~7	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Value must be less than or equal to associated Total Billed Amount value. 4. When populated, associated claim line Revenue Charge must be populated 5. Conditional

CLT205	CLT.003.205	ALLOWED-AMT	Allowed Amount	Conditional	The maximum amount displayed at the claim line level as determined by the payer as being "'allowable"' under the provisions of the contract prior to the determination of actual payment. On Fee for Service claims the Allowed Amount is determined by the state's MMIS (or PBM). On managed care encounters the Allowed Amount is determined by the managed care organization. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the amount that the sub-capitated entity allowed at the claim line detail level. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.	N/A	CLT00003	CLAIM-LINE-RECORD-LT	S9(11) V99	2019	220218	2320	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CLT206	CLT.003.206	TPL-AMT	Third Party LiabilityTPL Amount	Conditional	Third-party liability refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a state plan. This is the total amount denoted at the claim detail level paid by the third party.	N/A	CLT00003	CLAIM-LINE-RECORD-LT	S9(11) V99	2120	2331	2453	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CLT207	CLT.003.207	OTHER-INSURANCE-AMT	Other Insurance Amount	Conditional	The amount paid by insurance other than Medicare or Medicaid on this claim.	N/A	CLT00003	CLAIM-LINE-RECORD-LT	S9(11) V99	2221	2464	2586	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional

CLT208	CLT.003.208	MEDICAID-PAID-AMT	Medicaid Paid Amount	Conditional	The amount paid by Medicaid/CHIP agency or the managed care plan on this claim or adjustment at the claim detail level. ~~For claims where Medicaid payment is only available at the header level, report the entire payment amount on the T-MSIS record corresponding to the line item with the highest charge or the 1st detail. Zero fill Medicaid Amount Paid on all other MSIS records created from the original claim.~~For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the amount that the sub-capitated entity paid the provider at the claim line detail level. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.	N/A	CLT00003	CLAIM-LINE-RECORD-LT	S9(11) V99	~~23~~22	25~~9~~7	~~271~~269	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50~~)~~ ~~3. Conditional~~) 3. Conditional 4. Value should not be populated or should be equal to zero, when associated Claim Line Status is in [542,585,654]
CLT209	CLT.003.209	MEDICAID-FFS-EQUIVALENT-AMT	Medicaid FFS Equivalent Amount	Conditional	The amount that would have been paid had the services been provided on a Fee for Service basis.	N/A	CLT00003	CLAIM-LINE-RECORD-LT	S9(11) V99	~~24~~23	27~~2~~0	28~~4~~2	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Type of Claim value ~~equals '3,~~ in [3,C,W~~']~~, then value is mandatory and must be provided 4. Conditional
CLT210	CLT.003.210	BILLING-UNIT	Billing Unit	Conditional	Unit of billing that is used for billing services by the facility.	BILLING-UNIT	CLT00003	CLAIM-LINE-RECORD-LT	X(2)	~~25~~24	28~~5~~3	28~~6~~4	~~1.~~1. Value must be 2 characters 2. Value must be in Billing Unit List (VVL~~).~~ ~~2. Value must be 2 characters~~ ~~)~~ 3. Conditional

CLT211	CLT.003.211	TYPE-OF-SERVICE	Type of Service	Mandatory	A code to categorize the services provided to a Medicaid or CHIP enrollee.	TYPE-OF-SERVICE-LT	CLT00003	CLAIM-LINE-RECORD-LT	X(3)	~~26~~25	28~~7~~5	28~~9~~7	1. Value must be 3 characters 2. Mandatory 3. Value must ~~satisfy the requirements of~~be in Type of Service ~~(Long Term Claim)~~LT List (VVL)
CLT212	CLT.003.212	SERVICING-PROV-NUM	Servicing Provider Number	Conditional	A unique number to identify the provider who treated the recipient. The Servicing Provider Number should be for the individual doctor who rendered the service. If "Servicing" provider and the "Billing" provider such as a sole-practitioner are the same then use the same number in both fields. The value is conditional as its usage varies by state.	N/A	CLT00003	CLAIM-LINE-RECORD-LT	X(30)	~~27~~26	~~290~~288	31~~9~~7	1. Value must be 30 characters or less 2. ~~Value must be reported in Provider Identifier (PRV.005.080) with an associated Provider Identifier Type (PRV.005.081) equal to '1'~~ ~~3.~~ Conditional ~~4~~3. When Type of Claim not in ~~('Z','3','C','W',"2","B","V"," 4","D","X")~~[3,C,W], then value may match (PRV.005.081) Provider Identifier or 4. When Type of Claim not in ~~('Z','3','C','W',"2","B","V"," 4","D","X")~~ [3,C,W], then value may match (PRV.002.019) Submitting State Provider ID
CLT213	CLT.003.213	SERVICING-PROV-NPI-NUM	Servicing Provider NPI Number	Conditional	~~A National Provider Identifier (NPI) is a unique 10-digit identification number issued to health care providers in the United States by CMS. Healthcare providers acquire their unique 10-digit NPIs to identify themselves in a standard way throughout their industry. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number).~~The NPI of the health care professional who delivers or completes a particular medical service or non-surgical procedure. The Servicing Provider NPI Number is required when rendering provider is different than the attending provider and state or federal regulatory requirements call for a "combined claim" (i.e., a claim that includes both facility and professional components). Examples are Medicaid clinic bills or critical access hospital claims.	N/A	CLT00003	CLAIM-LINE-RECORD-LT	X(10)	~~28~~27	~~320~~318	32~~9~~7	1. Value must be 10 digits~~, consisting of 9 numeric digits followed by one check digit calculated using the Luhn formula (algorithm)~~ ~~2.~~ 2. Value must have an associated Provider Identifier Type equal to ~~'2'~~"2" 3. Conditional 4. ~~When~~If Type of Claim (CLT.002.052) not in ~~('3','C','W')~~[3,C,W], then value must match Provider Identifier (PRV.005.081) 5. Value must exist in the NPPES NPI data file

~~CLT214~~	~~CLT.003.214~~	~~SERVICING-PROV-TAXONOMY~~	~~Servicing Provider Taxonomy~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~CLT00003~~	~~CLAIM-LINE-RECORD-LT~~	~~X(12)~~	~~29~~	~~330~~	~~341~~	~~1. Not Applicable~~
CLT215	CLT.003.215	SERVICING-PROV-TYPE	Servicing Provider Type	Conditional	A code to describe the type of ~~entity billing for the service~~provider being reported.	PROV-TYPE	CLT00003	CLAIM-LINE-RECORD-LT	X(2)	~~30~~28	3~~4~~28	~~343~~329	~~1.~~1. Value must be 2 characters 2. Value must be in Provider Type Code List (VVL). ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional
CLT216	CLT.003.216	SERVICING-PROV-SPECIALTY	Servicing Provider Specialty	Conditional	This code describes the area of specialty for the provider being reported.	PROV-SPECIALTY	CLT00003	CLAIM-LINE-RECORD-LT	X(2)	~~31~~29	~~344~~330	~~345~~331	~~1.~~1. Value must be 2 characters 2. Value must be in Provider Specialty List (VVL~~).~~ ~~2. Value must be 2 characters~~) 3. Conditional
CLT217	CLT.003.217	OTHER-TPL-COLLECTION	Other TPL Collection	~~Conditional~~ Mandatory	This data element indicates that the claim is for a beneficiary for whom other third party resource development and collection activities are in progress, when the liability is not another health insurance plan for which the eligible is a beneficiary.	OTHER-TPL-COLLECTION	CLT00003	CLAIM-LINE-RECORD-LT	X(3)	~~32~~30	~~346~~332	3~~4~~8	~~1.~~1. Value must be 3 characters 2. Value must be in Other TPL Collection List (VVL) ~~2. Value must be 3 characters~~ ~~3. Conditional~~3. Mandatory
~~CLT218~~	~~CLT.003.218~~	~~BENEFIT-TYPE~~	~~Benefit Type~~	~~Mandatory~~	~~The benefit category corresponding to the service reported on the claim or encounter record. Note: The code definitions in the valid value list originate from the Medicaid and CHIP Program Data System (MACPro) benefit type list. See Appendix H: Benefit Types~~	~~BENEFIT-TYPE~~	~~CLT00003~~	~~CLAIM-LINE-RECORD-LT~~	~~X(3)~~	~~33~~	~~349~~	~~351~~	~~1. Value must be in Benefit Type Code List (VVL)~~ ~~2. Value must be 3 characters~~ ~~3. Mandatory~~

CLT219	CLT.003.219	~~CMS-64-~~ CATEGORY-FOR-FEDERAL-REIMBURSEMENT	~~CMS-64~~ Category for Federal Reimbursement	Conditional	A code to indicate the Federal funding source for the payment.	~~CMS-64-~~ CATEGORY-FOR-FEDERAL-REIMBURSEMENT	CLT00003	CLAIM-LINE-RECORD-LT	X(2)	~~34~~31	3~~3~~52	3~~5~~36	1. Value must be 2 characters 2. Value must be in ~~CMS-64~~ Category for Federal Reimbursement List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. (Federal Funding under Title XXI) if value equals ~~'~~"02~~'~~", then the eligible's CHIP Code (ELG.003.054) must be in [~~'2', '3'~~2,3] 4. (Federal Funding under Title XIX) if value equals ~~'~~"01~~'~~" then the eligible's CHIP Code (ELG.003.054) must be ~~'1'~~"1" 5. Conditional 6. If Type of Claim is in [~~'1','2','5','A','B','E','U','V','Y'~~1,A,U] and the Total Medicaid Paid Amount is populated on the corresponding claim header, then value must be reported~~.~~ ~~7. If Type of Claim is in ['4','D'] and the Service Tracking Payment Amount on the relevant record is populated, then value must be reported.~~
CLT221	CLT.003.221	PROV-FACILITY-TYPE	Provider Facility Type	Mandatory	The type of facility in which services on the claim were rendered. The Provider Facility Type code set is based on corresponding groups of HIPAA provider taxonomy codes.	PROV-FACILITY-TYPE	CLT00003	CLAIM-LINE-RECORD-LT	X(9)	~~35~~32	~~354~~337	~~362~~345	~~1.~~1. Value must be 9 characters or less 2. Value must be in Provider Facility Type List (VVL) ~~2. Value must be 9 characters or less~~ ~~3.~~3. Mandatory
~~CLT224~~	~~CLT.003.224~~	~~XIX-MBESCBES-CATEGORY-OF-SERVICE~~	~~XIX MBESCBES Category of Service~~	~~Conditional~~	~~A code indicating the category of service for the paid claim. The category of service is the line item from the CMS-64 form that states use to report their expenditures and request federal financial participation.~~	~~XIX-MBESCBES-CATEGORY-OF-SERVICE~~	~~CLT00003~~	~~CLAIM-LINE-RECORD-LT~~	~~X(4)~~	~~36~~	~~363~~	~~366~~	~~1. Value must be in XIX MBESCBES Category of Service List (VVL)~~ ~~2. Value must be 4 characters or less~~ ~~3. Conditional~~ ~~4. (Medicaid Claim) if the associated CMS-64 Category for Federal Reimbursement value is '1', then a valid value is mandatory and must be reported~~ ~~5. If value is in ['14', '35', '42' or '44'], then Sex (ELG.002.023) must not equals 'M'~~ ~~6. If XXI MBESCBES Category of Service is populated then must not be populated~~

~~CLT225~~	~~CLT.003.225~~	~~XXI-MBESCBES-CATEGORY-OF-SERVICE~~	~~XXI MBESCBES Category of Service~~	~~Conditional~~	~~A code to indicate the category of service for the paid claim. The category of service is the line item from the CMS-21 form that states use to report their expenditures and request federal financial participation.~~	~~XXI-MBESCBES-CATEGORY-OF-SERVICE~~	~~CLT00003~~	~~CLAIM-LINE-RECORD-LT~~	~~X(3)~~	~~37~~	~~367~~	~~369~~	~~1. Value must be in XXI MBESCBES Category of Service List (VVL)~~ ~~2. Conditional~~ ~~3. (CHIP Claim) if the associated CMS-64 Category for Federal Reimbursement value is '2', then a valid value is mandatory and must be reported~~ ~~4. If XIX MBESCBES Category of Service is populated then value must not be populated~~ ~~5. Value must be 3 characters or less~~
CLT226	CLT.003.226	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	CLT00003	CLAIM-LINE-RECORD-LT	X(500)	~~38~~49	~~370~~619	~~869~~1118	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
CLT227	CLT.001.227	SEQUENCE-NUMBER	Sequence Number	Mandatory	To enable states to sequentially number files, when related, follow-on files are necessary (i.e. update files, replace files). This should begin with 1 for the original Create submission type and be incremented by one for each Replacement or Update submission for the same reporting period and file type (subject area).	N/A	CLT00001	FILE-HEADER-RECORD-LT	X(4)	14	79	82	~~1.~~1. Value must be 4 characters or less 2. Value must between 1 and 9999 ~~2~~3. Value must be equal to the largest of any prior values for the same reporting period and file type, plus 1 (i.e. incremented by 1) ~~3~~4. Value must not contain a pipe symbol ~~4. Value must be 4 characters or less~~ 5. Mandatory
CLT228	CLT.003.228	NATIONAL-DRUG-CODE	National Drug Code	Conditional	A code following the National Drug Code format indicating the drug, device, or medical supply covered by this claim.	N/A	CLT00003	CLAIM-LINE-RECORD-LT	X(12)	~~39~~33	~~870~~346	~~881~~357	~~1. Characters 1-5 of value must be numeric~~ ~~2. Characters 6-9 of value must be numeric~~ ~~3. Characters 10-12 of value must be numeric or blank~~ ~~4.~~1. Value must be 12 digits or less ~~5~~2. Value must be a valid National Drug Code ~~6~~3. Conditional
CLT229	CLT.003.229	NDC-UNIT-OF-MEASURE	NDC Unit of Measure	Conditional	A code to indicate the basis by which the quantity of the National Drug Code is expressed.	NDC-UNIT-OF-MEASURE	CLT00003	CLAIM-LINE-RECORD-LT	X(2)	~~40~~34	~~882~~358	~~883~~359	~~1.~~1. Value must be 2 characters 2. Value must be in NDC Unit of Measure List (VVL~~).~~ ~~2. Value must be 2 characters~~) 3. Conditional

CLT230	CLT.003.230	NDC-QUANTITY	NDC Quantity	Conditional	This field is to capture the actual quantity of the National Drug Code being prescribed on the claim/encounters.	N/A	CLT00003	CLAIM-LINE-RECORD-LT	S9(~~6~~)V9~~99~~)V(9)	~~41~~35	~~884~~360	~~892~~377	1. Value may include up to ~~6~~9 digits to the left of the decimal point, and ~~3~~9 digits to the right e.g. ~~123456.789~~123456789.123456789 2. Conditional
~~CLT231~~	~~CLT.003.231~~	~~HCPCS-RATE~~	~~HCPCS Rate~~	~~Conditional~~	~~This data element is expected to capture data from the HIPAA 837I claim loop 2400 SV206 or UB-04 FL 44. (NOTE: This element varies slightly by claim file time, and claim-file-specific requirements will be specified at in the file specification for each claim type.)~~	~~HCPCS-RATE~~	~~CLT00003~~	~~CLAIM-LINE-RECORD-LT~~	~~X(14)~~	~~42~~	~~893~~	~~906~~	~~1. Value must be in HCPCS Rate List (VVL).~~ ~~2. Value must be 14 characters or less~~ ~~3. Value must not contain a pipe or asterisk symbols~~ ~~4. Conditional~~
CLT233	CLT.003.233	ADJUDICATION-DATE	Adjudication Date	Mandatory	The date on which the payment status of the claim was finally adjudicated by the state. For Encounter Records (Type of Claim = 3, C, W), use date the encounter was processed by the state.	N/A	CLT00003	CLAIM-LINE-RECORD-LT	9(8)	~~43~~36	~~907~~378	~~914~~385	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value should be on or before End of Time Period ~~value found in associated T-MSIS File Header Record~~ ~~4.~~ (CLT.001.010) 3. Mandatory ~~5~~4. Value should be on or after associated Admission Date value
CLT234	CLT.003.234	SELF-DIRECTION-TYPE	Self Direction Type	~~Conditional~~ Mandatory	This data element is not applicable to this file type.	SELF-DIRECTION-TYPE	CLT00003	CLAIM-LINE-RECORD-LT	X(3)	~~44~~37	~~915~~386	~~917~~388	~~1.~~1. Value must be 3 characters 2. Value must be in Self Direction Type List (VVL) ~~2. Value must be 3 characters~~ ~~3. Conditional~~3. Mandatory
CLT235	CLT.003.235	PRE-AUTHORIZATION-NUM	Preauthorization Number	Conditional	A number, code or other value that indicates the services provided on this claim have been authorized by the payee or other service organization, or that a referral for services has been approved. (Also referred to as a Prior Authorization or Referral Number).	N/A	CLT00003	CLAIM-LINE-RECORD-LT	X(18)	~~45~~38	~~918~~389	~~935~~406	1. Value must be 18 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional

CLT237	CLT.002.237	PROV-LOCATION-ID	Provider Location ID	Mandatory	A code to uniquely identify the geographic location where the provider's services were performed. The Provider Location Identifier values reported on Inpatient, Long-Term Care, Other, and Pharmacy Claim Header Segments must correspond to an active Provider Location Identifier value on a Provider Location ~~&~~and Contact Info (~~PRV00003~~PRV.003) segment. If a particular license (e.g., a physician's medical license) or provider identifier (e.g., an individual provider's NPI or SSN) is applicable to all of their servicing locations, value "000" (a string of exactly three zeros) can be used in the ~~PRV00004~~PRV.004 or ~~PRV00005~~PRV.005, respectively, to represent all locations, however that location identifier must not be attributed to claims or provider bed type info.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(5)	~~160~~129	1127~~95~~	~~179~~1131	~~1.~~1. Value must be 5 characters or less 2. Value must not contain a pipe or asterisk symbols ~~2. Value must be 5 characters or less~~ ~~3.~~3. Mandatory
CLT239	CLT.002.239	TOT-BENEFICIARY-COPAYMENT-LIABLE-AMOUNT	Total Beneficiary Copayment Liable Amount	Conditional	The total copayment amount on a claim that the beneficiary is obligated to pay for covered services. This is the total Medicaid or contract negotiated beneficiary copayment liability for covered service on the claim. Do not subtract out any payments made toward the copayment.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11)V99	130	1132	1144	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CLT240	CLT.002.240	TOT-BENEFICIARY-COINSURANCE-LIABLE-AMOUNT	Total Beneficiary Coinsurance Liable Amount	Conditional	The total coinsurance amount on a claim the beneficiary is obligated to pay for covered services. This amount is the total Medicaid or contract negotiated beneficiary coinsurance liability for covered services on the claim. Do not subtract out any payments made toward the coinsurance.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11)V99	131	1145	1157	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional

CLT241	CLT.002.241	TOT-BENEFICIARY-DEDUCTIBLE-LIABLE-AMOUNT	Total Beneficiary Deductible Liable Amount	Conditional	The total deductible amount on a claim the beneficiary is obligated to pay for covered services. This amount is the total Medicaid or contract negotiated beneficiary deductible liability minus previous beneficiary payments that went toward their deductible. Do not subtract out any payments for the given claim that went toward the deductible.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11) V99	132	1158	1170	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CLT242	CLT.002.242	COMBINED-BENE-COST-SHARING-PAID-AMOUNT	Combined Beneficiary Cost Sharing Paid Amount	Conditional	The combined amounts the beneficiary or his or her representative (e.g., their guardian) paid towards their copayment, coinsurance, and/or deductible for the covered services on the claim. Only report this data element when the claim does not differentiate among copayment, coinsurance, and/or deductible payments made by the beneficiary. Do not include beneficiary cost sharing payments made by a third party/ies on behalf of the beneficiary.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11) V99	133	1171	1183	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CLT243	CLT.003.243	IHS-SERVICE-IND	IHS Service Indicator	Mandatory	To indicate Services received by Medicaid-eligible individuals who are American Indian or Alaska Native (AI/AN) through facilities of the Indian Health Service (IHS), whether operated by IHS or by Tribes.	IHS-SERVICE-IND	CLT00003	CLAIM-LINE-RECORD-LT	X(1)	39	407	407	1. Value must be 1 character 2. Value must be in the IHS Service Indicator List (VVL) 3. Mandatory
CLT244	CLT.002.244	BILLING-PROV-ADDR-LN-1	Billing Provider Address Line 1	Mandatory	Billing provider address line 1 from X12 837I loop 2010AA.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(60)	134	1184	1243	1. Value must not be more than 60 characters long 2. Mandatory 3. Value must not contain a pipe or asterisk symbols

CLT245	CLT.002.245	BILLING-PROV-ADDR-LN-2	Billing Provider Address Line 2	Conditional	Billing provider address line 2 from X12 837I loop 2010AA.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(60)	135	1244	1303	1. Value must not be more than 60 characters long 2. Conditional 3. Value must not be equal to associated Address Line 1 4. Value must not contain a pipe or asterisk symbols 5. There must be an Address Line 1 in order to have an Address Line 2
CLT246	CLT.002.246	BILLING-PROV-CITY	Billing Provider City	Mandatory	Billing provider address city name from X12 837I loop 2010AA.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(28)	136	1304	1331	1. Value must not be more than 28 characters long 2. Mandatory
CLT247	CLT.002.247	BILLING-PROV-STATE	Billing Provider State Code	Mandatory	Billing provider address state code from X12 837I loop 2010AA.	STATE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	137	1332	1333	1. Value must not be more than 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory
CLT248	CLT.002.248	BILLING-PROV-ZIP-CODE	Billing Provider ZIP Code	Mandatory	Billing provider address ZIP code from X12 837I loop 2010AA.	ZIP-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(9)	138	1334	1342	1. Value may only be 5 digits (0-9) (Example: 91320) or 9 digits (0-9) (Example: 913200011) 2. Value must be in ZIP Code List (VVL) 3. Mandatory
CLT249	CLT.002.249	SERVICE-FACILITY-LOCATION-ORG-NPI	Service Facility Location Organization NPI	Conditional	Service facility location organization NPI from X12 837I loop 2310E.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(10)	139	1343	1352	1.Value must be 10 digits 2. Value must have an associated Provider Identifier Type equal to "2" 3. Value must exist in the NPPES NPI data file 4. Conditional 5. When populated, value must match Provider Identifier (PRV.005.081) and Facility Group Individual Code (PRV.002.028) must equal "01" 6. NPPES Entity Type Code associated with this NPI must equal "2" (Organization)

CLT250	CLT.002.250	SERVICE-FACILITY-LOCATION-ADDR-LN-1	Service Facility Location Address Line 1	Conditional	Service facility location address line 1 from X12 837I loop 2310E.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(60)	140	1353	1412	1. Value must not be more than 60 characters long 2. Conditional 3. Value must not contain a pipe or asterisk symbols
CLT251	CLT.002.251	SERVICE-FACILITY-LOCATION-ADDR-LN-2	Service Facility Location Address Line 2	Conditional	Service facility location address line 2 from X12 837I loop 2310E.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(60)	141	1413	1472	1. Value must not be more than 60 characters long 2. Conditional 3. Value must not be equal to associated Address Line 1 4. There must be an Address Line 1 in order to have an Address Line 2 5. Value must not contain a pipe or asterisk symbols
CLT252	CLT.002.252	SERVICE-FACILITY-LOCATION-CITY	Service Facility Location City	Conditional	Service facility location address city name from X12 837I loop 2310E.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(28)	142	1473	1500	1. Value must not be more than 28 characters long 2. Conditional
CLT253	CLT.002.253	SERVICE-FACILITY-LOCATION-STATE	Service Facility Location State	Conditional	Service facility location address state code from X12 837I loop 2310E.	STATE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	143	1501	1502	1. Value must not be more than 2 characters 2. Value must be in State Code list (VVL) 3. Conditional
CLT254	CLT.002.254	SERVICE-FACILITY-LOCATION-ZIP-CODE	Service Facility Location ZIP Code	Conditional	Service facility location address ZIP code from X12 837I loop 2310E.	ZIP-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(9)	144	1503	1511	1. Value may only be 5 digits (0-9) (Example: 91320) or 9 digits (0-9) (Example: 913200011) 2. Value must be in ZIP Code List (VVL) 3. Conditional
CLT255	CLT.002.255	PROVIDER-CLAIM-FORM-CODE	Provider Claim Form Code	Mandatory	A code indicating the format in which the provider submitted their claim. Very few if any claims should be classified as "Other".	PROVIDER-CLAIM-FORM-CODE	CLT00002	CLAIM-HEADER-RECORD-LT	X(2)	145	1512	1513	1. Value must not be more than 2 characters 2. Value must be in Provider Claim Form Code List (VVL) 3. Mandatory

CLT256	CLT.002.256	PROVIDER-CLAIM-FORM-OTHER-TEXT	Provider Claim Form Other Text	Conditional	A free-form text field where a state can identify the "other" claim form used by the provider to submit their claim. Required when "Other" is reported to Provider Claim Form Code.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	X(50)	146	1514	1563	1. Value must not be more than 50 characters long 2. Conditional 3. Value must be provided when corresponding Provider Claim Form Code is "Other"
CLT257	CLT.002.257	TOT-GME-AMOUNT-PAID	Total GME Amount Paid	Conditional	The amount included in the Total Medicaid Amount (CLT.002.065) that is attributable to a Graduate Medical Education (GME) payment, when the state makes GME payments by claim.	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11)V99	147	1564	1576	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CLT258	CLT.002.258	TOT-SDP-ALLOWED-AMT	Total State Directed Payment Allowed Amount	Conditional	The component (in dollar and cents) of the total allowed amount that represents the difference between what would have been the managed care plan's typical contractual allowed amount and the enhanced allowed amount for this specific claim as defined by the State's SPA, waiver, or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11)V99	148	1577	1589	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CLT259	CLT.002.259	TOT-SDP-PAID-AMT	Total State Directed Payment Paid Amount	Conditional	The component (in dollar and cents) of the total paid amount that represents the difference between what would have been the managed care plan's typical contractual paid amount and the enhanced paid amount for this specific claim as defined by the State's SPA, waiver, or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).	N/A	CLT00002	CLAIM-HEADER-RECORD-LT	S9(11)V99	149	1590	1602	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CLT260	CLT.003.260	UNIQUE-DEVICE-IDENTIFIER	Unique Device Identifier	Conditional	An unique identifier assigned to every medical device that meets the requirements of 21 CFR 801 and 830.	N/A	CLT00003	CLAIM-LINE-RECORD-LT	X(76)	40	408	483	1. Value must not be more than 76 characters long 2. Conditional

CLT261	CLT.003.261	MBESCBES-CATEGORY-OF-SERVICE	MBESCBES Category of Service	Conditional	A code indicating the category of service for the paid claim. The category of service is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.) that states use to report their expenditures and request federal financial participation.	21.P-FORM, 21BASE-FORM, 64.21U-FORM, 64.10BASE-FORM, 64.9P-FORM, 64.9A-FORM, 64.9BASE-FORM, 64.21UP-FORM	CLT00003	CLAIM-LINE-RECORD-LT	X(5)	43	535	539	1. Value must be 5 characters or less 2. When MBESCBES Form equals "21.P", value must be in 21.P Form List (VVL) 3. When MBESCBES Form equals "21BASE", value must be in 21BASE Form List (VVL) 4. When MBESCBES Form equals "64.21U", value must be in 64.21U Form List (VVL) 5. When MBESCBES Form equals "64.10BASE", value must be in 64.10BASE Form List (VVL) 6. When MBESCBES Form equals "64.9P", value must be in 64.9P Form List (VVL) 7. When MBESCBES Form equals "64.9A", value must be in 64.9A Form List (VVL) 8. When MBESCBES Form equals "64.9BASE", value must be in 64.9BASE Form List (VVL) 9. When MBESCBES Form equals "64.21UP", value must be in 64.21UP Form List (VVL) 10. Conditional 11. If Type of Claim in [1,A,U], then value must be populated on all claim lines with a Medicaid Paid Amount greater than $0 12. When populated, an associated MBESCBES Form Group and MBESCBES Form must be populated

CLT262	CLT.003.262	MBESCBES-FORM	MBESCBES Form	Conditional	The MBES or CBES form to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.). This should be determined by the state's MBES/CBES reporting process. The MBES or CBES form reported here will determine what the meaning of the corresponding MBES/CBES category of service value is.	MBESCBES-FORMGP-1, MBESCBES-FORMGP-2, MBESCBES-FORMGP-3	CLT00003	CLAIM-LINE-RECORD-LT	X(50)	42	485	534	1. Value must be 50 characters or less 2. When MBESCBES Form Group equals "1", value must be in MBESCBES Form Group 1 List (VVL) 3. When MBESCBES Form Group equals "2", value must be in MBESCBES Form Group 2 List (VVL) 4. When MBESCBES Form Group equals "3", value must be in MBESCBES Form Group 3 List (VVL) 5. Conditional 6. If Type of Claim in [1,A,U], then value must be populated on all claim lines with a Medicaid Paid Amount greater than $0
CLT263	CLT.003.263	GME-AMOUNT-PAID	GME Amount Paid	Conditional	The amount included in the Medicaid Amount (CLT.003.208) that is attributable to a Graduate Medical Education (GME) payment, when the state makes GME payments by claim.	N/A	CLT00003	CLAIM-LINE-RECORD-LT	S9(11)V99	44	540	552	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CLT264	CLT.003.264	REFERRING-PROV-NUM	Referring Provider Number	Conditional	A unique identification number assigned to a provider which identifies the physician or other provider who referred the patient. For physicians, this must be the individual's ID number, not a group identification number. If the referring provider number 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.	N/A	CLT00003	CLAIM-LINE-RECORD-LT	X(30)	45	553	582	1. Value must be 30 characters or less 2. Conditional
CLT265	CLT.003.265	REFERRING-PROV-NPI-NUM	Referring Provider NPI Number	Conditional	The National Provider ID (NPI) of the provider who recommended the servicing provider to the patient.	N/A	CLT00003	CLAIM-LINE-RECORD-LT	X(10)	46	583	592	1. Value must be 10 digits 2. Conditional 3. Value must have an associated Provider Identifier Type equal to "2" 4. Value must exist in the NPPES NPI File

CLT266	CLT.003.266	SDP-ALLOWED-AMT	State Directed Payment Allowed Amount	Conditional	The component (in dollar and cents) of the allowed amount that represents the difference between what would have been the managed care plan's typical contractual allowed amount and the enhanced allowed amount for this specific claim as defined by the State's SPA, waiver, or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).	N/A	CLT00003	CLAIM-LINE-RECORD-LT	S9(11)V99	47	593	605	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CLT267	CLT.003.267	SDP-PAID-AMT	State Directed Payment Paid Amount	Conditional	The component (in dollar and cents) of the paid amount that represents the difference between what would have been the managed care plan's typical contractual paid amount and the enhanced paid amount for this specific claim as defined by the State's SPA, waiver, or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).	N/A	CLT00003	CLAIM-LINE-RECORD-LT	S9(11)V99	48	606	618	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CLT268	CLT.004.268	RECORD-ID	Record ID	Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	CLT00004	CLAIM-DX-LT	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "CLT00004"
CLT269	CLT.004.269	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	CLT00004	CLAIM-DX-LT	X(2)	2	9	10	1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (CLT.001.007)

CLT270	CLT.004.270	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	CLT00004	CLAIM-DX-LT	9(11)	3	11	21	1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
CLT271	CLT.004.271	ICN-ORIG	Original ICN	Mandatory	A unique number assigned by the state's payment system that identifies an original or adjustment claim.	N/A	CLT00004	CLAIM-DX-LT	X(50)	4	22	71	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
CLT272	CLT.004.272	ICN-ADJ	Adjustment ICN	Conditional	A unique claim number assigned by the state's payment system that identifies the adjustment claim for an original transaction.	N/A	CLT00004	CLAIM-DX-LT	X(50)	5	72	121	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
CLT273	CLT.004.273	ADJUSTMENT-IND	Adjustment Indicator	Mandatory	Indicates the type of adjustment record.	ADJUSTMENT-IND	CLT00004	CLAIM-DX-LT	X(1)	6	122	122	1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Value must be in [0,1,4] 4. Mandatory 5. If value equals "0", then associated Adjustment ICN must not be populated 6. Value must equal "1", when associated Claim Status equals "686" 7. Value must match the adjustment indicator in the header (CLT.002.025)

CLT274	CLT.004.274	ADJUDICATION-DATE	Adjudication Date	Mandatory	The date on which the payment status of the claim was finally adjudicated by the state. For Encounter Records (Type of Claim = 3, C, W), use date the encounter was processed by the state.	N/A	CLT00004	CLAIM-DX-LT	9(8)	7	123	130	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value should be on or before End of Time Period (CLT.001.010) 3. Mandatory 4. Value should be on or after associated Admission Date value
CLT275	CLT.004.275	DIAGNOSIS-TYPE	Diagnosis Type	Mandatory	Indicates the context of the diagnosis code from the provider's claim (i.e., an 837I claim can have one principal diagnosis code, one admitting diagnosis code, up to 12 external cause of injury diagnosis codes, and up to 24 other diagnosis codes; a UB-04 claim can have one principal diagnosis code, one admitting diagnosis code, and up to 17 other diagnosis codes). The type of diagnosis code (e.g., principal, admitting, external cause of injury, or other) is captured here. The order in which the diagnosis code was reported is captured in the Diagnosis Sequence Number.	DIAGNOSIS-TYPE	CLT00004	CLAIM-DX-LT	X(1)	8	131	131	1. Value must be 1 character 2. Value must be in Diagnosis Type Code List (VVL) 3. Value must be in [P,A,E,O] 4. Mandatory
CLT276	CLT.004.276	DIAGNOSIS-SEQUENCE-NUMBER	Diagnosis Sequence Number	Mandatory	The order in which the diagnosis occurred on the provider's claim for a given type of diagnosis code (e.g., an 837I claim can have up to 12 external cause of injury diagnosis codes and up to 24 other diagnosis codes).	N/A	CLT00004	CLAIM-DX-LT	9(2)	9	132	133	1. Value must be in [01-24] 2. Mandatory
CLT277	CLT.004.277	DIAGNOSIS-CODE-FLAG	Diagnosis Code Flag	Mandatory	Flag used to identify wither the associated Diagnosis Code value is a ICD-9 or ICD-10 code.	DIAGNOSIS-CODE-FLAG	CLT00004	CLAIM-DX-LT	X(1)	10	134	134	1. Value must be 1 character 2. Value must be in Diagnosis Code Flag List (VVL) 3. Mandatory

CLT278	CLT.004.278	DIAGNOSIS-CODE	Diagnosis Code	Mandatory	ICD-9 or ICD-10 diagnosis codes used as a tool to group and identify diseases, disorders, symptoms, poisonings, adverse effects of drugs and chemicals, injuries and other reasons for patient encounters. Diagnosis codes should be passed through to T-MSIS exactly as they were submitted by the provider on their claim (with the exception of removing the decimal). For example: 210.5 is coded as '2105'.	DIAGNOSIS-CODE	CLT00004	CLAIM-DX-LT	X(7)	11	135	141	1. Value must be a minimum of 3 characters 2. If associated Diagnosis Code Flag value equals "1" (ICD-9), then value must be in ICD-9 Diagnosis Code List (VVL) 3. If associated Diagnosis Code Flag value equals "2" (ICD-10), then value must be in ICD-10 Diagnosis Code List (VVL) 4. Value must not contain a decimal point 5. Mandatory
CLT279	CLT.004.279	DIAGNOSIS-POA-FLAG	Diagnosis POA Flag	Conditional	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator is used to identify certain preventable conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. *States that do not use the grouper methodology may use CMS-approved methodology that is prospective in nature.	DIAGNOSIS-POA-FLAG	CLT00004	CLAIM-DX-LT	X(1)	12	142	142	1. Value must be 1 character 2. Value must be in Diagnosis POA Flag List (VVL) 3. Conditional
CLT280	CLT.004.280	STATE-NOTATION	State Notation	Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	CLT00004	CLAIM-DX-LT	X(500)	13	143	642	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational

CLT282	CLT.003.282	MBESCBES-FORM-GROUP	MBESCBES Form Group	Conditional	Indicates group of MBES/CBES forms that this payment applies to (e.g., the CMS-64.9 Base form is for Title XIX-funded Medicaid, the CMS-64.21 form is for Title XXI-funded Medicaid-expansion CHIP (M-CHIP), and the CMS-21 Base form is for Title XXI-funded separate CHIP (S-CHIP)).	MBESCBES-FORM-GROUP	CLT00003	CLAIM-LINE-RECORD-LT	X(1)	41	484	484	1. Value must be 1 character 2. Value must be in MBESCBES Form Group List (VVL) 3. Conditional 4. If Type of Claim in [1,A,U], then value must be populated on all claim lines with a Medicaid Paid Amount greater than $0

T-MSIS Data Dictionary – COT File Changes Between Versions 2.4.0 and 4.0.0

Data Element Number	System Data Element Number	Data Element	Data Element Name Text	Data Element Necessity	Definition	Valid Value List (VVL)	File Segment Number	File Segment Name	Size	Pipe Separated Value Segment Data Element Order	Fixed Length Field Start Position	Fixed Length Field Stop Position	Coding Requirements
COT001	COT.001.001	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	COT00001	FILE-HEADER-RECORD-OT	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "COT00001"
COT002	COT.001.002	DATA-DICTIONARY-VERSION	Data Dictionary Version	Mandatory	A data element to capture the version of the T-MSIS data dictionary that was used to build the file. ~~Use the version number specified on the Cover Sheet of the data dictionary" to V2.4.~~	DATA-DICTIONARY-VERSION	COT00001	FILE-HEADER-RECORD-OT	X(10)	2	9	18	1. Value must be 10 characters or less 2. Value must be in Data Dictionary Version List (VVL) 3. Value must not include the pipe ("|") symbol ~~3~~4. Mandatory
COT003	COT.001.003	SUBMISSION-TRANSACTION-TYPE	Submission Transaction Type	Mandatory	A data element to identify the whether the transactions in the file are original submissions of the data, a resubmission of a previously submitted file, or corrections of edit rejects.	SUBMISSION-TRANSACTION-TYPE	COT00001	FILE-HEADER-RECORD-OT	X(1)	3	19	19	~~1.~~1. Value must be 1 character 2. Value must be in Submission Transaction Type List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory

COT004	COT.001.004	FILE-ENCODING-SPECIFICATION	File Encoding Specification	Mandatory	Denotes which supported file encoding standard was used to create the file.	FILE-ENCODING-SPECIFICATION	COT00001	FILE-HEADER-RECORD-OT	X(3)	4	20	22	~~1.~~1. Value must be 3 characters 2. Value must be in File Encoding Specification List (VVL) ~~2. Value must be 3 characters~~ ~~3.~~3. Mandatory
COT005	COT.001.005	DATA-MAPPING-DOCUMENT-VERSION	Data Mapping Document Version	Mandatory	Identifies the version of the T-MSIS data mapping document used to build a state submission file. ~~Use the version number specified on the title page of the data mapping document~~	N/A	COT00001	FILE-HEADER-RECORD-OT	X(9)	5	23	31	1. Value must be 9 characters or less 2. Mandatory
COT006	COT.001.006	FILE-NAME	File Name	~~Not Applicable~~ Mandatory	A code to identify the subject area to which the records in its file relate. Each T-MSIS submission file should only contain records for one subject area (i.e., Eligible, Third-party liability, Provider, Managed Care Plan Information, Inpatient, Long-Term Care, Other, ~~and~~ Pharmacy Claim, and Financial Transactions).	N/A	COT00001	FILE-HEADER-RECORD-OT	X(8)	6	32	39	1. Value must equal ~~'CLAIM-OT'~~"CLAIM-OT" 2. Mandatory
COT007	COT.001.007	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	COT00001	FILE-HEADER-RECORD-OT	X(2)	7	40	41	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ 3. Mandatory
COT008	COT.001.008	DATE-FILE-CREATED	Date File Created	Mandatory	The date on which the file was created.	N/A	COT00001	FILE-HEADER-RECORD-OT	9(8)	8	42	49	~~1.~~1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" ~~2~~3. Value must be ~~8 characters in the form "CCYYMMDD"~~ ~~3. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~4.~~less than current date 4. Value must be equal to or after the value of associated End of Time Period 5. Mandatory

COT009	COT.001.009	START-OF-TIME-PERIOD	Start of Time Period	Mandatory	This value must be the first day of the reporting month, regardless of the actual date span of the data in the file.	N/A	COT00001	FILE-HEADER-RECORD-OT	9(8)	9	50	57	~~1. Value of the CC component must be "20"~~ ~~2. Value must be 8 characters in the form "CCYYMMDD"~~ ~~3.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~4. Value must be less than current date~~ ~~5.~~in the form "CCYYMMDD" 2. Value must be equal to or earlier than associated Date File Created ~~6~~3. Value must be before associated End of Time Period ~~7~~4. Mandatory 5. Value of the CC component must be "20"
COT010	COT.001.010	END-OF-TIME-PERIOD	End of Time Period	Mandatory	This value must be the last day of the reporting month, regardless of the actual date span.	N/A	COT00001	FILE-HEADER-RECORD-OT	9(8)	10	58	65	1. ~~Value~~The date must be ~~8 characters~~a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" 3. ~~The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~4.~~ Value must be equal to or earlier than associated Date File Created ~~5~~4. Value must be equal to or after associated Start of Time Period ~~6~~5. Mandatory
COT011	COT.001.011	FILE-STATUS-INDICATOR	File Status Indicator	Mandatory	A code to indicate whether the records in the file are test or production records.	FILE-STATUS-INDICATOR	COT00001	FILE-HEADER-RECORD-OT	X(1)	11	66	66	~~1.~~1. Value must be 1 character 2. For production files, value must be equal to ~~'P'~~ ~~2. Value must be 1 character "P"~~ 3. Value must be in File Status Indicator List (VVL) 4. Mandatory

COT012	COT.001.012	SSN-INDICATOR	SSN Indicator	Mandatory	Indicates whether the state uses the eligible person's social security number instead of an MSIS Identification Number as the unique, unchanging eligible person identifier. A state's SSN/Non-SSN designation on the eligibility file should match on the claims and third party liability files.	SSN-INDICATOR	COT00001	FILE-HEADER-RECORD-OT	X(1)	12	67	67	~~1.~~1. Value must be 1 character 2. Value must be in SSN Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory
COT013	COT.001.013	TOT-REC-CNT	Total Record Count	Mandatory	A count of all records in the file except for the file header record. This count will be used as a control total to help assure that the file did not become corrupted during transmission.	N/A	COT00001	FILE-HEADER-RECORD-OT	9(11)	13	68	78	~~1.~~1. Value must be 11 digits or less 2. Value must be a positive integer ~~2~~3. Value must be between 0:99999999999 (inclusive) ~~3. Value must be 11 digits or less~~ ~~4.~~4. Value must equal the number of records included in the file submission except for the file header record. 5. Mandatory
COT014	COT.001.014	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	COT00001	FILE-HEADER-RECORD-OT	X(500)	15	83	582	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
COT016	COT.002.016	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier	RECORD-ID	COT00002	CLAIM-HEADER-RECORD-OT	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "COT00002"

					padded with leading zeros (e.g., 00001, 00002, 00003, etc.).							
COT017	COT.002.017	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (COT.001.007)
COT018	COT.002.018	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory
COT019	COT.002.019	ICN-ORIG	Original ICN	Mandatory	A unique number assigned by the state's payment system that identifies an original or adjustment claim.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(50)	4	22	71	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory

COT020	COT.002.020	ICN-ADJ	Adjustment ICN	Conditional	A unique claim number assigned by the state's payment system that identifies the adjustment claim for an original transaction.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(50)	5	72	121	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value ~~is~~ equals "0~~,~~", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
COT021	COT.002.021	SUBMITTER-ID	Submitter ID	Mandatory	The Submitter Identification number is the value that identifies the provider/trading partner/clearing house organization to the state's claim adjudication system.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(12)	6	122	133	1. Value must be 12 characters or less 2. Mandatory
COT022	COT.002.022	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual ~~(except on service tracking payments). .~~ Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47572~~reporting-shared-msis-identification-numbers-eligibility/	N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(20)	7	134	153	~~1. Mandatory~~ ~~2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN~~ ~~3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN~~ ~~4. Value must be 20 characters or less~~ ~~5. Populated value must begin with an '&', when Type of Claim (COT.002.037) = 4, D or X (lump sum payment)~~ ~~6.~~1. Value must be 20 characters or less 2. Mandatory 3. Value must match MSIS Identification Number (ELG.021.251) and the Beginning Date of Service (COT.002.033) must be between Enrollment Effective Date (ELG.021.253) and Enrollment End Date (ELG.021.254)

COT023	COT.002.023	CROSSOVER-INDICATOR	Crossover Indicator	~~Conditional~~ Mandatory	An indicator specifying whether the claim is a crossover claim where a portion is paid by Medicare.	CROSSOVER-INDICATOR	COT00002	CLAIM-HEADER-RECORD-OT	X(1)	8	154	154	~~1.~~1. Value must be 1 character 2. Value must be in Crossover Indicator List (VVL) ~~2~~3. If Crossover Indicator value ~~is~~equals "1", then associated Dual Eligible Code (ELG.005.085) value must be in ~~"~~[01~~", "~~,02~~", "~~,04~~", "~~,08~~", "~~,09~~", or "~~,10~~"] for the same time period (by date of service) ~~3. Value must be 1 character~~ ~~4. Conditional~~ ~~5. If the TYPE-OF-CLAIM value is in ["1", "3", "A", "C"], then value is mandatory and must be reported.~~4. Mandatory
COT024	COT.002.024	1115A-DEMONSTRATION-IND	1115A Demonstration Indicator	Conditional	~~Indicates that~~In the claims files this data element indicates whether the claim or encounter was covered under the authority of an ~~1115(A)~~1115A demonstration. ~~1115(A) is a Center for Medicare and Medicaid Innovation~~In the Eligibility file, this data element indicates whether the individual participates in an 1115A demonstration.	1115A-DEMONSTRATION-IND	COT00002	CLAIM-HEADER-RECORD-OT	X(1)	9	155	155	~~1.~~1. Value must be 1 character 2. Value must be in 1115A Demonstration Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Conditional 4. When value equals ~~"~~"0~~"~~, is invalid or not populated, then the associated 1115A Demonstration Indicator (ELG.018.2~~2~~33) must equal ~~"~~"0~~"~~, is invalid or not populated
COT025	COT.002.025	ADJUSTMENT-IND	Adjustment Indicator	Mandatory	Indicates the type of adjustment record.	ADJUSTMENT-IND	COT00002	CLAIM-HEADER-RECORD-OT	X(1)	10	156	156	~~1.~~1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) ~~2. If associated Type of Claim value is in [1,~~ 3~~, 5, A, C, E, U, W, Y], then value must be in [0, 1, 4]~~ ~~3. If associated Type of Claim value is '4, D, X', then value~~. Value must be in [~~ 5, 6~~ 0,1,4] 4. ~~Value must be 1 character~~ ~~5.~~Mandatory 5. If value equals "0", then associated Adjustment ICN must not be populated 6. Value must equal "1", when associated Claim Status equals "686"

COT026	COT.002.026	ADJUSTMENT-REASON-CODE	Adjustment Reason Code	Conditional	Claim adjustment reason codes communicate why a claim was paid differently than it was billed. ~~If the amount paid is different from the amount billed you need an adjustment reason code.~~	ADJUSTMENT-REASON-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(3)	11	157	159	~~1.~~1. Value must be 3 characters or less 2. Value must be in Adjustment Reason Code List (VVL) ~~2. Value must be 3 characters or less~~ ~~3.~~3. Conditional 4. Value must ~~not~~ be populated when ~~associated Adjustment Indicator equals "0"~~the total paid amount is different from the total billed amount
~~COT027~~	~~COT.002.027~~	~~DIAGNOSIS-CODE-1~~	~~Diagnosis Code 1~~	~~Conditional~~	~~ICD-9 or ICD-10 diagnosis codes used as a tool to group and identify diseases, disorders, symptoms, poisonings, adverse effects of drugs and chemicals, injuries and other reasons for patient encounters. Diagnosis codes should be passed through to T-MSIS exactly as they were submitted by the provider on their claim (with the exception of removing the decimal). For example: 210.5 is coded as "2105".~~	~~DIAGNOSIS-CODE~~	~~COT00002~~	~~CLAIM-HEADER-RECORD-OT~~	~~X(7)~~	~~12~~	~~160~~	~~166~~	~~1. When populated, a Diagnosis Code Flag is required~~ ~~2. If associated Diagnosis Code Flag value is "1" (ICD-9), then value must be in ICD-9 Diagnosis Codes List (VVL)~~ ~~3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Codes List (VVL)~~ ~~4. Value must be a minimum of 3 characters~~ ~~5. Value must not contain a decimal point~~ ~~6. If associated Diagnosis Code Flag value is '"1" (ICD-9), value must not exceed 5 characters~~ ~~7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 characters~~ ~~8. When there is more than one diagnosis code on a claim, each value must be unique~~ ~~9. Conditional~~ ~~10. If Type of Claim (COT.002.037) is in ("1", "3", "A", "C", "U", "W") then Diagnosis Code 1 (COT.002.027) must be populated.~~
~~COT028~~	~~COT.002.028~~	~~DIAGNOSIS-CODE-FLAG-1~~	~~Diagnosis Code Flag 1~~	~~Conditional~~	~~Flag used to identify if associated Diagnosis Code field is reported with ICD-9 or ICD-10 code. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.~~	~~DIAGNOSIS-CODE-FLAG~~	~~COT00002~~	~~CLAIM-HEADER-RECORD-OT~~	~~X(1)~~	~~13~~	~~167~~	~~167~~	~~1. Value must be in Diagnosis Code Flag List (VVL)~~ ~~2. Value must be 1 character~~ ~~3. Conditional~~ ~~4. Value should not be populated, if the associated diagnosis code is not populated~~

COT029	COT.002.029	DIAGNOSIS POA FLAG 1	Diagnosis POA Flag 1	Conditional	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator is used to identify certain preventable conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. *States that do not use the grouper methodology may use CMS-approved methodology that is prospective in nature. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.	DIAGNOSIS POA FLAG	COT00002	CLAIM HEADER RECORD OT	X(1)	14	168	168	1. Value must be in Diagnosis POA Flag List (VVL) 2. Value must be 1 character 3. Conditional
COT030	COT.002.030	DIAGNOSIS CODE 2	Diagnosis Code 2	Conditional	ICD-9 or ICD-10 diagnosis codes used as a tool to group and identify diseases, disorders, symptoms, poisonings, adverse effects of drugs and chemicals, injuries and other reasons for patient encounters. Diagnosis codes should be passed through to T-MSIS exactly as they were submitted by the provider on their claim (with the exception of removing the decimal). For example: 210.5 is coded as "2105".	DIAGNOSIS CODE	COT00002	CLAIM HEADER RECORD OT	X(7)	15	169	175	1. When populated, a Diagnosis Code Flag is required 2. If associated Diagnosis Code Flag value is "1" (ICD-9), then value must be in ICD-9 Diagnosis Codes List (VVL) 3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Codes List (VVL) 4. Value must be a minimum of 3 characters 5. Value must not contain a decimal point 6. If associated Diagnosis Code Flag value is '"1" (ICD-9), value must not exceed 5 characters 7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 characters 8. When there is more than one diagnosis code on a claim, each value must be unique 9. Conditional

													10. When populated, value cannot equal Diagnosis Code 1 (COT.002.027) 11. When Diagnosis Code 1 (COT.002.027) is not populated, value should not be populated
COT031	COT.002.031	DIAGNOSIS-CODE-FLAG-2	Diagnosis Code Flag 2	Conditional	Flag used to identify if associated Diagnosis Code field is reported with ICD-9 or ICD-10 code. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.	DIAGNOSIS-CODE-FLAG	COT00002	CLAIM-HEADER-RECORD-OT	X(1)	16	176	176	1. Value must be in Diagnosis Code Flag List (VVL) 2. Value must be 1 character 3. Conditional 4. Value should not be populated, if the associated diagnosis code is not populated
COT032	COT.002.032	DIAGNOSIS-POA-FLAG-2	Diagnosis POA Flag 2	Conditional	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator is used to identify certain preventable conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. *States that do not use the grouper methodology may use CMS-approved methodology that is prospective in nature. Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given file segment record. For example, Diagnosis Code n is associated with Diagnosis Code Flag n, where n can be any integer greater than or equal to 1.	DIAGNOSIS-POA-FLAG	COT00002	CLAIM-HEADER-RECORD-OT	X(1)	17	177	177	1. Value must be in Diagnosis POA Flag List (VVL) 2. Value must be 1 character 3. Conditional

COT033	COT.002.033	BEGINNING-DATE-OF-SERVICE	Beginning Date of Service	Mandatory	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, this would be 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. For financial transactions reported to the OT file, populate with the first day of the time period covered by this financial transaction.~~	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	~~18~~12	~~178~~160	~~185~~167	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3. When Type of Claim is not in ['2', '4', 'B', 'D', 'V'] value must be~~ in the form "CCYYMMDD" 2. Value must be less than or equal to associated End of Time Period value ~~4~~3. Value must be less than or equal to associated Ending Date of Service value ~~5. When Type of Claim is not in ['2', '4', 'B', 'D', 'V'] value~~4. Value must be less than or equal to associated Adjudication Date value ~~6~~5. Value must be less than or equal to associated Date of Death (ELG.002.025) value when populated ~~7~~6. Value must be less than or equal to at least one of the eligible's Enrollment End Date (ELG.021.254) values ~~8~~7. Mandatory
COT034	COT.002.034	ENDING-DATE-OF-SERVICE	Ending Date of Service	Mandatory	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. For financial transactions reported to the OT file, populate with the first day of the time period covered by this financial transaction.~~	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	~~19~~13	1~~8~~68	~~193~~175	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3. When Type of Claim is not in ['2', '4', 'B', 'D', 'V'] value must be~~ in the form "CCYYMMDD" 2. Value must be less than or equal to associated End of Time Period value ~~4~~3. Value must be greater than or equal to associated Beginning Date of Service value ~~5. When Type of Claim is not in ['2', '4', 'B', 'D', 'V'] value~~4. Value must be less than or equal to associated Adjudication Date value ~~6~~5. Value must be less than or equal to associated Date of Death (ELG.002.025) value

													when populated ~~7~~6. Value must be equal to or greater than associated Date of Birth (ELG.002.024) value ~~8~~7. Mandatory
COT035	COT.002.035	ADJUDICATION-DATE	Adjudication Date	Mandatory	The date on which the payment status of the claim was finally adjudicated by the state. For Encounter Records (Type of Claim = 3, C, W), use date the encounter was processed by the state.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	~~20~~14	~~194~~176	~~201~~183	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value should be on or before End of Time Period ~~value found in~~(CIP.001.010) 3. Mandatory 4. Value should be on or after associated ~~T-MSIS File Header Record~~ ~~4. Mandatory~~Admission Date value
COT036	COT.002.036	MEDICAID-PAID-DATE	Medicaid Paid Date	Mandatory	The date Medicaid paid this claim or adjustment. For Encounter Records (Type of Claim = 3, C, W), the date the managed care organization paid the provider for the claim or adjustment.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	~~21~~15	~~202~~184	~~209~~191	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Total Medicaid Paid Amount ~~4~~3. Mandatory

COT037	COT.002.037	TYPE-OF-CLAIM	Type of Claim	Mandatory	A code to indicate what type of payment is covered in this claim. For sub-capitated encounters from a sub-capitated entity or sub-capitated network provider, report TYPE-OF-CLAIM = '3' for a Medicaid sub-capitated encounter record or “C” for an S-CHIP sub-capitated encounter record	TYPE-OF-CLAIM	COT00002	CLAIM-HEADER-RECORD-OT	X(1)	2216	210192	210192	1.1. Value must be 1 character 2. Value must be in Type of Claim List (VVL) 2. Value must be 1 character 3.3. Mandatory 4. When value equals 'Z', claim denied indicator must equal '0'
COT038	COT.002.038	TYPE-OF-BILL	Type of Bill	Conditional	A data element corresponding with UB-04 form locator FL4 that classifies the claim as to the type of facility (2nd digit), type of care (3rd digit) and the billing record's sequence in the episode of care (4th digit). (Note that the 1st digit is always zero.)	TYPE-OF-BILL	COT00002	CLAIM-HEADER-RECORD-OT	X(4)	2317	211193	214196	1.1. Value must be 4 characters 2. Value must be in Type of Bill List (VVL) 2. Value must be 4 characters 3.3. First character must be a '0'"0" 4. Conditional
COT039	COT.002.039	CLAIM-STATUS	Claim Status	Conditional	The health care claim status codes convey the status of an entire claim. status codes from the 277 transaction set. Only report the claim status for the final, adjudicated claim.	CLAIM-STATUS	COT00002	CLAIM-HEADER-RECORD-OT	X(3)	2418	215197	217199	1.1. Value must be 3 characters or less 2. Value must be in Claim Status List (VVL) 2. Value must be 3 characters or less 3.3. Conditional 4. If value in [26, 87, 542,585,654 1,], then Claim Denied Indicator must be '0'"0" and Claim Status Category must be "F2"
COT040	COT.002.040	CLAIM-STATUS-CATEGORY	Claim Status Category	Mandatory	The Claim Status Category conveys the status general category of the entire claim using the X12 Claim Status Category Codesstatus (accepted, rejected, pended, finalized, additional information requested, etc.) from the 277 transaction set which is then further detailed in the companion data element claim adjudication processstatus.	CLAIM-STATUS-CATEGORY	COT00002	CLAIM-HEADER-RECORD-OT	X(3)	2519	218200	2202	1.1. Value must be 3 characters or less 2. Value must be in Claim Status Category List (VVL) 23. (Denied Claim) if associated Claim Denied Indicator indicates the claim was denied, then value must be "F2" 34. (Denied Claim) if associated Type of Claim equals Z or associated Claim Status is in [26, 87, 542, 8585,654], then value must be "F2" 4. Value must be 3 characters or less 5. Mandatory

COT041	COT.002.041	SOURCE-LOCATION	Source Location	Mandatory	~~The field denotes the claims payment system from which the claim was extracted.~~The field denotes the claims payment system from which the claim was extracted. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report a SOURCE-LOCATION = '22' to indicate that the sub-capitated entity paid a provider for the service to the enrollee on a FFS basis. For sub-capitated encounters from a sub-capitated network provider that were submitted to sub-capitated entity, report a SOURCE-LOCATION = '23' to indicate that the sub-capitated network provider provided the service directly to the enrollee. For sub-capitated encounters from a sub-capitated network provider, report a SOURCE-LOCATION = “23” to indicate that the sub-capitated network provider provided the service directly to the enrollee.	SOURCE-LOCATION	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	~~26~~20	~~221~~203	~~222~~204	~~1.~~1. Value must be 2 characters 2. Value must be in Source Location List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory
COT042	COT.002.042	CHECK-NUM	Check Number	Conditional	The check or electronic funds transfer number.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(15)	~~27~~21	~~223~~205	~~237~~219	1. Value must be 15 characters or less 2. Value must have an associated Check Effective Date 3. Value must not contain a pipe or asterisk symbols 4. Conditional
COT043	COT.002.043	CHECK-EFF-DATE	Check Effective Date	Conditional	The date a check is issued to the payee. In the case of electronic funds transfer, it is the date the transfer is made.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	~~28~~22	~~238~~220	~~245~~227	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3. Value may be the same as associated~~

													~~Remittance Date~~ ~~4.~~ in the form "CCYYMMDD" 2. Must have an associated Check Number ~~5~~3. Conditional
COT044	COT.002.044	CLAIM-PYMT-REM-CODE-1	~~Claim Payment~~Remittance Advice Remark Code 1	Conditional	Remittance Advice Remark Codes are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Each Remittance Advice Remark Code identifies a specific message as shown in the Remittance Advice Remark Code List. It is a code set used by the health care industry to convey non-financial information critical to understanding the adjudication of a health care claim for payment. It is an external code set whose use is as mandated by the Administrative Simplification provisions of the Health Insurance Portability and Accountably Act of 1996 (P.L.104-191, commonly referred to as HIPAA).	CLAIM-PYMT-REM-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(5)	~~29~~23	~~246~~228	~~250~~232	~~1.~~1. Value must be 5 characters or less 2. Value must be in Claim Payment Remittance Code List (VVL) ~~2. Value must be 5 characters or less~~ ~~3.~~3. Conditional 4. When more than one ~~code~~occurrence of Claim Payment Remark Code 1 through Claim Payment Remark Code 4 is populated on a claim, all values must be unique
COT045	COT.002.045	CLAIM-PYMT-REM-CODE-2	~~Claim Payment~~Remittance Advice Remark Code 2	Conditional	Remittance Advice Remark Codes are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Each Remittance Advice Remark Code identifies a specific message as shown in the Remittance Advice Remark Code List. It is a code set used by the health care industry to convey non-financial information critical to understanding the adjudication of a health care claim for payment. It is an external code set whose use is as mandated by the Administrative Simplification provisions of the Health Insurance Portability	CLAIM-PYMT-REM-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(5)	~~30~~24	~~251~~233	~~255~~237	~~1.~~1. Value must be 5 characters or less 2. Value must be in Claim Payment Remittance Code List (VVL) ~~2. Value must be 5 characters or less~~ ~~3.~~3. Conditional 4. When more than one ~~code~~occurrence of Claim Payment Remark Code 1 through Claim Payment Remark Code 4 is populated on a claim, all values must be unique 5. Value must not be populated when ~~Claim Payment~~Remittance Advice Remark Code 1 (COT.002.044) is not populated

					and Accountably Act of 1996 (P.L.104-191, commonly referred to as HIPAA).								
COT046	COT.002.046	CLAIM-PYMT-REM-CODE-3	~~Claim Payment~~Remittance Advice Remark Code 3	Conditional	Remittance Advice Remark Codes are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Each Remittance Advice Remark Code identifies a specific message as shown in the Remittance Advice Remark Code List. It is a code set used by the health care industry to convey non-financial information critical to understanding the adjudication of a health care claim for payment. It is an external code set whose use is as mandated by the Administrative Simplification provisions of the Health Insurance Portability and Accountably Act of 1996 (P.L.104-191, commonly referred to as HIPAA).	CLAIM-PYMT-REM-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(5)	~~31~~25	~~256~~238	~~260~~242	~~1.~~1. Value must be 5 characters or less 2. Value must be in Claim Payment Remittance Code List (VVL) ~~2. Value must be 5 characters or less~~ ~~3.~~3. Conditional 4. When more than one ~~code~~occurrence of Claim Payment Remark Code 1 through Claim Payment Remark Code 4 is populated on a claim, all values must be unique 5. Value must not be populated when ~~Claim Payment~~Remittance Advice Remark Code 2 (CLT.002.045) is not populated

COT047	COT.002.047	CLAIM-PYMT-REM-CODE-4	~~Claim Payment~~Remittance Advice Remark Code 4	Conditional	Remittance Advice Remark Codes are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Each Remittance Advice Remark Code identifies a specific message as shown in the Remittance Advice Remark Code List. It is a code set used by the health care industry to convey non-financial information critical to understanding the adjudication of a health care claim for payment. It is an external code set whose use is as mandated by the Administrative Simplification provisions of the Health Insurance Portability and Accountably Act of 1996 (P.L.104-191, commonly referred to as HIPAA).	CLAIM-PYMT-REM-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(5)	~~32~~26	~~261~~243	~~265~~247	~~1.~~1. Value must be 5 characters or less 2. Value must be in Claim Payment Remittance Code List (VVL) ~~2. Value must be 5 characters or less~~ ~~3.~~3. Conditional 4. When more than one ~~code~~occurrence of Claim Payment Remark Code 1 through Claim Payment Remark Code 4 is populated on a claim, all values must be unique 5. Value must not be populated when ~~Claim Payment~~Remittance Advice Remark Code 3 (COT.002.046) is not populated
COT048	COT.002.048	TOT-BILLED-AMT	Total Billed Amount	Conditional	The total amount billed for this claim at the claim header level as submitted by the provider. For encounter records, when Type of Claim value is ~~[~~in [3, C, ~~or~~ W], then value must equal amount the provider billed to the managed care plan. ~~Total Billed Amount~~For sub-capitated encounters from a sub-capitated entity that is not ~~expected on financial transactions~~a sub-capitated network provider, report the total amount that the provider billed the sub-capitated entity for the service. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11) V99	~~33~~27	~~266~~248	~~278~~260	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Value must equal the sum of all Billed Amount instances for the associated claim 4. Conditional 5. ~~Value should not be populated when associated Type of Claim is in [2, 4, 5, B, D E or X]~~ ~~6. If associated Type of Claim value is 2, 4, 5, B, D, or E, then value should not be populated~~(individual line item payments) when populated and Payment Level Indicator (COT.002.068) equals "2" value must be greater than or equal to the sum of all claim line Revenue Charges (COT.003.168)

COT049	COT.002.049	TOT-ALLOWED-AMT	Total Allowed Amount	Conditional	The claim header level maximum amount determined by the payer as being 'allowable' under the provisions of the contract prior to the determination of actual payment. On FFS claims the Allowed Amount is determined by the state's MMIS. On managed care encounters the Allowed Amount is determined by the managed care organization. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the total amount that the sub-capitated entity allowed for the service. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11) V99	~~34~~28	~~279~~261	~~291~~273	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. When populated and Payment Level Indicator ~~= '2'~~equals "2", then value must equal the sum of all claim line Allowed Amount values 4. Conditional

COT050	COT.002.050	TOT-MEDICAID-PAID-AMT	Total Medicaid Paid Amount	Conditional	The total amount paid by Medicaid/CHIP or the managed care plan on this claim or adjustment at the claim header level, which is the sum of the amounts paid by Medicaid or the managed care plan at the detail level for the claim. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the total amount that the sub-capitated entity paid the provider for the service. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11) V99	~~35~~29	~~292~~274	~~304~~286	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Must have an associated Medicaid Paid Date 4. If Total Medicare Coinsurance Amount and Total Medicare Deductible Amount is reported it must equal Total Medicaid Paid Amount 5. When Payment Level Indicator equals '"2"', value must equal the sum of line level Medicaid Paid Amounts. 6. Conditional 7. Value must not be populated or equal to "0.00" when associated Claim Status is in [542,585,654] 8. Value must not be greater than Total Allowed Amount (COT.002.049)
~~COT051~~	~~COT.002.051~~	~~TOT-COPAY-AMT~~	~~Total Copayment Amount~~	~~Conditional~~	~~The total amount paid by Medicaid/CHIP enrollee for each office or emergency department visit or purchase of prescription drugs in addition to the amount paid by Medicaid/CHIP.~~	~~N/A~~	~~COT00002~~	~~CLAIM-HEADER-RECORD-OT~~	~~S9(11) V99~~	~~36~~	~~305~~	~~317~~	~~1. Value must be between -99999999999.99 and 99999999999.99~~ ~~2. Value must be expressed as a number with 2-digit precision (e.g. 100.50)~~ ~~3. Conditional~~

COT052	COT.002.052	TOT-MEDICARE-DEDUCTIBLE-AMT	Total Medicare Deductible Amount	Conditional	The amount paid by Medicaid/CHIP, on this claim at the claim header level, toward the beneficiary's Medicare deductible. 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, code Medicare Combined Indicator a "1"'1' and leave Total Medicare Coinsurance Amount unpopulated.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11) V99	3730	318287	330299	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Crossover Indicator value is '0'equals "0" (not a crossover claim), then value should not be populated. 4. (Medicare Enrolled) if associated Dual Eligible Code (ELG.005.085) value is in ["[01", "¿02", "¿03", "¿04", "¿05", "¿06", "¿08", "¿09", or "¿10"],, then value is mandatory and must be provided 5. Conditional 6. When populated, value must be less than or equal to Total Billed Amount
COT053	COT.002.053	TOT-MEDICARE-COINS-AMT	Total Medicare Coinsurance Amount	Conditional	The total amount paid by the Medicaid/CHIP agency or a managed care plan towards the portion of the Medicare allowed charges that Medicare applied to coinsurance.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11) V99	3831	331300	343312	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Crossover Indicator value is '0'equals "0" (not a crossover claim), then value should not be populated. 4. Conditional 5. If associated Medicare Combined Deductible Indicator is '1',equals "1", then value must not be populated 6. When populated, value must be less than or equal to Total Billed Amount

COT054	COT.002.054	TOT-TPL-AMT	Total ~~Third Party Liability~~TPL Amount	Conditional	Third-party liability refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a state plan. This is the total amount denoted at the claim header level paid by the third party.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11) V99	~~39~~32	~~344~~313	3~~25~~6	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Value must be less than associated Total Billed Amount - (Total Medicare Coinsurance Amount + Total Medicare Deductible Amount) 4. Conditional
COT056	COT.002.056	TOT-OTHER-INSURANCE-AMT	Total Other Insurance Amount	Conditional	The amount paid by insurance other than Medicare or Medicaid on this claim.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11) V99	~~40~~33	~~357~~326	~~369~~338	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
COT057	COT.002.057	OTHER-INSURANCE-IND	Other Insurance Indicator	Conditional	The field denotes whether the insured party is covered under an other insurance plan other than Medicare or Medicaid.	OTHER-INSURANCE-IND	COT00002	CLAIM-HEADER-RECORD-OT	X(1)	~~41~~34	~~370~~339	~~370~~339	~~1.~~1. Value must be 1 character 2. Value must be in Other Insurance Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Conditional
COT058	COT.002.058	OTHER-TPL-COLLECTION	Other TPL Collection	~~Conditional~~ Mandatory	This data element indicates that the claim is for a beneficiary for whom other third party resource development and collection activities are in progress, when the liability is not another health insurance plan for which the eligible is a beneficiary.	OTHER-TPL-COLLECTION	COT00002	CLAIM-HEADER-RECORD-OT	X(3)	~~42~~35	~~371~~340	~~373~~342	1. Value must be in Other TPL Collection List (VVL) 2. Value must be 3 characters 3. ~~Conditional~~Mandatory
~~COT059~~	~~COT.002.059~~	~~SERVICE-TRACKING-TYPE~~	~~Service Tracking Type~~	~~Conditional~~	~~A code to categorize service tracking claims. A "service tracking claim" is used to report lump sum payments that cannot be attributed to a single enrollee.~~	~~SERVICE-TRACKING-TYPE~~	~~COT00002~~	~~CLAIM-HEADER-RECORD-OT~~	~~X(2)~~	~~43~~	~~374~~	~~375~~	~~1. Value must be in Service Tracking Type List (VVL)~~ ~~2. (Service Tracking Claim) if associated Type of Claim is in ['4','D', 'X'] then value is mandatory and must be reported~~ ~~3. Value must be 2 characters~~ ~~4. Conditional~~

~~COT060~~	~~COT.002.060~~	~~SERVICE-TRACKING-PAYMENT-AMT~~	~~Service Tracking Payment Amount~~	~~Conditional~~	~~On service tracking claims, the payment amount is the lump sum that cannot be attributed to any one beneficiary paid to the provider.~~	~~N/A~~	~~COT00002~~	~~CLAIM-HEADER-RECORD-OT~~	~~S9(11) V99~~	~~44~~	~~376~~	~~388~~	~~1. Value must be between -99999999999.99 and 99999999999.99~~ ~~2. Value must be expressed as a number with 2-digit precision (e.g. 100.50)~~ ~~3. If associated Type of Claim value is in [4, D, or X], then value is mandatory and must be provided~~ ~~4. Conditional~~ ~~5. When populated, Service Tracking Type must be populated~~ ~~6. When populated, Total Medicaid Amount must not be populated~~
COT061	COT.002.061	FIXED-PAYMENT-IND	Fixed Payment Indicator	Conditional	This indicator indicates that the reimbursement amount included on the claim is for a fixed payment. Fixed payments are made by the state to insurers or providers for premiums or eligible coverage, not for a particular service. For example, some states have Primary Care Case Management programs where the state pays providers a monthly patient management fee of $3.50 for each eligible participant under their care. This fee is considered a fixed payment. It is very important for states to correctly identify fixed payments. Fixed payments do not have a defined ~~"medical record"~~'medical record' associated with the payment; therefore, fixed payments are not subject to medical record request and medical record review.	FIXED-PAYMENT-IND	COT00002	CLAIM-HEADER-RECORD-OT	X(1)	~~45~~36	~~389~~343	~~389~~343	~~1.~~1. Value must be 1 character 2. Value must be in Fixed Payment Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Conditional
COT062	COT.002.062	FUNDING-CODE	Funding Code	~~Mandatory~~Conditional	A code to indicate the source of non-federal share funds.	FUNDING-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	~~46~~37	~~390~~344	~~391~~345	~~1.~~1. Value must be 1 character 2. Value must be in Funding Code List (VVL) ~~2. Value must be 1 character~~ ~~3. Mandatory~~3. If Type of Claim is not in [3,C,W], then value must be populated 4. Conditional

COT063	COT.002.063	FUNDING-SOURCE-NONFEDERAL-SHARE	Funding Source Non-Federal Share	~~Not Applicable~~Conditional	A code to indicate the type of non-federal share used by the state to finance its expenditure to the provider. In the event of two sources, states are to report the portion which represents the largest proportion not funded by the Federal government.	FUNDING-SOURCE-NONFEDERAL-SHARE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	~~47~~38	~~392~~346	~~393~~347	~~1.~~1. Value must be 2 characters 2. Value must be in Funding Source Non-Federal Share List (VVL) ~~2. Value must be 2 characters~~ ~~3. Required~~3. If Type of Claim is in [3,C,W], then value must be populated 4. Conditional
COT064	COT.002.064	MEDICARE-COMB-DED-IND	Medicare Combined Deductible Indicator	Conditional	Code indicating that the amount paid by Medicaid/CHIP on this claim toward the recipient's Medicare deductible was combined with their coinsurance amount because the amounts could not be separated.	MEDICARE-COMB-DED-IND	COT00002	CLAIM-HEADER-RECORD-OT	X(1)	~~48~~39	3~~9~~48	3~~9~~48	~~1.~~1. Value must be 1 character 2. Value must be in Medicare Combined Deductible Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. If value equals ~~'~~'1~~'~~', then Total Medicare Coinsurance amount ~~is~~must not be populated~~.~~ 4. ~~Value must equal '0' if associated Type of Claim is '3', 'C' or 'W'~~If value equals "0", then Crossover Indicator must equals "0" 5. If value equals "1", then Crossover Indicator must equals "1" 6. Conditional
COT065	COT.002.065	PROGRAM-TYPE	Program Type	Mandatory	A code to indicate special Medicaid program under which the service was provided.	PROGRAM-TYPE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	~~49~~40	3~~9~~5~~5~~	~~396~~350	~~1.~~1. Value must be 2 characters 2. Value must be in Program Type List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. (Community First Choice) If value equals ~~'~~'11~~'~~', then State Plan Option Type (ELG.011.163) must equal ~~'~~'01~~'~~' for the same time period 5. If value equals ~~'~~'13~~'~~', then State Plan Option Type (ELG.011.163) must equal ~~'~~'02~~'~~' for the same time period

COT066	COT.002.066	PLAN-ID-NUMBER	Plan ID Number	Conditional	A unique number assigned by the state which represents a distinct comprehensive managed care plan, prepaid health plan, primary care case management program, a program for all-inclusive care for the elderly entity, or other approved plans. For sub-capitated encounters from a sub-capitated entity or sub-capitated network provider, report the PLAN-ID-NUMBER for the MCP (MCO, PIHP, or PAHP that has a contract with a state) that is making the payment to the sub-capitated entity or sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(12)	~~50~~41	~~397~~351	~~408~~362	1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional 4. Value must match Managed Care Plan ID (ELG.014.192) 5. Value must match State Plan ID Number (MCR.002.019) 6. When Type of Claim (COT.002.037) in ~~(~~[3,C,W~~, 2, B, V)~~] value must have a managed care enrollment (ELG.014) for the beneficiary where the Beginning DOS (COT.002.033) occurs between the managed care plan enrollment eff/end dates (ELG.014.197/198) 7. When Type of Claim (COT.002.037) in ~~(~~[3,C,W~~, 2, B, V)~~] value must have a managed care main record (MCR.002) for the plan where the Beginning DOS (COT.002.03~~3~~7) occurs between the managed care contract eff/end dates (MCR.002.020/021) ~~8. If Type of Claim (COT.002.037) does not equal 3, C, W (Encounter Record) and Type of Service (COT.003.186) does not equal 119, 120, 121, 122 (Capitation payments) value must not be populated~~
~~COT067~~	~~COT.002.067~~	~~NATIONAL-HEALTH-CARE-ENTITY-ID~~	~~National Health Care Entity ID~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~COT00002~~	~~CLAIM-HEADER-RECORD-OT~~	~~X(10)~~	~~51~~	~~409~~	~~418~~	~~1. Not Applicable~~

COT068	COT.002.068	PAYMENT-LEVEL-IND	Payment Level Indicator	Mandatory	~~The field denotes whether the payment amount was determined at the claim header or line/detail level.~~The field denotes whether the payment amount was determined at the claim header or line/detail level. For claims where payment is NOT determined at the individual line level (PAYMENT-LEVEL-IND = 1), the claim lines' associated allowed (ALLOWED-AMT) and paid (MEDICAID-PAID-AMT) amounts are left blank and the total allowed (TOT-ALLOWED-AMT) and total paid (TOT-MEDICAID-PAID-AMT) amount is reported at the header level only. For claims where payment/allowed amount is determined at the individual lines and when applicable, cost-sharing and/or coordination of benefits were deducted from one or more specific line-level payment/allowed amounts (PAYMENT-LEVEL-IND = 2), the allowed (ALLOWED-AMT) and paid (MEDICAID-PAID-AMT) amounts on the associated claim lines should sum to the total allowed (TOT-ALLOWED-AMT) and total paid (TOT-MEDICAID-PAID-AMT) amounts reported on the claim header. For claims where payment/allowed amount is determined at the individual lines but then cost sharing or coordination of benefits was deducted from the total paid/allowed amount at the header only (PAYMENT-LEVEL-IND = 3), then the line-level paid amount (MEDICAID-PAID-AMT) would be blank and line-level allowed (ALLOWED-AMT) and header level total allowed (TOT-ALLOWED-AMT) and total paid (TOT-MEDICAID-PAID-AMT) amounts must all be populated but the line level allowed amounts are not expected to sum exactly to the header level total allowed.	PAYMENT-LEVEL-IND	COT00002	CLAIM-HEADER-RECORD-OT	X(1)	~~52~~42	~~419~~363	~~419~~363	~~1.~~1. Value must be 1 character 2. Value must be in Payment Level Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory

					For example, if a claim for an office visit and a procedure is assigned a separate line-level allowed amount for each line, but then at the header level a copay is deducted from the header-level total allowed and/or total paid amounts, then the sum of line-level allowed amounts may not be equal to the header-level total allowed amounts or correspond directly to the total paid amount. If the state cannot distinguish between the scenarios for value 1 and value 3, then value 1 can be used for all claims with only header-level total allowed/paid amounts.								
COT069	COT.002.069	MEDICARE-REIM-TYPE	Medicare Reimbursement Type	Conditional	A code to indicate the type of Medicare reimbursement.	MEDICARE-REIM-TYPE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	~~53~~43	~~420~~364	~~421~~365	~~1.~~1. Value must be 2 characters 2. Value must be in Medicare Reimbursement Type List (VVL) ~~2. (Crossover Claim) if associated Crossover Indicator value indicates a crossover claim, value~~3. Value is mandatory and must be provided ~~3. Value must be 2 characters~~ , when Crossover Indicator is equal to "1"

													(Crossover Claim) 4. Conditional
COT070	COT.002.070	CLAIM-LINE-COUNT	Claim Line Count	Mandatory	The total number of lines on the claim.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(4)	~~5~~444	~~422~~366	~~425~~369	1. Value must be 4 characters or less 2. Value must be a positive integer ~~2~~3. Value must be between ~~0~~00000:9999 (inclusive) ~~3~~4. Value must not include commas or other non-numeric characters ~~4~~5. Value must be equal to the number of claim lines (e.g. Original Claim Line Number or Adjustment Claim Line Number instances) reported in the associated claim record being reported ~~5. Value must be 4 characters or less~~ 6. Mandatory
COT072	COT.002.072	FORCED-CLAIM-IND	Forced Claim Indicator	Conditional	~~The charges for inpatient care, which are not reimbursable by the primary payer. The non-covered charges do not refer to charges not covered for any other service. see US Dollar Amount (DT.008)~~Indicates if the claim was processed by forcing it through a manual override process.	FORCED-CLAIM-IND	COT00002	CLAIM-HEADER-RECORD-OT	X(1)	~~55~~45	~~426~~370	~~426~~370	~~1.~~1. Value must be 1 character 2. Value must be in Forced Claim Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Conditional
COT073	COT.002.073	HEALTH-CARE-ACQUIRED-CONDITION-IND	Healthcare Acquired Condition Indicator	Conditional	This code indicates whether the claim has a Health Care Acquired Condition. For additional coding information refer to the following site~~:~~ : https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html?redirect=/hospitalacqcond/05_Coding.asp#TopOfPage	HEALTH-CARE-ACQUIRED-CONDITION-IND	COT00002	CLAIM-HEADER-RECORD-OT	X(1)	~~56~~46	~~427~~371	~~427~~371	~~1.~~1. Value must be 1 character 2. Value must be in Healthcare Acquired Condition Indicator List (VVL~~).~~ ~~2. Value must be 1 character~~) 3. Conditional

COT074	COT.002.074	OCCURRENCE-CODE-01	Occurrence Code 1	Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are ~~FLs~~Form Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.	OCCURRENCE-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	~~57~~47	~~428~~372	~~429~~373	~~1.~~1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional
COT075	COT.002.075	OCCURRENCE-CODE-02	Occurrence Code 2	Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are ~~FLs~~Form Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.	OCCURRENCE-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	~~58~~48	~~430~~374	~~431~~375	~~1.~~1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional
COT076	COT.002.076	OCCURRENCE-CODE-03	Occurrence Code 3	Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are ~~FLs~~Form Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.	OCCURRENCE-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	~~59~~49	~~432~~376	~~433~~377	~~1.~~1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional
COT077	COT.002.077	OCCURRENCE-CODE-04	Occurrence Code 4	Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are ~~FLs~~Form Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.	OCCURRENCE-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	~~60~~50	~~434~~378	~~435~~379	~~1.~~1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional
COT078	COT.002.078	OCCURRENCE-CODE-05	Occurrence Code 5	Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are ~~FLs~~Form Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.	OCCURRENCE-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	~~61~~51	~~436~~380	~~437~~381	~~1.~~1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional

COT079	COT.002.079	OCCURRENCE-CODE-06	Occurrence Code 6	Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are ~~FLs~~Form Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.	OCCURRENCE-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	~~62~~52	~~4~~382	~~439~~383	~~1.~~1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional
COT080	COT.002.080	OCCURRENCE-CODE-07	Occurrence Code 7	Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are ~~FLs~~Form Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.	OCCURRENCE-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	~~63~~53	~~440~~384	~~441~~385	~~1.~~1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional
COT081	COT.002.081	OCCURRENCE-CODE-08	Occurrence Code 8	Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are ~~FLs~~Form Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.	OCCURRENCE-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	~~64~~54	~~442~~386	~~443~~387	~~1.~~1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional
COT082	COT.002.082	OCCURRENCE-CODE-09	Occurrence Code 9	Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are ~~FLs~~Form Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.	OCCURRENCE-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	~~65~~55	~~444~~388	~~445~~389	~~1.~~1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional
COT083	COT.002.083	OCCURRENCE-CODE-10	Occurrence Code 10	Conditional	A code to describe specific event(s) relating to this billing period covered by the claim. (These are ~~FLs~~Form Locators 31, 32, 33, 34, 35, and 36 - Occurrence Codes on the UB04.) These fields can be used for either occurrences or occurrence spans.	OCCURRENCE-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	~~66~~56	~~446~~390	~~447~~391	~~1.~~1. Value must be 2 characters 2. Value must be in Occurrence Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional

COT084	COT.002.084	OCCURRENCE-CODE-EFF-DATE-01	Occurrence Code Effective Date 1	Conditional	The start date of the corresponding occurrence code or occurrence span codes.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	~~67~~57	~~448~~392	~~455~~399	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code ~~4~~3. Conditional ~~5~~4. Value must be less than or equal to Occurrence Code End Date
COT085	COT.002.085	OCCURRENCE-CODE-EFF-DATE-02	Occurrence Code Effective Date 2	Conditional	The start date of the corresponding occurrence code or occurrence span codes.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	~~68~~58	~~456~~400	~~463~~407	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code ~~4~~3. Conditional ~~5~~4. Value must be less than or equal to Occurrence Code End Date
COT086	COT.002.086	OCCURRENCE-CODE-EFF-DATE-03	Occurrence Code Effective Date 3	Conditional	The start date of the corresponding occurrence code or occurrence span codes.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	~~69~~59	~~464~~408	4~~7~~15	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code ~~4~~3. Conditional ~~5~~4. Value must be less than or equal to Occurrence Code End Date

COT087	COT.002.087	OCCURRENCE-CODE-EFF-DATE-04	Occurrence Code Effective Date 4	Conditional	The start date of the corresponding occurrence code or occurrence span codes.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	~~70~~60	~~472~~416	~~479~~423	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code ~~4~~3. Conditional ~~5~~4. Value must be less than or equal to Occurrence Code End Date
COT088	COT.002.088	OCCURRENCE-CODE-EFF-DATE-05	Occurrence Code Effective Date 5	Conditional	The start date of the corresponding occurrence code or occurrence span codes.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	~~71~~61	~~480~~424	~~487~~431	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code ~~4~~3. Conditional ~~5~~4. Value must be less than or equal to Occurrence Code End Date
COT089	COT.002.089	OCCURRENCE-CODE-EFF-DATE-06	Occurrence Code Effective Date 6	Conditional	The start date of the corresponding occurrence code or occurrence span codes.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	~~72~~62	~~488~~432	43~~5~~	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code ~~4~~3. Conditional ~~5~~4. Value must be less than or equal to Occurrence Code End Date

COT090	COT.002.090	OCCURRENCE-CODE-EFF-DATE-07	Occurrence Code Effective Date 7	Conditional	The start date of the corresponding occurrence code or occurrence span codes.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	~~73~~63	~~496~~440	~~503~~447	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code ~~4~~3. Conditional ~~5~~4. Value must be less than or equal to Occurrence Code End Date
COT091	COT.002.091	OCCURRENCE-CODE-EFF-DATE-08	Occurrence Code Effective Date 8	Conditional	The start date of the corresponding occurrence code or occurrence span codes.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	~~74~~64	~~504~~448	~~511~~455	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code ~~4~~3. Conditional ~~5~~4. Value must be less than or equal to Occurrence Code End Date
COT092	COT.002.092	OCCURRENCE-CODE-EFF-DATE-09	Occurrence Code Effective Date 9	Conditional	The start date of the corresponding occurrence code or occurrence span codes.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	~~75~~65	~~512~~456	~~519~~463	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code ~~4~~3. Conditional ~~5~~4. Value must be less than or equal to Occurrence Code End Date

COT093	COT.002.093	OCCURRENCE-CODE-EFF-DATE-10	Occurrence Code Effective Date 10	Conditional	The start date of the corresponding occurrence code or occurrence span codes.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	~~76~~66	~~520~~464	~~527~~471	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. When populated, value must have an associated populated Occurrence Code ~~4~~3. Conditional ~~5~~4. Value must be less than or equal to Occurrence Code End Date
COT094	COT.002.094	OCCURRENCE-CODE-END-DATE-01	Occurrence Code End Date 1	Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	~~77~~67	~~528~~472	~~535~~479	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional
COT095	COT.002.095	OCCURRENCE-CODE-END-DATE-02	Occurrence Code End Date 2	Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	~~78~~68	~~536~~480	~~543~~487	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional

COT096	COT.002.096	OCCURRENCE-CODE-END-DATE-03	Occurrence Code End Date 3	Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	~~79~~69	~~544~~488	~~551~~495	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional
COT097	COT.002.097	OCCURRENCE-CODE-END-DATE-04	Occurrence Code End Date 4	Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	~~80~~70	~~552~~496	~~559~~503	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional
COT098	COT.002.098	OCCURRENCE-CODE-END-DATE-05	Occurrence Code End Date 5	Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	~~81~~71	5~~6~~04	~~567~~511	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional

COT099	COT.002.099	OCCURRENCE-CODE-END-DATE-06	Occurrence Code End Date 6	Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	~~82~~72	~~568~~512	~~575~~519	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional
COT100	COT.002.100	OCCURRENCE-CODE-END-DATE-07	Occurrence Code End Date 7	Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	~~83~~73	~~576~~520	~~583~~527	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional
COT101	COT.002.101	OCCURRENCE-CODE-END-DATE-08	Occurrence Code End Date 8	Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	~~84~~74	528~~4~~	~~591~~535	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional

COT102	COT.002.102	OCCURRENCE-CODE-END-DATE-09	Occurrence Code End Date 9	Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	~~85~~75	~~592~~536	~~599~~543	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional
COT103	COT.002.103	OCCURRENCE-CODE-END-DATE-10	Occurrence Code End Date 10	Conditional	The last date that the corresponding occurrence code or occurrence span code was applicable. If occurrence date span is a single day, value must be equal to the value of the associated Occurrence Code Effective Date.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	~~86~~76	~~600~~544	~~607~~551	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Occurrence Code 3. Must be greater than or equal to Occurrence Code Effective Date 4. Conditional
COT104	COT.002.104	PATIENT-CONTROL-NUM	Patient Control Number	Conditional	A patient's unique number assigned by the provider agency during claim submission, which identifies the client or the client's episode of service within the provider's system to facilitate retrieval of individual financial and clinical records and posting of payment	N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(20)	~~87~~77	~~608~~552	~~627~~571	1. Value must be 20 characters or less 2. Value must not contain a pipe or asterisk symbol 3. Conditional
COT105	COT.002.105	ELIGIBLE-LAST-NAME	Eligible Last Name	Conditional	The last name of the individual to whom the services were provided. (The patients name should be captured as it appears on the claim record, it does not need to be the same as it appears on the eligibility file. The MSIS Identification Number will be used to associate a claim record with the appropriate eligibility data.)	N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(30)	~~88~~78	~~628~~572	~~657~~601	1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional

COT106	COT.002.106	ELIGIBLE-FIRST-NAME	Eligible First Name	Conditional	The first name of the individual to whom the services were provided. (The patients name should be captured as it appears on the claim record, it does not need to be the same as it appears on the eligibility file. The MSIS Identification Number will be used to associate a claim record with the appropriate eligibility data.)	N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(30)	~~89~~79	~~658~~602	~~687~~631	1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional
COT107	COT.002.107	ELIGIBLE-MIDDLE-INIT	Eligible Middle Initial	Conditional	Individual's middle initial; middle initial component of full name (e.g. First Name, Middle Initial, Last Name).	N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(1)	~~90~~80	~~688~~632	~~688~~632	1. ~~Value may include any alphanumeric characters, digits or symbols~~ ~~2.~~ Value must be 1 character ~~3~~2. Value must not contain a pipe or asterisk symbols ~~4~~3. Conditional
COT108	COT.002.108	DATE-OF-BIRTH	Date of Birth	Mandatory	An individual's date of birth.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	~~91~~81	~~689~~633	~~696~~640	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Mandatory
COT109	COT.002.109	HEALTH-HOME-PROV-IND	Health Home Provider Indicator	Conditional	Indicates whether the claim is submitted by a provider or provider group enrolled in the Health Home care model~~.~~ to provide services for the beneficiary on the claim. Health home providers provide service for patients with chronic illnesses. ~~States should not submit claim records for an eligible individual that indicate the claim was submitted by a provider or provider group enrolled in a health home model if the eligible individual is not enrolled in the health home program.~~ States that do not specify an eligible individual's health home provider number, if applicable, should not report claims that indicate the claim is submitted by a provider or	HEALTH-HOME-PROV-IND	COT00002	CLAIM-HEADER-RECORD-OT	X(1)	~~92~~82	~~697~~641	~~697~~641	1. Value must be in Health Home Provider Indicator List (VVL) 2. Value must be 1 character 3. If there is an associated Health Home Entity Name value, then value must be "1" ~~3. Value must be 1 character~~ ~~4.~~4. Conditional

					provider group enrolled in the health home model.								
COT110	COT.002.110	WAIVER-TYPE	Waiver Type	Conditional	A code for specifying waiver type under which the eligible individual is covered during the month and receiving services/under which claim is submitted.	WAIVER-TYPE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	~~93~~83	~~698~~642	~~699~~643	~~1.~~1. Value must be 2 characters 2. Value must be in Waiver Type List (VVL) ~~2. Value must be 2 characters~~ ~~3. Value must be in ['06', '07', '08', '09', '10', '11', '12', '13', '14', '15', '16', '17', '18', '19', '20', '33'] when associated Program Type equals "07"~~ ~~4.~~3. Value must match Eligible Waiver Type (ELG.012.173) for the enrollee for the same time period (by date of service) 4. When populated, Waiver ID (COT.002.111) must be populated 5. Conditional 6. Value must be in [06,07,08,09,10,11,12,13,14,15,16,17,18,19,20,33] when associated Program Type equals "07"

COT111	COT.002.111	WAIVER-ID	Waiver ID	Conditional	Field specifying the waiver or demonstration which authorized payment for a claim. These IDs must be the approved, full federal waiver ID number assigned during the state submission and CMS approval process. Waiver IDs should actually only be the "core" part of the waiver IDs, without including suffixes for renewals or amendments.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(20)	~~94~~84	~~700~~644	~~719~~663	~~1.~~1. Value must be 20 characters or less 2. Value must be associated with a populated Waiver Type ~~2. Value must be 20 characters or less~~ ~~3.~~3. (1115 demonstration ~~waivers~~) If value begins with "11-W-" or "21-W-", the associated Claim Waiver Type value must be 01 or in [21-30] 4. (1115 demonstration) If value begins with"11-W-" or "21-W-", then the value must include slash "/" in the 11th position followed by the last digit of the CMS Region [0-9] in the 12th position 5. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation followed by a period (.), the associated Claim Waiver Type value must be in [02-20,32,33] ~~5~~6. Conditional

COT112	COT.002.112	BILLING-PROV-NUM	Billing Provider Number	Conditional	A unique identification number assigned by the state to a provider or ~~capitation~~managed care plan. This data element should represent the entity billing for the service. For encounter records, if associated Type of Claim value equals 3, C, or W, then value must be the state identifier of the provider or entity (billing or reporting) to the managed care plan.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(30)	~~95~~85	~~720~~664	~~749~~693	1. Value must be 30 characters or less 2. ~~Value must be reported in Provider Identifier (PRV.005.080) with an associated Provider Identifier Type (PRV.005.081) equal to '1'~~ ~~3.~~ Conditional ~~4~~3. When Type of Claim not in ~~('Z','3','C','W',"2","B","V"," 4","D","X")~~[3,C,W] then value may match (PRV.002.019) Submitting State Provider ID or 4. When Type of Claim not in ~~('Z','3','C','W',"2","B","V"," 4","D","X")~~[3,C,W] then value may match (PRV.005.081) Provider Identifier where the Provider Identifier Type ~~=~~ ~~'1'~~(PRV.005.077) equals "1" 5. Must have an enrollment where the Ending Date of Service (COT.003.167) may be between Provider Attributes Effective Date (PRV.002.020) and Provider Attributes End Date (PRV.002.021) or 6. Must have an enrollment where the Ending Date of Service (COT.003.167) may be between Provider Identifier Effective Date (PRV.005.079) and Provider Identifier End Date (PRV.005.080~~)~~ ~~6. When Type of Service (COT..003.186) is in ['119', '120', '122'] value must match Plan ID Number (COT.002.066)).~~ 7. Value must be reported in Provider Identifier (PRV.005.080) with an associated Provider Identifier Type (PRV.005.081) equal to '1'.

COT113	COT.002.113	BILLING-PROV-NPI-NUM	Billing Provider NPI Number	Conditional	~~A National Provider Identifier (NPI) is a unique 10-digit identification number issued to health care providers in the United States by CMS. Healthcare providers acquire their unique 10-digit NPIs to identify themselves in a standard way throughout their industry. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number).~~The National Provider ID (NPI) of the billing entity responsible for billing a patient for healthcare services. The billing provider can also be servicing, referring, or prescribing provider. Can be admitting provider except for Long Term Care. For sub-capitation payments, report the national provider identifier (NPI) for the sub-capitated entity if the provider has one.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(10)	~~96~~86	~~750~~694	~~759~~703	1. Value must be 10 digits~~, consisting of 9 numeric digits followed by one check digit calculated using the Luhn formula (algorithm) 2.~~ 2. Value must have an associated Provider Identifier Type equal to ~~'2'~~"2" 3. Value must exist in the NPPES NPI data file 4. Conditional ~~4~~5. When ~~Type of Claim (COT.002.037) not in ('3','C','W') then~~populated, value must match Provider Identifier (PRV.00~~2~~5.081) and Facility Group Individual Code (PRV.002.028) must equal "01" 6. NPPES Entity Type Code associated with this NPI must equal "2" (Organization)
COT114	COT.002.114	BILLING-PROV-TAXONOMY	Billing Provider Taxonomy	Conditional	The taxonomy code for the provider billing for the service.	PROV-TAXONOMY	COT00002	CLAIM-HEADER-RECORD-OT	X(12)	~~97~~87	7~~6~~04	7~~7~~15	1. Value must be in Provider Taxonomy List (VVL) 2. Value must be 12 characters or less 3. Conditional ~~4. Value is in [119, 120, 121, 122], then value should not be populated~~
COT115	COT.002.115	BILLING-PROV-TYPE	Billing Provider Type	Conditional	A code to describe the type of ~~entity billing for the service~~provider being reported.	PROV-TYPE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	~~98~~88	~~772~~716	717~~3~~	~~1.~~1. Value must be 2 characters 2. Value must be in Provider Type Code List (VVL~~).~~ ~~2. Value must be 2 characters~~) 3. Conditional
COT116	COT.002.116	BILLING-PROV-SPECIALTY	Billing Provider Specialty	Conditional	This code describes the area of specialty for the provider being reported.	PROV-SPECIALTY	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	~~99~~89	~~774~~718	~~775~~719	~~1.~~1. Value must be 2 characters 2. Value must be in Provider Specialty List (VVL~~).~~ ~~2. Value must be 2 characters~~) 3. Conditional

COT117	COT.002.117	REFERRING-PROV-NUM	Referring Provider Number	Conditional	A unique identification number assigned to a provider which identifies the physician or other provider who referred the patient. For physicians, this must be the individual's ID number, not a group identification number. If the referring provider number 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.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(30)	~~100~~90	~~776~~720	~~805~~749	1. Value must be 30 characters or less 2. ~~Value must be reported in Provider Identifier (PRV.005.080) with an associated Provider Identifier Type (PRV.005.081) equal to '1'~~ ~~3.~~ Conditional
COT118	COT.002.118	REFERRING-PROV-NPI-NUM	Referring Provider NPI Number	Conditional	~~A National Provider Identifier (NPI) is a unique 10-digit identification number issued to health care providers in the United States by CMS. Healthcare providers acquire their unique 10-digit NPIs to identify themselves in a standard way throughout their industry. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number).~~The National Provider ID (NPI) of the provider who recommended the servicing provider to the patient.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(10)	~~101~~91	~~806~~750	~~815~~759	1. Value must be 10 digits~~, consisting of 9 numeric digits followed by one check digit calculated using the Luhn formula (algorithm) 2.~~ 2. Conditional 3. Value must have an associated Provider Identifier Type equal to ~~'2'~~ ~~3. Conditional~~"2" 4. Value must exist in the NPPES NPI File
~~COT119~~	~~COT.002.119~~	~~REFERRING-PROV-TAXONOMY~~	~~Referring Provider Taxonomy~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~COT00002~~	~~CLAIM-HEADER-RECORD-OT~~	~~X(12)~~	~~102~~	~~816~~	~~827~~	~~1. Not Applicable~~
~~COT120~~	~~COT.002.120~~	~~REFERRING-PROV-TYPE~~	~~Referring Provider Type~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~COT00002~~	~~CLAIM-HEADER-RECORD-OT~~	~~X(2)~~	~~103~~	~~828~~	~~829~~	~~1. Not Applicable~~
~~COT121~~	~~COT.002.121~~	~~REFERRING-PROV-SPECIALTY~~	~~Referring Provider Specialty~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~COT00002~~	~~CLAIM-HEADER-RECORD-OT~~	~~X(2)~~	~~104~~	~~830~~	~~831~~	~~1. Not Applicable~~

COT122	COT.002.122	MEDICARE-HIC-NUM	Medicare HIC Number	Conditional	The Medicare HIC Number (HICN) is an identifier formerly used by SSA and CMS to identify all Medicare beneficiaries. For many beneficiaries, their SSN was a major component of their HICN. To prevent identify theft, among other reasons, HICN gradually were retired and replaced by the Medicare Beneficiary Identifier (MBI) over the course of 2018 and 2019. HICN continue to be used by Medicare for limited administrative purposes after 2019 but starting in 2020 the MBI became the primary identifier for Medicare beneficiaries. HICN consists of two components: SSN &and alpha-suffix or (for Railroad IDs) prefix and ID (not always SSN based).	N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(12)	1059<u>2</u>	832<u>760</u>	843<u>771</u>	1. ~~Conditional~~ ~~2.~~ Value must be 12 characters or less <u>2. Conditional</u> 3. Value must not contain a pipe or asterisk symbols 4. (Not Dual Eligible) if Dual Eligible Code (ELG.DE.085) value =<u>equals</u> "00", then value must not be populated~~.~~ 5. Value must be populated when Crossover Indicator (COT.002.023) equals ~~'1'~~<u>"1"</u> and Medicare Beneficiary Identifier (COT.002.147) is not populated~~.~~
COT123	COT.002.123	PLACE-OF-SERVICE	Place of Service	Conditional	A data element corresponding with line 24b on the CMS-1500 that indicates where the services took place. This is a pass-through data element that should not be modified or derived when missing unless otherwise specified.	PLACE-OF-SERVICE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	1069<u>3</u>	844<u>772</u>	845<u>773</u>	~~1.~~<u>1. Value must be 2 characters</u> <u>2.</u> Value must be in Place of Service <u>Code</u> List (VVL) ~~2. Value must be 2 characters~~ 3. Conditional 4. If value is populated ~~on a non-denied claim~~, then ~~Procedure Code (COT.003.169) must be populated.~~ ~~5. When~~ Type of ~~Service (COT.003.186) is in [119-122], Place of Service (COT.002.123) should~~ <u>Bill must</u> not be populated
~~COT125~~	~~COT.002.125~~	~~BMI~~	~~Body Mass Index~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~COT00002~~	~~CLAIM-HEADER-RECORD-OT~~	~~S9(5)V9~~	~~107~~	~~846~~	~~851~~	~~1. Not Applicable~~
COT126	COT.002.126	REMITTANCE-NUM	Remittance Number	Mandatory	The Remittance Advice Number is a sequential number that identifies the current Remittance Advice (RA) produced for a provider. The number is incremented by one each time a new RA is generated. ~~The first five (5) positions are Julian date following a YYDDD format.~~ The RA is the	N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(30)	1089<u>4</u>	852<u>774</u>	881<u>803</u>	1. Value must be 30 characters or less 2. ~~First five (5) characters of the value must be a Julian date express in the form YYDDD (e.g. 19095, 95th day of 20(19))~~ ~~3.~~ Value must not contain a pipe or asterisk

					detailed ~~.~~ explanation of the reason for the payment amount.~~ The RA number is not the check number.~~								symbols ~~4~~3. Mandatory
COT127	COT.002.127	DAILY-RATE	Daily Rate	Conditional	The amount a policy will pay per day for a covered service. In some cases for OT claims this is referred to as a flat rate.~~ see US Dollar Amount (DT.008)~~	N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(5)V99	~~109~~95	~~882~~804	~~888~~810	1. Value must be between 0.00 and 99999.99 2. Conditional 3. Value must be expressed as a number with 2-digit precision (e.g. 100.50)
COT128	COT.002.128	BORDER-STATE-IND	Border State Indicator	Conditional	A code to indicate whether an individual received services or equipment across state borders. (The provider location is out of state, but for payment purposes the provider is treated as an in-state provider.)	BORDER-STATE-IND	COT00002	CLAIM-HEADER-RECORD-OT	X(1)	~~110~~96	~~889~~811	~~889~~811	~~1.~~1. Value must be 1 character 2. Value must be in Border State Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Conditional
COT130	COT.002.130	TOT-BENEFICIARY-COINSURANCE-PAID-AMOUNT	Total Beneficiary Coinsurance Paid Amount	Conditional	The amount ~~of money~~ the beneficiary or his or her representative (e.g., their guardian) paid towards their coinsurance for the covered services on the claim. Do not include coinsurance payments made by a third party/s on behalf of the beneficiary.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11)V99	~~111~~97	~~890~~812	~~902~~824	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. ~~Must have an associated Beneficiary Coinsurance Date Paid~~ ~~4.~~Conditional
COT131	COT.002.131	BENEFICIARY-COINSURANCE-DATE-PAID	Beneficiary Coinsurance Date Paid	Conditional	The date the beneficiary paid the coinsurance amount.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	~~112~~98	~~903~~825	~~910~~832	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3. Must~~ in the form "CCYYMMDD" 2. When populated, value must have an associated Beneficiary Coinsurance Amount ~~4~~3. Conditional

COT132	COT.002.132	TOT-BENEFICIARY-COPAYMENT-PAID-AMOUNT	Total Beneficiary Copayment Paid Amount	Conditional	The amount ~~of money~~ the beneficiary or his or her representative (e.g., their guardian) paid towards their copayment for the covered services on the claim. Do not include copayment payments made by a ~~co-payment~~third party/s on behalf of the beneficiary.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11) V99	~~113~~99	~~911~~833	~~923~~845	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. ~~Must have an associated Beneficiary Copayment Date Paid~~ ~~4.~~ Conditional
COT133	COT.002.133	BENEFICIARY-COPAYMENT-DATE-PAID	Beneficiary Copayment Date Paid	Conditional	The date the beneficiary paid the copayment amount.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	~~114~~100	~~924~~846	~~931~~853	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3. Must~~ in the form "CCYYMMDD" 2. When populated, value must have an associated Beneficiary Copayment Amount ~~4~~3. Conditional
COT134	COT.002.134	TOT-BENEFICIARY-DEDUCTIBLE-PAID-AMOUNT	Total Beneficiary Deductible Paid Amount	Conditional	The amount ~~of money~~ the beneficiary or his or her representative (e.g., their guardian) paid towards ~~an annual~~their deductible for the covered services on the claim. Do not include deductible payments made by a third party/s on behalf of the beneficiary.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11) V99	101~~5~~	~~932~~854	~~944~~866	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. ~~Must have an associated Beneficiary Deductible Date Paid~~ ~~4.~~ Conditional
COT135	COT.002.135	BENEFICIARY-DEDUCTIBLE-DATE-PAID	Beneficiary Deductible Date Paid	Conditional	The date the beneficiary paid the deductible amount.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	~~116~~102	~~945~~867	~~952~~874	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3. Must~~ in the form "CCYYMMDD" 2. When populated, value must have an associated Beneficiary Deductible ~~Date Paid~~ 4Amount 3. Conditional

COT136	COT.002.136	CLAIM-DENIED-INDICATOR	Claim Denied Indicator	Mandatory	An indicator to identify a claim that the state refused pay in its entirety.	CLAIM-DENIED-INDICATOR	COT00002	CLAIM-HEADER-RECORD-OT	X(1)	~~117~~103	~~953~~875	~~953~~875	~~1.~~1. Value must be 1 character 2. Value must be in Claim Denied Indicator List (VVL) ~~2~~3. If value ~~is '0',~~equals "0", then Claim Status Category must equal "F2" ~~3. Value must be 1 character~~ ~~4.~~4. Mandatory
COT137	COT.002.137	COPAY-WAIVED-IND	Copayment Waived Indicator	~~Op~~Situational	An indicator signifying that the copay was waived by the provider~~.~~	COPAY-WAIVED-IND	COT00002	CLAIM-HEADER-RECORD-OT	X(1)	~~118~~104	~~954~~876	~~954~~876	~~1.~~1. Value must be 1 character 2. Value must be in Copay Waived Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3. Optional~~3. Situational
COT138	COT.002.138	HEALTH-HOME-ENTITY-NAME	Health Home Entity Name	Conditional	A free-form text field to indicate the health home program that authorized payment for the service on the claim~~.~~ or to identify the health home SPA in which an individual is enrolled. The name entered should be the name that the state uses to uniquely identify the team. A "Health Home Entity" can be a designated provider (e.g., physician, clinic, behavioral health organization), a health team which links to a designated provider, or a health team (physicians, nurses, behavioral health professionals). Because an identification numbering schema has not been established, the entities' names are being used instead.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(50)	~~119~~105	~~955~~877	~~100~~4926	~~1. Value must 50 characters or less~~ ~~2.~~1. Value must not contain a pipe or asterisk symbols 2. Value must 50 characters or less 3. Conditional
COT140	COT.002.140	THIRD-PARTY-COINSURANCE-AMOUNT-PAID	Third Party Coinsurance Amount Paid	~~Op~~Situational	The amount of money paid by a third party on behalf of the beneficiary towards coinsurance ~~on the claim or claim line item~~.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11)V99	1~~2~~06	~~100~~927	~~101~~7939	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. ~~Op~~Situational

COT141	COT.002.141	THIRD-PARTY-COINSURANCE-DATE-PAID	Third Party Coinsurance Date Paid	Conditional	The date ~~a Third Party Coinsurance~~the third party paid the coinsurance amount ~~was paid on this claim or adjustment.~~	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	~~121~~107	~~1018~~940	~~1025~~947	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~in the form "CCYYMMDD" 2. When populated, value must have an associated Third Party Coinsurance Amount 3. Conditional
COT142	COT.002.142	THIRD-PARTY-COPAYMENT-AMOUNT-PAID	Third Party Copayment Amount Paid	~~Op~~Situational	The amount of money paid by a third ~~-~~party on behalf of the beneficiary ~~paid~~ towards ~~a~~ copayment.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11) V99	~~122~~108	~~1026~~948	~~1038~~960	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. ~~Op~~Situational
COT143	COT.002.143	THIRD-PARTY-COPAYMENT-DATE-PAID	Third Party Copayment Date Paid	~~Op~~Situational	The date ~~a Third Party~~the third party paid the copayment amount ~~was paid on a claim or adjustment~~.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	9(8)	~~123~~109	~~1039~~961	~~1046~~968	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~in the form "CCYYMMDD" 2. When populated, value must have an associated Third Party Copayment Amount 3. ~~Op~~Situational
~~COT144~~	~~COT.002.144~~	~~DATE-CAPITATED-AMOUNT-REQUESTED~~	~~Date Capitated Amount Requested~~	~~Conditional~~	~~The date that the managed care entity submitted the capitated payment bill to the state. see Date (DT.001)~~	~~N/A~~	~~COT00002~~	~~CLAIM-HEADER-RECORD-OT~~	~~9(8)~~	~~124~~	~~1047~~	~~1054~~	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3. Conditional~~
~~COT145~~	~~COT.002.145~~	~~CAPITATED-PAYMENT-AMT-REQUESTED~~	~~Capitated Payment Amount Requested~~	~~Conditional~~	~~The amount of the capitated payment bill submitted by the managed care entity to the state.~~	~~N/A~~	~~COT00002~~	~~CLAIM-HEADER-RECORD-OT~~	~~S9(11) V99~~	~~125~~	~~1055~~	~~1067~~	~~1. Value must be between -99999999999.99 and 99999999999.99~~ ~~2. Value must be expressed as a number with 2-digit precision (e.g. 100.50)~~ ~~3. Conditional~~

COT146	COT.002.146	HEALTH-HOME-PROVIDER-NPI	Health Home Provider NPI Number	Conditional	~~A National Provider Identifier (NPI) is a unique 10-digit identification number issued to health care providers in the United States by CMS. Healthcare providers acquire their unique 10-digit NPIs to identify themselves in a standard way throughout their industry. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number).~~The National Provider ID (NPI) of the health home provider.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(10)	~~126~~110	~~106~~896	~~107~~978	1. Value must be 10 digits~~, consisting of 9 numeric digits followed by one check digit calculated using the Luhn formula (algorithm) 2.~~ 2. Value must have an associated Provider Identifier, where Provider Identifier Type ~~equal to '2'~~ ~~3. Conditional~~ ~~4. When Type of Service (COT.003.186~~(PRV.005.077) equals ~~'121',~~ ~~value~~"2" 3. Value must ~~not be populated~~exist in the NPPES NPI data file 4. Conditional

COT147	COT.002.147	MEDICARE-BENEFICIARY-IDENTIFIER	Medicare Beneficiary Identifier	Conditional	The Medicare Beneficiary Identifier (MBI) is a randomly generated identifier used to identify all Medicare beneficiaries. It replaced the previously-used SSN-based Medicare HIC Number (HICN). To prevent identify theft, among other reasons, HICN gradually were retired and replaced by the MBI over the course of 2018 and 2019. Starting in 2020, the MBI became the primary identifier for Medicare beneficiaries.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(12)	~~127~~111	~~1078~~97 9	~~1089~~99 0	1. Conditional 2. Value must be an 11-character string 3. Character 1 must be numeric values 1 thru 9 4. Character 2 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 5. Character 3 must be alphanumeric values 0 thru 9 or A thru Z (minus S,L,O,I,B,Z) 6. Character 4 must be numeric values 0 thru 9 7. Character 5 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 8. Character 6 must be alphanumeric values 0 thru 9 or A thru Z (minus S,L,O,I,B,Z) 9. Character 7 must be numeric values 0 thru 9 10. Character 8 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 11. Character 9 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 12. Character 10 must be numeric values 0 thru 9 13. Character 11 must be numeric values 0 thru 9 14. Value must not contain a pipe or asterisk symbols
~~COT148~~	~~COT.002.148~~	~~UNDER-DIRECTION-OF-PROV-NPI~~	~~Under Direction of Provider NPI~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~COT00002~~	~~CLAIM-HEADER-RECORD-OT~~	~~X(10)~~	~~128~~	~~1090~~	~~1099~~	~~1. Not Applicable~~
~~COT149~~	~~COT.002.149~~	~~UNDER-DIRECTION-OF-PROV-TAXONOMY~~	~~Under Direction of Provider Taxonomy~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~COT00002~~	~~CLAIM-HEADER-RECORD-OT~~	~~X(12)~~	~~129~~	~~1100~~	~~1111~~	~~1. Not Applicable~~

~~COT150~~	~~COT.002.150~~	~~UNDER-SUPERVISION-OF-PROV-NPI~~	~~Under Supervision of Provider NPI~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~COT00002~~	~~CLAIM-HEADER-RECORD-OT~~	~~X(10)~~	~~130~~	~~1112~~	~~1121~~	~~1. Not Applicable~~
~~COT151~~	~~COT.002.151~~	~~UNDER-SUPERVISION-OF-PROV-TAXONOMY~~	~~Under Supervision of Provider Taxonomy~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~COT00002~~	~~CLAIM-HEADER-RECORD-OT~~	~~X(12)~~	~~131~~	~~1122~~	~~1133~~	~~1. Not Applicable~~
COT152	COT.002.152	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(500)	13~~2~~6	~~113~~4115 20	~~163~~3 2019	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
COT154	COT.003.154	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	COT00003	CLAIM-LINE-RECORD-OT	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "COT00003"
COT155	COT.003.155	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	COT00003	CLAIM-LINE-RECORD-OT	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory

													4. Value must be the same as Submitting State (COT.001.007)
COT156	COT.003.156	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	COT00003	CLAIM-LINE-RECORD-OT	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory
COT157	COT.003.157	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual ~~(except on service tracking payments). .~~ Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47572~~reporting-shared-msis-identification-numbers-eligibility/	N/A	COT00003	CLAIM-LINE-RECORD-OT	X(20)	4	22	41	~~1. Mandatory~~ ~~2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN~~ ~~3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN~~ ~~4. Value must be 20 characters or less~~ ~~5. When Type of Claim (COT.002.037) equals 4, D or X (lump sum payment) value must begin with an '&'~~1. Value must be 20 characters or less 2. Mandatory

COT158	COT.003.158	ICN-ORIG	Original ICN	Mandatory	A unique number assigned by the state's payment system that identifies an original or adjustment claim.	N/A	COT00003	CLAIM-LINE-RECORD-OT	X(50)	5	42	91	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
COT159	COT.003.159	ICN-ADJ	Adjustment ICN	Conditional	A unique claim number assigned by the state's payment system that identifies the adjustment claim for an original transaction.	N/A	COT00003	CLAIM-LINE-RECORD-OT	X(50)	6	92	141	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value ~~is~~ equals "0~~,~~", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
COT160	COT.003.160	LINE-NUM-ORIG	Original Line Number	Mandatory	A unique number to identify the transaction line number that is being reported on the original claim.	N/A	COT00003	CLAIM-LINE-RECORD-OT	X(3)	7	142	144	1. Value must be 3 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory 4. ~~When populated, value~~Value must be one or greater
COT161	COT.003.161	LINE-NUM-ADJ	Adjustment Line Number	Conditional	A unique number to identify the transaction line number that identifies the line number on the adjustment claim.	N/A	COT00003	CLAIM-LINE-RECORD-OT	X(3)	8	145	147	1. Value must be 3 characters or less 2. If associated Line Adjustment Indicator value ~~is~~ equals "0~~,~~", then value must not be populated 3. If associated Line Adjustment Indicator value ~~is~~ equals "1~~,~~", then value is mandatory and must be provided 4. Conditional 5. When populated, value must be one or greater

COT162	COT.003.162	LINE-ADJUSTMENT-IND	Line Adjustment Indicator	Conditional	A code to indicate the type of adjustment record claim/encounter represents at claim detail level.	LINE-ADJUSTMENT-IND	COT00003	CLAIM-LINE-RECORD-OT	X(1)	9	148	148	~~1.~~1. Value must be 1 character 2. Value must be in Line Adjustment Indicator List (VVL) ~~2. If associated Type of Claim value is in [1,~~ 3~~, 5, A, C, E, U, W, Y], then value must be in [0, 1, 4]~~ ~~3. If associated Type of Claim value is in [4, D, X], then value~~. Value must be in [~~5, 6~~] ~~4. Value must be 1 character~~ ~~5.~~0,1,4] 4. Conditional ~~6~~5. If associated Line Adjustment Number is populated, then value must be populated
COT163	COT.003.163	LINE-ADJUSTMENT-REASON-CODE	Line Adjustment Reason Code	Conditional	Claim adjustment reason codes communicate why a service line was paid differently than it was billed.	LINE-ADJUSTMENT-REASON-CODE	COT00003	CLAIM-LINE-RECORD-OT	X(3)	10	149	151	~~1.~~1. Value must be 3 characters or less 2. Value must be in Line Adjustment Reason Code List (VVL) ~~2. Value must be 3 characters or less~~ ~~3.~~3. Conditional 4. ~~When populated, Line Adjustment Indicator~~Value must be populated when the total paid amount is different from the total billed amount
COT164	COT.003.164	SUBMITTER-ID	Submitter ID	Mandatory	The Submitter Identification number is the value that identifies the provider/trading partner/clearing house organization to the state's claim adjudication system.	N/A	COT00003	CLAIM-LINE-RECORD-OT	X(12)	11	152	163	1. Value must be 12 characters or less 2. Mandatory
COT165	COT.003.165	CLAIM-LINE-STATUS	Claim Line Status	Conditional	The ~~Claim Line Status conveys~~claim line status codes from the 277 transaction set identify the status of a specific ~~service~~detail claim line ~~using~~rather than the ~~X12 Claim Status Codes from~~entire claim. Only report the claim ~~adjudication process~~line for the final, adjudicated claim.	CLAIM-STATUS	COT00003	CLAIM-LINE-RECORD-OT	X(3)	12	164	166	~~1.~~1. Value must be 3 characters or less 2. Value must be in Claim Status List (VVL) ~~2. Value must be 3 characters or less~~ ~~3.~~3. Conditional 4. If value in [545,585,654], then Claim Denied Indicator must be "0" and Claim Status Category must be"F2"

COT166	COT.003.166	BEGINNING-DATE-OF-SERVICE	Beginning Date of Service	Mandatory	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, this would be 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. For financial transactions reported to the OT file, populate with the first day of the time period covered by this financial transaction.~~	N/A	COT00003	CLAIM-LINE-RECORD-OT	9(8)	13	167	174	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3. When Type of Claim is not in ['2', '4', 'B', 'D', 'V'] value must be~~ in the form "CCYYMMDD" 2. Value must be less than or equal to associated End of Time Period value ~~4~~3. Value must be less than or equal to associated Ending Date of Service value ~~5. When Type of Claim is not in ['2', '4', 'B', 'D', 'V'] value~~4. Value must be less than or equal to associated Adjudication Date value ~~6~~5. Value must be less than or equal to associated Date of Death (ELG.002.025) value when populated ~~7~~6. Value must be less than or equal to at least one of the eligible's Enrollment End Date (ELG.021.254) values ~~8~~7. Mandatory
COT167	COT.003.167	ENDING-DATE-OF-SERVICE	Ending Date of Service	Mandatory	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. For financial transactions reported to the OT file, populate with the first day of the time period covered by this financial transaction.~~	N/A	COT00003	CLAIM-LINE-RECORD-OT	9(8)	14	175	182	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3. When Type of Claim is not in ['2', '4', 'B', 'D', 'V'] value must be~~ in the form "CCYYMMDD" 2. Value must be less than or equal to associated End of Time Period value ~~4~~3. Value must be greater than or equal to associated Beginning Date of Service value ~~5. When Type of Claim is not in ['2', '4', 'B', 'D', 'V'] value~~4. Value must be less than or equal to associated Adjudication Date value ~~6~~5. Value must be less than or equal to associated Date of Death (ELG.002.025) value

													when populated ~~7~~6. Value must be equal to or greater than associated Date of Birth (ELG.002.024) value ~~8~~7. Mandatory
COT168	COT.003.168	REVENUE-CODE	Revenue Code	Conditional	A code which identifies a specific accommodation, ancillary service or billing calculation (as defined by UB-04 Billing Manual). Revenue Code should be passed through to T-MSIS exactly as it was billed by the provider on the provider's 837I or UB-04 claim. It is only required on Inpatient, Long-Term Care and Other Fee for Service claims and managed care encounters that have a valid Type of Bill value. It's not required on financial transactions or non-institutional claims.	REVENUE-CODE	COT00003	CLAIM-LINE-RECORD-OT	X(4)	15	183	186	~~1.~~1. Value must be 4 characters or less 2. Value must be in Revenue Code List (VVL) ~~2~~3. A Revenue Code value requires an associated Revenue Charge ~~3. Value must be 4 characters or less~~ ~~4.~~4. Conditional

COT169	COT.003.169	PROCEDURE-CODE	Procedure Code	Conditional	A field to capture the CPT or HCPCS code that describes a service or good rendered by the provider to an enrollee on the specified date of service.	PROCEDURE-CODE	COT00003	CLAIM-LINE-RECORD-OT	X(8)	16	187	194	~~1.~~1. Value must be 8 characters or less 2. Value must be in Procedure Code List (VVL) 3. When populated, there must be a corresponding Procedure Code Flag ~~2~~4. If associated Procedure Code Flag ~~List (VVL)~~ value indicates an CPT-4 encoding ~~'~~"01~~'~~", then value must be a valid CPT-4 procedure code ~~3~~5. If associated Procedure Code Flag ~~List (VVL)~~ value indicates an "Other" encoding ~~'10-87',~~"10-87", then State must provide T-MSIS system with State-specific procedure code list, and value must be a valid State-specific procedure code ~~4~~6. If associated Procedure Code Flag List (VVL) value indicates an HCPCS encoding ~~'~~"06~~'~~", then value must be a valid HCPCS code ~~5. Value must be 8 characters or less~~ ~~6.~~7. Conditional
COT170	COT.003.170	PROCEDURE-CODE-DATE	Procedure Code Date	Conditional	The date upon which a reported medical procedure was performed.	N/A	COT00003	CLAIM-LINE-RECORD-OT	9(8)	17	195	202	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only~~ in the form "CCYYMMDD" 2. Value must be on ~~the leap year, never April 31st~~ or ~~Sept 31st)~~ ~~3. Value must be~~ before associated ~~Ending~~Discharge Date ~~of Service~~ value ~~4~~3. Value must be provided with an associated Procedure Code value ~~5~~4. Value must be on or after associated Beginning Date of Service value ~~6~~5. Value must be on or before associated Eligible Date of Death value ~~7~~6. Value must be not be populated when associated Procedure Code is not populated ~~8~~7. Conditional

													~~9. Value must be populated when Procedure Code (COT.003.169) is populated~~
COT171	COT.003.171	PROCEDURE-CODE-FLAG	Procedure Code Flag	Conditional	A flag that identifies the coding system used for an associated procedure code.	PROCEDURE-CODE-FLAG	COT00003	CLAIM-LINE-RECORD-OT	X(2)	18	203	204	1. Value must be 2 characters 2. Value must be in Procedure Code Flag List (VVL) 3. When populated, there must be a corresponding Procedure Code ~~2. Value must be in Procedure Code Flag List (VVL)~~ ~~3. Value must be 2 characters~~ ~~4.~~4. Conditional
COT172	COT.003.172	PROCEDURE-CODE-MOD-1	Procedure Code Modifier 1	Conditional	The procedure code modifier used with an associated procedure code. For example, some states use modifiers to indicate assistance in surgery or anesthesia services.	PROCEDURE-CODE-MOD	COT00003	CLAIM-LINE-RECORD-OT	X(2)	19	205	206	~~1.~~1. Value must be 2 characters 2. Value must be in Procedure Code Mod List (VVL) 3. Must be associated with a Procedure Code ~~2. Value must be 2 characters~~ ~~3.~~4. Conditional
~~COT173~~	~~COT.003.173~~	~~IMMUNIZATION-TYPE~~	~~Immunization Type~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~COT00003~~	~~CLAIM-LINE-RECORD-OT~~	~~X(2)~~	~~20~~	~~207~~	~~208~~	~~1. Not Applicable~~

COT174	COT.003.174	BILLED-AMT	Billed Amount	Conditional	The amount billed at the claim detail level as submitted by the provider. For encounter records, Type of Claim = 3, C, or W, this field should be populated with the amount that the provider billed the managed care plan. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the amount that the provider billed the sub-capitated entity at the claim line detail level. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.	N/A	COT00003	CLAIM-LINE-RECORD-OT	S9(11)V99	~~21~~20	20~~9~~7	2~~2~~19	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional

COT175	COT.003.175	ALLOWED-AMT	Allowed Amount	Conditional	The maximum amount displayed at the claim line level as determined by the payer as being "'allowable"' under the provisions of the contract prior to the determination of actual payment. On Fee for Service claims the Allowed Amount is determined by the state's MMIS (or PBM). On managed care encounters the Allowed Amount is determined by the managed care organization. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the amount that the sub-capitated entity allowed at the claim line detail level. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.	N/A	COT00003	CLAIM-LINE-RECORD-OT	S9(11) V99	~~22~~21	22~~2~~0	23~~4~~2	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
COT176	COT.003.176	~~COPAY-AMT~~BENEFICIARY-COPAYMENT-PAID-AMOUNT	Beneficiary Copayment Paid Amount	Conditional	~~The copayment amount paid by an enrollee for the service, which does not include the amount paid by the insurance company.~~The amount the beneficiary or his or her representative (e.g., their guardian) paid towards their copayment for the covered services on a claim line. Do not include copayment payments made by a third party/ies on behalf of the beneficiary. This is a copayment paid for a service in the corresponding claim line for OT and RX claim files. The Beneficiary Copayment Paid Amount is an optional line level data element reported for OT and RX claim file types, only. If the beneficiary copayment paid amount is not available at the claim line level, report the total	N/A	COT00003	CLAIM-LINE-RECORD-OT	S9(11) V99	~~23~~22	23~~5~~3	24~~7~~5	1. Value must be ~~5 digits or less left of the decimal i.e. 99999~~between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional

					copayment paid amount in the header level copayment data element.								
COT177	COT.003.177	TPL-AMT	~~Third Party Liability~~TPL Amount	Conditional	Third-party liability refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a state plan. This is the total amount denoted at the claim detail level paid by the third party.	N/A	COT00003	CLAIM-LINE-RECORD-OT	S9(11) V99	~~24~~23	24~~8~~6	~~260~~258	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
COT178	COT.003.178	MEDICAID-PAID-AMT	Medicaid Paid Amount	Conditional	The amount paid by Medicaid/CHIP agency or the managed care plan on this claim or adjustment at the claim detail level. ~~For claims where Medicaid payment is only available at the header level, report the entire payment amount on the T-MSIS record corresponding to the line item with the highest charge or the 1st detail. Zero fill Medicaid Amount Paid on all other MSIS records created from the original claim.~~For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the amount that the sub-capitated entity paid the provider at the claim line detail level. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-	N/A	COT00003	CLAIM-LINE-RECORD-OT	S9(11) V99	~~25~~24	~~261~~259	27~~3~~1	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50~~)~~ ~~3. Conditional~~) 3. Conditional 4. Value should not be populated or should be equal to zero, when associated Claim Line Status is in [542,585,654]\

					capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.								
COT179	COT.003.179	MEDICAID-FFS-EQUIVALENT-AMT	Medicaid FFS Equivalent Amount	Conditional	The amount that would have been paid had the services been provided on a Fee for Service basis.	N/A	COT00003	CLAIM-LINE-RECORD-OT	S9(11) V99	~~26~~25	2742	28~~6~~4	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Type of Claim value ~~equals '3,~~ in [3,C,W~~:~~], then value is mandatory and must be provided 4. Conditional
COT182	COT.003.182	MEDICARE-PAID-AMT	Medicare Paid Amount	Conditional	The amount paid by Medicare on this claim. For claims where Medicare payment is only available at the header level, report the entire payment amount on the T-MSIS claim line with the highest charge or ~~adjustment~~the 1st non-denied line. Zero fill Medicare Paid Amount on all other claim lines.	N/A	COT00003	CLAIM-LINE-RECORD-OT	S9(11) V99	~~27~~26	28~~7~~5	29~~9~~7	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Crossover Indicator value ~~is~~equals "0", then the ~~Medicare Paid Amount~~ value must not be populated~~.~~ 4. Conditional 5. If value is populated, Crossover Indicator must be equal to "1"

COT183	COT.003.183	~~OT-RX-CLAIM~~SERVICE-QUANTITY-ACTUAL	~~OT RX Claim~~Service Quantity Actual	~~Conditional~~ Mandatory	The quantity of a ~~drug,~~ service~~,~~ or product that is rendered~~/dispensed~~ for a ~~prescription,~~ specific date of service~~,~~ or billing time span~~. This field is only applicable when~~ as reported by revenue code or procedure code on 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.~~claim/encounter line. 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.~~ use with CLAIMOT claims. For ~~drugs not identifiable or dispensed by a normal unit, e.g. powder filled vials~~CLAIMRX claims/encounters, use ~~1 as the number of units~~the Prescription Quantity Actual field. For CLAIMIP and CLAIMLT claims/encounters, use the Revenue Center Quantity Actual field.	N/A	COT00003	CLAIM-LINE-RECORD-OT	S9(~~6~~8) V999	~~28~~27	~~300~~298	308	1. Value may include up to ~~6~~8 digits to the left of the decimal point, and 3 digits to the right e.g. ~~123456.789~~12345678.999 2. ~~Conditional~~ ~~3. If Type of Claim is in [1, 3, A, C, U, W], then this value must be reported.~~ ~~4. When populated, corresponding Unit of Measure must be populated~~Mandatory
COT184	COT.003.184	~~OT-RX-CLAIM~~SERVICE-QUANTITY-ALLOWED	~~OT RX Claim~~Service Quantity Allowed	Conditional	~~The maximum allowable quantity of a drug or service that may be dispensed per prescription per date of service or per month. Quantity limits are applied to medications when the majority of appropriate clinical utilizations will be addressed within the quantity allowed.~~The maximum allowable quantity of a service that may be rendered per date of service or per month. For use with CLAIMOT claims/encounters. For CLAIMIP and CLAIMLT claims/encounters, use the Revenue Center Quantity Allowed field. NOTE: One prescription for 100 250 milligram tablets results in Service Quantity Allowed = 100. 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	N/A	COT00003	CLAIM-LINE-RECORD-OT	S9(~~6~~8) V999	~~29~~28	309	31~~7~~9	1. Value may include up to ~~6~~8 digits to the left of the decimal point, and 3 digits to the right e.g. ~~123456.789~~12345678.999 2. Conditional ~~3. If Type of Claim is in [1, 3, A, C, U, W], then this value must be reported.~~

					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.								
COT186	COT.003.186	TYPE-OF-SERVICE	Type of Service	Mandatory	A code to categorize the services provided to a Medicaid or CHIP enrollee.	TYPE-OF-SERVICE-OT	COT00003	CLAIM-LINE-RECORD-OT	X(3)	~~30~~29	~~318~~320	32~~0~~2	~~1. Value must be in Dual Eligible Code List (VVL)~~ ~~2. If value is "05", then Eligibility Group (ELG.005.087) must be "24"~~ ~~3. If value is "06", then Eligibility Group (ELG.005.087) must be "26"~~ ~~4. If Dual Eligible Code (ELG.005.085) is "01", "02", "03", 04", 05", "06", "08", "09", or "10", then Primary Eligibility Group Indicator (ELG.005.086) must be "1" (Yes)~~ ~~5. Conditional~~ ~~6. A partial dual eligible (values="01', "03", "05" or "06") then Restricted Benefits Code (ELG.005.097) must be "3"~~ ~~7. (Not Dual Eligible) if value = "00", then associated Medicare Beneficiary Identifier (ELG.003.051) value must not be populated.~~ ~~8. Value must be 2 characters~~ ~~9. If value is in ["08", "10"] then Restricted Benefits Code (ELG.005.097) must be "1"~~ ~~10. If value is "09", then Eligibility Group (ELG.005.087) and Restricted Benefits Code~~

													~~(ELG.005.097) must not be populated~~ ~~11. If value equals "10", then CHIP Code (ELG.003.054) must be "03" (S-CHIP) and Medicare Beneficiary Identifier (ELG.003.051) must be populated~~ ~~12. If value is "01", then Eligibility Group (ELG.005.087) must be "23"~~ ~~13. If value is "03", then Eligibility Group (ELG.005.087) must be "25"~~1. Value must be 3 characters. 2. Mandatory 3. Value must be in Type of Service OT List (VVL) 4. When value is not in [025,085], Sex (ELG.002.023) equals "M"
COT187	COT.003.187	HCBS-SERVICE-CODE	HCBS Service Code	Conditional	A code to indicate that the service represents a long-term care home and community based service or support for an individual with chronic medical and/or mental conditions. The codes help to delineate between acute care and long-term care provided in the home and community setting (e.g. 1915(c), 1915(i), 1915(j), and 1915(k) services).	HCBS-SERVICE-CODE	COT00003	CLAIM-LINE-RECORD-OT	X(1)	~~31~~30	32~~1~~3	32~~1~~3	~~1.~~1. Value must be 1 character 2. Value must be in HCBS Service Code List (VVL~~).~~ ~~2. Value must be 1 character~~ ~~)~~ 3. If value is in [1-7~~,~~], then HCBS Taxonomy must be populated~~.~~ 4. Conditional

COT188	COT.003.188	HCBS-TAXONOMY	HCBS Taxonomy	Conditional	~~A code to classify the home and community based services listed on the claim into the HCBS taxonomy.~~A code to classify the home and community based services listed on the claim into the HCBS taxonomy. The HCBS Taxonomic classification system was adopted by CMS in August 2012. To acknowledge state variation, services and categories are defined based on the minimum definition necessary to establish mutually distinct categories and services. Some services are defined in part by characteristics that are NOT in that service. For example, the difference between companion services and personal care is that companion services do not include assistance with activities of daily living (ADLs) such as bathing, dressing, eating, and toileting. Some of the services reflected by the HCBS Taxonomy including, but not limited to personal care, case management, home health aide, and physician services, may (and in some case, must) also be covered under the Medicaid State Plan. The definitions below only define these services for purposes of Section 1915(c) Waivers and the State Plan Home and Community-Based Services benefit authorized by Section 1915(i). States interested in reflecting services as “extended state plan” services must offer them in accordance with state plan service definitions. Consult with the CMS Division of Benefits and Coverage in those instances to ensure definition alignment. The services and categories are arranged in order of consideration for placing a particular	HCBS-TAXONOMY	COT00003	CLAIM-LINE-RECORD-OT	X(5)	~~32~~31	32~~2~~4	32~~6~~8	~~1.~~1. Value must be 5 characters or less 2. Value must be in HCBS Taxonomy Code List (VVL~~).~~ ~~2. Value must be 5 characters or less~~) 3. Conditional

					state service in the taxonomy. If one is not sure how to map a state's service to the taxonomy, one should first consider Case Management, then Round-the-Clock Services, then Supported Employment, etc. Documentation of the HCBS Taxonomy from the CMS Waiver Management System can be found here: https://wms-mmdl.cms.gov/WMS/help/TaxonomyCategoryDefinitions.pdf.								
COT189	COT.003.189	SERVICING-PROV-NUM	Servicing Provider Number	Conditional	A unique number to identify the provider who treated the recipient. The Servicing Provider Number should be for the individual doctor who rendered the service. If "Servicing" provider and the "Billing" provider such as a sole-practitioner are the same then use the same number in both fields. The value is conditional as its usage varies by state.	N/A	COT00003	CLAIM-LINE-RECORD-OT	X(30)	~~33~~32	32~~7~~9	35~~6~~8	1. Value must be 30 characters or less 2. ~~Value must be reported in Provider Identifier (PRV.005.080) with an associated Provider Identifier Type (PRV.005.081) equal to '1'~~ ~~3.~~ Conditional ~~4~~3. When Type of Claim not in ~~('Z','3','C','W',"2","B","V",'4',"D","X")~~[3,C,W], then value may match (PRV.005.081) Provider Identifier or

													4. When Type of Claim not in ('2','3','C','W","2","B","V"," 4","D","X") [3,C,W], then value may match (PRV.002.019) Submitting State Provider ID
COT190	COT.003.190	SERVICING-PROV-NPI-NUM	Servicing Provider NPI Number	Conditional	A National Provider Identifier (NPI) is a unique 10-digit identification number issued to health care providers in the United States by CMS. Healthcare providers acquire their unique 10-digit NPIs to identify themselves in a standard way throughout their industry. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number).The NPI of the health care professional who delivers or completes a particular medical service or non-surgical procedure. The SERVICING-PROV-NPI-NUM is required when rendering provider is different than the attending provider and state or federal regulatory requirements call for a "combined claim" (i.e., a claim that includes both facility and professional components). Examples are Medicaid clinic bills or critical access hospital claims.	N/A	COT00003	CLAIM-LINE-RECORD-OT	X(10)	3433	3579	3668	1. Value must be 10 digits, consisting of 9 numeric digits followed by one check digit calculated using the Luhn formula (algorithm) 2. 2. Value must have an associated Provider Identifier Type equal to '2'"2" 3. Conditional 4. WhenIf Type of Claim (COT.002.037) not in ('3','C','W')[3,C,W], then value must match Provider Identifier (PRV.005.081) 5. Value must exist in the NPPES NPI data file
COT191	COT.003.191	SERVICING-PROV-TAXONOMY	Servicing Provider Taxonomy	Not ApplicableConditional	[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]The taxonomy code for the provider who treated the recipient.	N/APROV-TAXONOMY	COT00003	CLAIM-LINE-RECORD-OT	X(12)	3534	3679	3780	1. Not Applicable1. Value must be 12 characters or less 2. Value must be in Provider Taxonomy List (VVL) 3. Conditional
COT192	COT.003.192	SERVICING-PROV-TYPE	Servicing Provider Type	Conditional	A code to describe the type of entity billing for the serviceprovider being reported.	PROV-TYPE	COT00003	CLAIM-LINE-RECORD-OT	X(2)	3635	379381	3802	1.1. Value must be 2 characters 2. Value must be in Provider Type Code List (VVL). 2. Value must be 2 characters 3.3. Conditional

COT193	COT.003.193	SERVICING-PROV-SPECIALTY	Servicing Provider Specialty	Conditional	This code describes the area of specialty for the provider being reported.	PROV-SPECIALTY	COT00003	CLAIM-LINE-RECORD-OT	X(2)	~~37~~36	38~~1~~3	38~~2~~4	~~1.~~1. Value must be 2 characters 2. Value must be in Provider Specialty List (VVL~~).~~ ~~2. Value must be 2 characters~~) 3. Conditional
COT194	COT.003.194	OTHER-TPL-COLLECTION	Other TPL Collection	~~Conditional~~ Mandatory	This data element indicates that the claim is for a beneficiary for whom other third party resource development and collection activities are in progress, when the liability is not another health insurance plan for which the eligible is a beneficiary.	OTHER-TPL-COLLECTION	COT00003	CLAIM-LINE-RECORD-OT	X(3)	~~38~~37	38~~3~~5	38~~5~~7	~~1.~~1. Value must be 3 characters 2. Value must be in Other TPL Collection List (VVL) ~~2. Value must be 3 characters~~ ~~3. Conditional~~3. Mandatory
COT195	COT.003.195	TOOTH-DESIGNATION-SYSTEM	Tooth Designation System	Conditional	A code to identify the tooth numbering system ~~is~~ being used.	TOOTH-DESIGNATION-SYSTEM	COT00003	CLAIM-LINE-RECORD-OT	X(2)	~~39~~38	38~~6~~8	38~~7~~9	~~1.~~1. Value must be 2 characters 2. Value must be in Tooth Designation System List (VVL) ~~2~~3. Value must not contain a pipe symbol ~~3. Value must be 2 characters~~ 4. Conditional
COT196	COT.003.196	TOOTH-NUM	Tooth Number	Conditional	The tooth number serviced based on the tooth numbering system identified in the TOOTH-DESIGNATION-SYSTEM field.~~ see Tooth Number List (VVL.171)~~	TOOTH-NUM	COT00003	CLAIM-LINE-RECORD-OT	X(2)	~~40~~39	~~388~~390	3~~8~~91	~~1.~~1. Value must be 2 characters or less 2. Value must be in Tooth Number List (VVL) ~~2~~3. If Tooth Designation System (COT.003.195) is ~~'~~'JP~~'~~' value must be found in [1..32][51-82][A..T]or [AS..KS] ~~3~~4. If Tooth Designation System (COT.003.195) is ~~'~~'JO~~'~~' value must have 1 digit before and after the decimal (N.N) ~~4~~5. If Tooth Designation System (COT.003.195) is ~~'~~'JO~~'~~' value must be a first digit of 1-4 and the decimal must be between 1-8 ~~5. Value must be 2 characters or less~~ ~~6.~~6. Conditional 7. When value is in [~~'A'-'T'~~A-T], the difference between Ending Date of Service

													(COT.002.034) and Date of Birth (COT.002.108) is less than 15 years
COT197	COT.003.197	TOOTH-QUAD-CODE	Tooth Quad Code	Conditional	The area of the oral cavity is designated by a two-digit code.	TOOTH-QUAD-CODE	COT00003	CLAIM-LINE-RECORD-OT	X(2)	~~41~~40	390~~0~~2	391~~3~~3	~~1.~~1. Value must be 2 characters 2. Value must be in Tooth Quad Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional 4. When populated, associated type of service value must be in [013,029,035]
COT198	COT.003.198	TOOTH-SURFACE-CODE	Tooth Surface Code	Conditional	A code to identify the tooth's surface on which the service was performed.	TOOTH-SURFACE-CODE	COT00003	CLAIM-LINE-RECORD-OT	X(1)	~~42~~41	392~~4~~4	392~~4~~4	~~1.~~1. Value must be 1 character 2. Value must be in Tooth Surface Code List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Conditional 4. When populated, associated type of service value must be in [013,029,035]

COT199	COT.003.199	ORIGINATION-ADDR-LN1	Origination Address Line 1	Conditional	The street address of the origination point from which a patient is transported either from home or Long term care facility to a health care provider for healthcare services or vice versa. For transportation claims, this is only required if state has captured this information, otherwise it is conditional.	N/A	COT00003	CLAIM-LINE-RECORD-OT	X(60)	~~43~~42	39~~3~~5	45~~24~~	1. Value must be 60 characters or less 2. Value must not be equal to associated Address Line 2 or Address Line 3 value(s) 3. Value must not contain a pipe or asterisk symbols 4. ~~When populated, the associated Address Type is required~~ ~~5.~~ Conditional
COT200	COT.003.200	ORIGINATION-ADDR-LN2	Origination Address Line 2	Conditional	The second line of the street address of the ~~or~~desti~~gi~~nation point ~~from~~to which a patient is transported either from home or Long term care facility to a health care provider for healthcare services or vice versa. For transportation claims, this is only required if state has captured this information, otherwise it is conditional.	N/A	COT00003	CLAIM-LINE-RECORD-OT	X(60)	~~44~~43	45~~3~~5	51~~24~~	1. Value must be 60 characters or less 2. Value must not be equal to associated Address Line 1 or Address Line 3 value(s) 3. There must be an Address Line 1 in order to have an Address Line 2 4. Value must not contain a pipe or asterisk symbols 5. Conditional
COT201	COT.003.201	ORIGINATION-CITY	Origination City	Conditional	The name of the origination city from which a patient is transported either from home or a long term care facility to a health care provider for healthcare services or vice versa. For transportation claims, this is only required if state has captured this information, otherwise it is conditional.	N/A	COT00003	CLAIM-LINE-RECORD-OT	X(28)	~~45~~44	51~~3~~5	540~~2~~	1. Value must be 28 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional
COT202	COT.003.202	ORIGINATION-STATE	Origination State	Conditional	The ANSI numeric code of the origination state in which a patient is transported either from home or a long term care facility to a health care provider to a health care provider for healthcare services or vice versa.	STATE	COT00003	CLAIM-LINE-RECORD-OT	X(2)	~~46~~45	54~~1~~3	54~~24~~	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ 3. Conditional ~~4. (transportation claim) value is mandatory and must be provided for all transportation claims~~
COT203	COT.003.203	ORIGINATION-ZIP-CODE	Origination ~~Zip~~ZIP Code	Conditional	~~U.S. Zip Code component of an address associated with a given entity (e.g. person, organization, agency, etc.)~~The zip code of the origination city from which a patient is transported either from home	ZIP-CODE	COT00003	CLAIM-LINE-RECORD-OT	X(9)	~~47~~46	54~~3~~5	55~~1~~3	1. Value may only be 5 digits (0-9) (Example: 91320) or 9 digits (0-9) (Example: 913200011) 2. Value must be in ZIP Code List (VVL) 3. Conditional

					or long term care facility to a health care provider for healthcare services or vice versa.								
COT204	COT.003.204	DESTINATION-ADDR-LN1	Destination Address Line 1	Conditional	The street address of the destination point to which a patient is transported either from home or Long term care facility to a health care provider for healthcare services or vice versa. For transportation claims only. Required if state has captured this information, otherwise it is conditional.	N/A	COT00003	CLAIM-LINE-RECORD-OT	X(60)	~~48~~47	55~~2~~4	61~~1~~3	1. Value must be 60 characters or less 2. Value must not be equal to associated Address Line 2 or Address Line 3 value(s) 3. Value must not contain a pipe or asterisk symbols 4. ~~When populated, the associated Address Type is required~~ ~~5.~~ Conditional
COT205	COT.003.205	DESTINATION-ADDR-LN2	Destination Address Line 2	Conditional	The street address of the destination point to which a patient is transported either from home or Long term care facility to a health care provider for healthcare services or vice versa. For transportation claims only. Required if state has captured this information, otherwise it is conditional.	N/A	COT00003	CLAIM-LINE-RECORD-OT	X(60)	~~49~~48	61~~2~~4	67~~1~~3	1. Value must be 60 characters or less 2. Value must not be equal to associated Address Line 1 or Address Line 3 value(s) 3. There must be an Address Line 1 in order to have an Address Line 2 4. Value must not contain a pipe or asterisk symbols 5. Conditional
COT206	COT.003.206	DESTINATION-CITY	Destination City	Conditional	The name of the destination city to which a patient is transported either from home or a long term care facility to a health care provider for healthcare services or vice versa. For transportation claims only. Required if state has captured this information, otherwise it is conditional.	N/A	COT00003	CLAIM-LINE-RECORD-OT	X(28)	~~50~~49	67~~2~~4	~~699~~701	1. Value must be 28 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional

COT207	COT.003.207	DESTINATION-STATE	Destination State	Conditional	The ANSI state numeric code for the U.S. state, Territory, or the District of Columbia code of the destination state in which a patient is transported either from home or a long term care facility to a health care provider for healthcare services or vice versa. For transportation claims only. Required if state has captured this information, otherwise it is conditional.	STATE	COT00003	CLAIM-LINE-RECORD-OT	X(2)	~~51~~50	70~~0~~2	70~~1~~3	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ 3. ~~(transportation claim) value is mandatory and must be provided for all transportation claims~~ ~~4.~~ Conditional
COT208	COT.003.208	DESTINATION-ZIP-CODE	Destination ~~Zip~~ZIP Code	Conditional	~~U.S. Zip Code component of an address associated with a given entity (e.g. person, organization, agency, etc.)~~The zip code of the destination city to which a patient is transported either from home or long term care facility to a health care provider for healthcare services or vice versa. For transportation claims only. Required if state has captured this information, otherwise it is conditional.	ZIP-CODE	COT00003	CLAIM-LINE-RECORD-OT	X(9)	~~52~~51	70~~2~~4	71~~0~~2	1. Value may only be 5 digits (0-9) (Example: 91320) or 9 digits (0-9) (Example: 913200011) 2. Value must be in ZIP Code List (VVL) 3. Conditional
~~COT209~~	~~COT.003.209~~	~~BENEFIT TYPE~~	~~Benefit Type~~	~~Mandatory~~	~~The benefit category corresponding to the service reported on the claim or encounter record. Note: The code definitions in the valid value list originate from the Medicaid and CHIP Program Data System (MACPro) benefit type list. See Appendix H: Benefit Types~~	~~BENEFIT TYPE~~	~~COT00003~~	~~CLAIM-LINE-RECORD-OT~~	~~X(3)~~	~~53~~	~~711~~	~~713~~	~~1. Value must be in Benefit Type Code List (VVL)~~ ~~2. Value must be 3 characters~~ ~~3. Mandatory~~

COT210	COT.003.210	~~CMS-64-~~ CATEGORY-FOR-FEDERAL-REIMBURSEMENT	~~CMS-64~~ Category for Federal Reimbursement	Conditional	A code to indicate the Federal funding source for the payment.	~~CMS-64-~~ CATEGORY-FOR-FEDERAL-REIMBURSEMENT	COT00003	CLAIM-LINE-RECORD-OT	X(2)	~~54~~52	714~~3~~	715~~4~~	1. Value must be 2 characters 2. Value must be in ~~CMS-64~~ Category for Federal Reimbursement List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. (Federal Funding under Title XXI) if value equals ~~'~~"02~~'~~", then the eligible's CHIP Code (ELG.003.054) must be in [~~'2', '3'~~2,3] 4. (Federal Funding under Title XIX) if value equals ~~'~~"01~~'~~" then the eligible's CHIP Code (ELG.003.054) must be ~~'1'~~"1" 5. Conditional 6. If Type of Claim is in [~~'1','2','5','A','B','E','U','V','Y'~~1,A,U] and the Total Medicaid Paid Amount is populated on the corresponding claim header, then value must be reported~~.~~ ~~7. If Type of Claim is in ['4','D'] and the Service Tracking Payment Amount on the relevant record is populated, then value must be reported.~~
~~COT211~~	~~COT.003.211~~	~~XIX-MBESCBES-CATEGORY-OF-SERVICE~~	~~XIX MBESCBES Category of Service~~	~~Conditional~~	~~A code indicating the category of service for the paid claim. The category of service is the line item from the CMS-64 form that states use to report their expenditures and request federal financial participation.~~	~~XIX-MBESCBES-CATEGORY-OF-SERVICE~~	~~COT00003~~	~~CLAIM-LINE-RECORD-OT~~	~~X(4)~~	~~55~~	~~716~~	~~719~~	~~1. Value must be in XIX MBESCBES Category of Service List (VVL)~~ ~~2. Value must be 4 characters or less~~ ~~3. Conditional~~ ~~4. (Medicaid Claim) if the associated CMS-64 Category for Federal Reimbursement value is '1', then a valid value is mandatory and must be reported~~ ~~5. If value is in ['14', '35', '42' or '44'], then Sex (ELG.002.023) must not equals 'M'~~ ~~6. If XXI MBESCBES Category of Service is populated then must not be populated~~
~~COT212~~	~~COT.003.212~~	~~XXI-MBESCBES-CATEGORY-OF-SERVICE~~	~~XXI MBESCBES Category of Service~~	~~Conditional~~	~~A code to indicate the category of service for the paid claim. The category of service is the line item from the CMS-21 form that states use to report their expenditures and request federal financial participation.~~	~~XXI-MBESCBES-CATEGORY-OF-SERVICE~~	~~COT00003~~	~~CLAIM-LINE-RECORD-OT~~	~~X(3)~~	~~56~~	~~720~~	~~722~~	~~1. Value must be in XXI MBESCBES Category of Service List (VVL)~~ ~~2. Conditional~~ ~~3. (CHIP Claim) if the associated CMS-64 Category for Federal Reimbursement value is '2', then a valid value is mandatory and must be reported~~

													~~4. If XIX MBESCBES Category of Service is populated then value must not be populated~~ ~~5. Value must be 3 characters or less~~
COT213	COT.003.213	OTHER-INSURANCE-AMT	Other Insurance Amount	Conditional	The amount paid by insurance other than Medicare or Medicaid on this claim.	N/A	COT00003	CLAIM-LINE-RECORD-OT	S9(11)V99	~~57~~53	~~723~~715	~~735~~727	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
COT214	COT.003.214	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	COT00003	CLAIM-LINE-RECORD-OT	X(500)	~~58~~88	~~736~~1266	1~~23~~765	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
COT216	COT.001.216	SEQUENCE-NUMBER	Sequence Number	Mandatory	To enable states to sequentially number files, when related, follow-on files are necessary (i.e. update files, replace files). This should begin with 1 for the original Create submission type and be incremented by one for each Replacement or Update submission for the same reporting period and file type (subject area).	N/A	COT00001	FILE-HEADER-RECORD-OT	X(4)	14	79	82	~~1.~~1. Value must be 4 characters or less 2. Value must between 1 and 9999 ~~2~~3. Value must be equal to the largest of any prior values for the same reporting period and file type, plus 1 (i.e. incremented by 1) ~~3~~4. Value must not contain a pipe symbol ~~4. Value must be 4 characters or less~~ 5. Mandatory
COT217	COT.003.217	NATIONAL-DRUG-CODE	National Drug Code	Conditional	A code following the National Drug Code format indicating the drug, device, or medical supply covered by this claim.	N/A	COT00003	CLAIM-LINE-RECORD-OT	X(12)	~~59~~54	~~1236~~728	~~1247~~739	~~1. Characters 1-5 of value must be numeric~~ ~~2. Characters 6-9 of value must be numeric~~ ~~3. Characters 10-12 of value must be numeric or blank~~ ~~4.~~1. Value must be 12 digits or less ~~5~~2. Value must be a valid National Drug Code ~~6~~3. Conditional
COT218	COT.003.218	PROCEDURE-CODE-MOD-3	Procedure Code Modifier 3	Conditional	The procedure code modifier used with an associated procedure code. For example, some states use modifiers to indicate assistance in surgery or anesthesia services.	PROCEDURE-CODE-MOD	COT00003	CLAIM-LINE-RECORD-OT	X(2)	~~61~~56	~~1250~~742	~~1251~~743	~~1.~~1. Value must be 2 characters 2. Value must be in Procedure Code Mod List (VVL) 3. Must be associated with a Procedure Code

													~~2. Value must be 2 characters~~ ~~3.~~4. Conditional
COT219	COT.003.219	PROCEDURE-CODE-MOD-4	Procedure Code Modifier 4	Conditional	The procedure code modifier used with an associated procedure code. For example, some states use modifiers to indicate assistance in surgery or anesthesia services.	PROCEDURE-CODE-MOD	COT00003	CLAIM-LINE-RECORD-OT	X(2)	~~62~~57	~~125~~274	~~125~~374	~~1.~~1. Value must be 2 characters 2. Value must be in Procedure Code Mod List (VVL) 3. Must be associated with a Procedure Code ~~2. Value must be 2 characters~~ ~~3.~~4. Conditional
~~COT220~~	~~COT.003.220~~	~~HCPCS-RATE~~	~~HCPCS Rate~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~COT00003~~	~~CLAIM-LINE-RECORD-OT~~	~~X(14)~~	~~63~~	~~1254~~	~~1267~~	~~1. Not Applicable~~
COT221	COT.003.221	ADJUDICATION-DATE	Adjudication Date	Mandatory	The date on which the payment status of the claim was finally adjudicated by the state. For Encounter Records (Type of Claim = 3, C, W), use date the encounter was processed by the state.	N/A	COT00003	CLAIM-LINE-RECORD-OT	9(8)	~~64~~58	~~126~~874 6	~~12~~753	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value should be on or before End of Time Period ~~value found in~~(COT.001.010) 3. Mandatory 4. Value should be on or after associated ~~T-MSIS File Header Record~~ ~~4. Mandatory~~Admission Date value
COT222	COT.003.222	SELF-DIRECTION-TYPE	Self Direction Type	~~Conditional~~ Mandatory	A data element to identify how the beneficiary self-directed the service, i.e. hiring authority (the beneficiary has decision-making authority to recruit, hire, train and supervise the individuals who furnish his/her services), budget authority (The beneficiary has decision-making authority over how the Medicaid funds in a	SELF-DIRECTION-TYPE	COT00003	CLAIM-LINE-RECORD-OT	X(3)	~~65~~59	~~127~~675 4	~~127~~875 6	~~1.~~1. Value must be 3 characters 2. Value must be in Self Direction Type List (VVL) ~~2. Value must be 3 characters~~ ~~3. Conditional~~3. Mandatory

					budget are spent), or both hiring and budget authority.									
COT223	COT.003.223	PRE-AUTHORIZATION-NUM	Preauthorization Number	Conditional	A number, code or other value that indicates the services provided on this claim have been authorized by the payee or other service organization, or that a referral for services has been approved. (Also referred to as a Prior Authorization or Referral Number).	N/A	COT00003	CLAIM-LINE-RECORD-OT	X(18)	~~66~~60	~~1279~~757	~~1296~~774	1. Value must be 18 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional
COT224	COT.003.224	NDC-UNIT-OF-MEASURE	NDC Unit of Measure	Conditional	A code to indicate the basis by which the quantity of the National Drug Code is expressed.	NDC-UNIT-OF-MEASURE	COT00003	CLAIM-LINE-RECORD-OT	X(2)	~~67~~61	~~1297~~775	~~1298~~776	~~1.~~1. Value must be 2 characters 2. Value must be in NDC Unit of Measure List (VVL~~).~~ ~~2. Value must be 2 characters~~) 3. Conditional
COT225	COT.003.225	NDC-QUANTITY	NDC Quantity	Conditional	This field is to capture the actual quantity of the National Drug Code being prescribed on the claim/encounters.	N/A	COT00003	CLAIM-LINE-RECORD-OT	S9(~~6)V9 99~~9)V(9)	~~68~~62	~~1299~~777	~~1307~~794	1. Value may include up to ~~6~~9 digits to the left of the decimal point, and ~~3~~9 digits to the right e.g. ~~123456.789~~123456789.123456789 2. Conditional

COT226	COT.002.226	PROV-LOCATION-ID	Provider Location ID	Mandatory	A code to uniquely identify the geographic location where the provider's services were performed. The Provider Location Identifier values reported on Inpatient, Long-Term Care, Other, and Pharmacy Claim Header Segments must correspond to an active Provider Location Identifier value on a Provider Location ~~&~~and Contact Info (~~PRV00003~~PRV.003) segment. If a particular license (e.g., a physician's medical license) or provider identifier (e.g., an individual provider's NPI or SSN) is applicable to all of their servicing locations, value "000" (a string of exactly three zeros) can be used in the ~~PRV00004~~PRV.004 or ~~PRV00005~~PRV.005, respectively, to represent all locations, however that location identifier must not be attributed to claims or provider bed type info.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(5)	~~133~~112	~~163~~4991	~~163~~8995	~~1.~~1. Value must be 5 characters or less 2. Value must not contain a pipe or asterisk symbols ~~2. Value must be 5 characters or less~~ ~~3.~~3. Mandatory
COT227	COT.003.227	PROCEDURE-CODE-MOD-2	Procedure Code Modifier 2	Conditional	The procedure code modifier used with an associated procedure code. For example, some states use modifiers to indicate assistance in surgery or anesthesia services.	PROCEDURE-CODE-MOD	COT00003	CLAIM-LINE-RECORD-OT	X(2)	~~60~~55	~~124~~8740	~~124~~9741	~~1.~~1. Value must be 2 characters 2. Value must be in Procedure Code Mod List (VVL) 3. Must be associated with a Procedure Code ~~2. Value must be 2 characters~~ ~~3.~~4. Conditional
COT230	COT.002.230	TOT-BENEFICIARY-COPAYMENT-LIABLE-AMOUNT	Total Beneficiary Copayment Liable Amount	Conditional	The total copayment amount on a claim that the beneficiary is obligated to pay for covered services. This is the total Medicaid or contract negotiated beneficiary copayment liability for covered service on the claim. Do not subtract out any payments made toward the copayment.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11)V99	113	996	1008	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional

COT231	COT.002.231	TOT-BENEFICIARY-COINSURANCE-LIABLE-AMOUNT	Total Beneficiary Coinsurance Liable Amount	Conditional	The total coinsurance amount on a claim the beneficiary is obligated to pay for covered services. This amount is the total Medicaid or contract negotiated beneficiary coinsurance liability for covered services on the claim. Do not subtract out any payments made toward the coinsurance.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11) V99	114	1009	1021	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
COT232	COT.002.232	TOT-BENEFICIARY-DEDUCTIBLE-LIABLE-AMOUNT	Total Beneficiary Deductible Liable Amount	Conditional	The total deductible amount on a claim the beneficiary is obligated to pay for covered services. This amount is the total Medicaid or contract negotiated beneficiary deductible liability minus previous beneficiary payments that went toward their deductible. Do not subtract out any payments for the given claim that went toward the deductible.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11) V99	115	1022	1034	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
COT233	COT.002.233	COMBINED-BENE-COST-SHARING-PAID-AMOUNT	Combined Beneficiary Cost Sharing Paid Amount	Conditional	The combined amounts the beneficiary or his or her representative (e.g., their guardian) paid towards their copayment, coinsurance, and/or deductible for the covered services on the claim. Only report this data element when the claim does not differentiate among copayment, coinsurance, and/or deductible payments made by the beneficiary. Do not include beneficiary cost sharing payments made by a third party/ies on behalf of the beneficiary.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11) V99	116	1035	1047	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
COT234	COT.003.234	IHS-SERVICE-IND	IHS Service Indicator	Mandatory	To indicate Services received by Medicaid-eligible individuals who are American Indian or Alaska Native (AI/AN) through facilities of the Indian Health Service (IHS), whether operated by IHS or by Tribes.	IHS-SERVICE-IND	COT00003	CLAIM-LINE-RECORD-OT	X(1)	63	795	795	1. Value must be 1 character 2. Value must be in the IHS Service Indicator List (VVL) 3. Mandatory

COT235	COT.002.235	LTC-RCP-LIAB-AMT	LTC RCP Liability Amount	Conditional	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.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11)V99	117	1048	1060	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
COT236	COT.002.236	BILLING-PROV-ADDR-LN-1	Billing Provider Address Line 1	Mandatory	Billing provider address line 1 from X12 837I, 837P, and 837D loop 2010AA.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(60)	118	1061	1120	1. Value must not be more than 60 characters long 2. Mandatory 3. Value must not contain a pipe or asterisk symbols
COT237	COT.002.237	BILLING-PROV-ADDR-LN-2	Billing Provider Address Line 2	Conditional	Billing provider address line 2 from X12 837I, 837P, and 837D loop 2010AA.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(60)	119	1121	1180	1. Value must not be more than 60 characters long 2. Conditional 3. Value must not be equal to associated Address Line 1 4. Value must not contain a pipe or asterisk symbols 5. There must be an Address Line 1 in order to have an Address Line 2
COT238	COT.002.238	BILLING-PROV-CITY	Billing Provider City	Mandatory	Billing provider address city name from X12 837I, 837P, and 837D loop 2010AA.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(28)	120	1181	1208	1. Value must not be more than 28 characters long 2. Mandatory
COT239	COT.002.239	BILLING-PROV-STATE	Billing Provider State Code	Mandatory	Billing provider address state code from X12 837I, 837P, and 837D loop 2010AA.	STATE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	121	1209	1210	1. Value must not be more than 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory
COT240	COT.002.240	BILLING-PROV-ZIP-CODE	Billing Provider ZIP Code	Mandatory	Billing provider address ZIP code from X12 837I, 837P, and 837D loop 2010AA.	ZIP-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(9)	122	1211	1219	1. Value may only be 5 digits (0-9) (Example: 91320) or 9 digits (0-9) (Example: 913200011) 2. Value must be in ZIP Code List (VVL) 3. Mandatory

COT241	COT.002.241	SERVICE-FACILITY-LOCATION-ORG-NPI	Service Facility Location Organization NPI	Conditional	Service facility location organization NPI from X12 837I loop 2310E or 837P and 837D loop 2310C.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(10)	123	1220	1229	1.Value must be 10 digits 2. Value must have an associated Provider Identifier Type equal to "2" 3. Value must exist in the NPPES NPI data file 4. Conditional 5. When populated, value must match Provider Identifier (PRV.005.081) and Facility Group Individual Code (PRV.002.028) must equal "01" 6. NPPES Entity Type Code associated with this NPI must equal "2" (Organization)
COT242	COT.002.242	SERVICE-FACILITY-LOCATION-ADDR-LN-1	Service Facility Location Address Line 1	Conditional	Service facility location address line 1 from X12 837I loop 2310E or 837P and 837D loop 2310C.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(60)	124	1230	1289	1. Value must not be more than 60 characters long 2. Conditional 3. Value must not contain a pipe or asterisk symbols
COT243	COT.002.243	SERVICE-FACILITY-LOCATION-ADDR-LN-2	Service Facility Location Address Line 2	Conditional	Service facility location address line 2 from X12 837I loop 2310E or 837P and 837D loop 2310C.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(60)	125	1290	1349	1. Value must not be more than 60 characters long 2. Conditional 3. Value must not be equal to associated Address Line 1 4. There must be an Address Line 1 in order to have an Address Line 2 5. Value must not contain a pipe or asterisk symbols
COT244	COT.002.244	SERVICE-FACILITY-LOCATION-CITY	Service Facility Location City	Conditional	Service facility location address city name from X12 837I loop 2310E or 837P and 837D loop 2310C.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(28)	126	1350	1377	1. Value must not be more than 28 characters long 2. Conditional
COT245	COT.002.245	SERVICE-FACILITY-LOCATION-STATE	Service Facility Location State	Conditional	Service facility location address state code from X12 837I loop 2310E or 837P and 837D loop 2310C.	STATE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	127	1378	1379	1. Value must not be more than 2 characters 2. Value must be in State Code list (VVL) 3. Conditional

COT246	COT.002.246	SERVICE-FACILITY-LOCATION-ZIP-CODE	Service Facility Location ZIP Code	Conditional	Service facility location address ZIP code from X12 837I loop 2310E or 837P and 837D loop 2310C.	ZIP-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(9)	128	1380	1388	1. Value may only be 5 digits (0-9) (Example: 91320) or 9 digits (0-9) (Example: 913200011) 2. Value must be in ZIP Code List (VVL) 3. Conditional
COT247	COT.002.247	PROVIDER-CLAIM-FORM-CODE	Provider Claim Form Code	Mandatory	A code indicating the format in which the provider submitted their claim. Very few if any claims should be classified as "Other".	PROVIDER-CLAIM-FORM-CODE	COT00002	CLAIM-HEADER-RECORD-OT	X(2)	129	1389	1390	1. Value must not be more than 2 characters 2. Value must be in Provider Claim Form Code List (VVL) 3. Mandatory
COT248	COT.002.248	PROVIDER-CLAIM-FORM-OTHER-TEXT	Provider Claim Form Other Text	Conditional	A free-form text field where a state can identify the "other" claim form used by the provider to submit their claim. Required when "Other" is reported to Provider Claim Form Code.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(50)	130	1391	1440	1. Value must not be more than 50 characters long 2. Conditional 3. Value must be provided when corresponding Provider Claim Form Code is "Other"
COT249	COT.002.249	TOT-GME-AMOUNT-PAID	Total GME Amount Paid	Conditional	The amount included in the Total Medicaid Amount (COT.002.050) that is attributable to a Graduate Medical Education (GME) payment, when the state makes GME payments by claim.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11)V99	131	1441	1453	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
COT250	COT.002.250	REFERRING-PROV-NUM-2	Referring Provider Number 2	Conditional	A unique identification number assigned to a provider which identifies the physician or other provider who referred the patient. For physicians, this must be the individual's ID number, not a group identification number. If the referring provider number 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. This is only applicable when a provider reports a second referral at the header of their claim.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(30)	132	1454	1483	1. Value must be 30 characters or less 2. Conditional 3. Value must not be populated when Referring Provider Number is not populated. 4. Value must not equal Referring Provider Number

COT251	COT.002.251	REFERRING-PROV-NPI-NUM-2	Referring Provider NPI Number 2	Conditional	The National Provider ID (NPI) of the provider who recommended the servicing provider to the patient. This is only applicable when a provider reports a second referral at the header of their claim.	N/A	COT00002	CLAIM-HEADER-RECORD-OT	X(10)	133	1484	1493	1. Value must be 10 digits 2. Conditional 3. Value must have an associated Provider Identifier Type equal to "2" 4. Value must exist in the NPPES NPI File 5. Value must not be populated when Referring Provider NPI Number is not populated 6. Value must not equal Referring Provider NPI Number
COT252	COT.002.252	TOT-SDP-ALLOWED-AMT	Total State Directed Payment Allowed Amount	Conditional	The component (in dollar and cents) of the total allowed amount that represents the difference between what would have been the managed care plan's typical contractual allowed amount and the enhanced allowed amount for this specific claim as defined by the State's SPA, waiver, or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).	N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11)V99	134	1494	1506	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
COT253	COT.002.253	TOT-SDP-PAID-AMT	Total State Directed Payment Paid Amount	Conditional	The component (in dollar and cents) of the total paid amount that represents the difference between what would have been the managed care plan's typical contractual paid amount and the enhanced paid amount for this specific claim as defined by the State's SPA, waiver, or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).	N/A	COT00002	CLAIM-HEADER-RECORD-OT	S9(11)V99	135	1507	1519	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
COT254	COT.003.254	DIAGNOSIS-CODE-POINTER-1	Diagnosis Code Pointer 1	Mandatory	A pointer to the diagnosis code in the order of importance to this service.	N/A	COT00003	CLAIM-LINE-RECORD-OT	9(2)	64	796	797	1. Value must be numeric 2. Value must be 2 digits or less 3. Value must be between 1 and 12 4. Mandatory
COT255	COT.003.255	UNIQUE-DEVICE-IDENTIFIER	Unique Device Identifier	Conditional	An unique identifier assigned to every medical device that meets the requirements of 21 CFR 801 and 830.	N/A	COT00003	CLAIM-LINE-RECORD-OT	X(76)	68	804	879	1. Value must not be more than 76 characters long 2. Conditional

COT256	COT.003.256	MBESCBES-CATEGORY-OF-SERVICE	MBESCBES Category of Service	Conditional	A code indicating the category of service for the paid claim. The category of service is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.) that states use to report their expenditures and request federal financial participation.	21.P-FORM, 21BASE-FORM, 64.21U-FORM, 64.10BASE-FORM, 64.9P-FORM, 64.9A-FORM, 64.9BASE-FORM, 64.21UP-FORM	COT00003	CLAIM-LINE-RECORD-OT	X(5)	71	931	935	1. Value must be 5 characters or less 2. When MBESCBES Form equals "21.P", value must be in 21.P Form List (VVL) 3. When MBESCBES Form equals "21BASE", value must be in 21BASE Form List (VVL) 4. When MBESCBES Form equals "64.21U", value must be in 64.21U Form List (VVL) 5. When MBESCBES Form equals "64.10BASE", value must be in 64.10BASE Form List (VVL) 6. When MBESCBES Form equals "64.9P", value must be in 64.9P Form List (VVL) 7. When MBESCBES Form equals "64.9A", value must be in 64.9A Form List (VVL) 8. When MBESCBES Form equals "64.9BASE", value must be in 64.9BASE Form List (VVL) 9. When MBESCBES Form equals "64.21UP", value must be in 64.21UP Form List (VVL) 10. Conditional 11. If Type of Claim in [1,A,U], then value must be populated on all claim lines with a Medicaid Paid Amount greater than $0 12. When populated, an associated MBESCBES Form Group and MBESCBES Form must be populated

COT257	COT.003.257	MBESCBES-FORM	MBESCBES Form	Conditional	The MBES or CBES form to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.). This should be determined by the state's MBES/CBES reporting process. The MBES or CBES form reported here will determine what the meaning of the corresponding MBES/CBES category of service value is.	MBESCBES-FORMGP-1, MBESCBES-FORMGP-2, MBESCBES-FORMGP-3	COT00003	CLAIM-LINE-RECORD-OT	X(50)	70	881	930	1. Value must be 50 characters or less 2. When MBESCBES Form Group equals "1", value must be in MBESCBES Form Group 1 List (VVL) 3. When MBESCBES Form Group equals "2", value must be in MBESCBES Form Group 2 List (VVL) 4. When MBESCBES Form Group equals "3", value must be in MBESCBES Form Group 3 List (VVL) 5. Conditional 6. If Type of Claim in [1,A,U], then value must be populated on all claim lines with a Medicaid Paid Amount greater than $0
COT258	COT.003.258	SERVICE-FACILITY-LOCATION-ORG-NPI	Service Facility Location Organization NPI	Conditional	Service facility location organization NPI from X12 837P loop 2420C and 837D loop 2420D.	N/A	COT00003	CLAIM-LINE-RECORD-OT	X(10)	72	936	945	1.Value must be 10 digits 2. Value must have an associated Provider Identifier Type equal to "2" 3. Value must exist in the NPPES NPI data file 4. Conditional 5. When populated, value must match Provider Identifier (PRV.005.081) and Facility Group Individual Code (PRV.002.028) must equal "01" 6. NPPES Entity Type Code associated with this NPI must equal "2" (Organization)
COT259	COT.003.259	SERVICE-FACILITY-LOCATION-ADDR-LN-1	Service Facility Location Address Line 1	Conditional	Service facility location address line 1 from X12 837P loop 2420C and 837D loop 2420D.	N/A	COT00003	CLAIM-LINE-RECORD-OT	X(60)	73	946	1005	1. Value must not be more than 60 characters long 2. Conditional 3. Value must not contain a pipe or asterisk symbols

COT260	COT.003.260	SERVICE-FACILITY-LOCATION-ADDR-LN-2	Service Facility Location Address Line 2	Conditional	Service facility location address line 2 from X12 837P loop 2420C and 837D loop 2420D.	N/A	COT00003	CLAIM-LINE-RECORD-OT	X(60)	74	1006	1065	1. Value must not be more than 60 characters long 2. Conditional 3. Value must not be equal to associated Address Line 1 4. There must be an Address Line 1 in order to have an Address Line 2 5. Value must not contain a pipe or asterisk symbols
COT261	COT.003.261	SERVICE-FACILITY-LOCATION-CITY	Service Facility Location City	Conditional	Service facility location address city name from X12 837P loop 2420C and 837D loop 2420D.	N/A	COT00003	CLAIM-LINE-RECORD-OT	X(28)	75	1066	1093	1. Value must not be more than 28 characters long 2. Conditional
COT262	COT.003.262	SERVICE-FACILITY-LOCATION-STATE	Service Facility Location State	Conditional	Service facility location address state code from X12 837P loop 2420C and 837D loop 2420D.	STATE	COT00003	CLAIM-LINE-RECORD-OT	X(2)	76	1094	1095	1. Value must not be more than 2 characters 2. Value must be in State Code list (VVL) 3. Conditional
COT263	COT.003.263	SERVICE-FACILITY-LOCATION-ZIP-CODE	Service Facility Location ZIP Code	Conditional	Service facility location address ZIP code from X12 837P loop 2420C and 837D loop 2420D.	ZIP-CODE	COT00003	CLAIM-LINE-RECORD-OT	X(9)	77	1096	1104	1. Value may only be 5 digits (0-9) (Example: 91320) or 9 digits (0-9) (Example: 913200011) 2. Value must be in ZIP Code List (VVL) 3. Conditional

COT264	COT.003.264	PLACE-OF-SERVICE	Place of Service	Conditional	PLACE-OF-SERVICE is a pass-through data element meaning that the state should report the field in T-MSIS as reported by the provider on the claims form (i.e., 837P, CMS-1500, or 837D). If the claim is submitted on the 837p electronic claims form and the Facility Code Qualifier is reported with any value other than "B", then the PLACE-OF-SERVICE value should be blank or space-filled. If the claim is submitted on the CMS 1450 (UB04) institutional claims form, the PLACE-OF-SERVICE field should be blank or space-filled. Otherwise, if the claim is submitted with the place of service populated with any value other than the valid values listed in T-MSIS Data Guide for PLACE-OF-SERVICE values, that value should still be reported in the PLACE-OF-SERVICE data element. If the claim is submitted by a provider with the place of service fields blank, then the PLACE-OF-SERVICE on the T-MSIS OT claims file should be blank or space-filled.	PLACE-OF-SERVICE	COT00003	CLAIM-LINE-RECORD-OT	X(2)	78	1105	1106	1. Value must not be more than 2 characters 2. Value must be in Place of Service Code List (VVL) 3. Conditional 4. if value is populated, then Revenue Code must be null
COT265	COT.003.265	GME-AMOUNT-PAID	GME Amount Paid	Conditional	The amount included in the Medicaid Amount (COT.003.178) that is attributable to a Graduate Medical Education (GME) payment, when the state makes GME payments by claim.	N/A	COT00003	CLAIM-LINE-RECORD-OT	S9(11)V99	79	1107	1119	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional

COT266	COT.003.266	REFERRING-PROV-NUM	Referring Provider Number	Conditional	A unique identification number assigned to a provider which identifies the physician or other provider who referred the patient. For physicians, this must be the individual's ID number, not a group identification number. If the referring provider number 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. This is only applicable when a provider reports a second referral at the header of their claim.	N/A	COT00003	CLAIM-LINE-RECORD-OT	X(30)	80	1120	1149	1. Value must be 30 characters or less 2. Conditional
COT267	COT.003.267	REFERRING-PROV-NPI-NUM	Referring Provider NPI Number	Conditional	The National Provider ID (NPI) of the provider who recommended the servicing provider to the patient.	N/A	COT00003	CLAIM-LINE-RECORD-OT	X(10)	81	1150	1159	1. Value must be 10 digits 2. Conditional 3. Value must have an associated Provider Identifier Type equal to "2" 4. Value must exist in the NPPES NPI File
COT268	COT.003.268	REFERRING-PROV-NUM-2	Referring Provider Number 2	Conditional	A unique identification number assigned to a provider which identifies the physician or other provider who referred the patient. For physicians, this must be the individual's ID number, not a group identification number. If the referring provider number 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. This is only applicable when a provider reports a second referral at the header of their claim.	N/A	COT00003	CLAIM-LINE-RECORD-OT	X(30)	82	1160	1189	1. Value must be 30 characters or less 2. Conditional

COT269	COT.003.269	REFERRING-PROV-NPI-NUM-2	Referring Provider NPI Number 2	Conditional	The National Provider ID (NPI) of the provider who recommended the servicing provider to the patient. This is only applicable when a provider reports a second referral at the line/detail of their claim.	N/A	COT00003	CLAIM-LINE-RECORD-OT	X(10)	83	1190	1199	1. Value must be 10 digits 2. Conditional 3. Value must have an associated Provider Identifier Type equal to "2" 4. Value must exist in the NPPES NPI File 5. Value must not be populated when Referring Provider NPI Number is not populated. 6. Value must not equal Referring Provider NPI Number
COT270	COT.003.270	ORDERING-PROV-NUM	Ordering Provider Number	Conditional	The Medicaid provider ID of the Ordering Provider is the individual who requested the services or items being reported on this service line. Examples include, but are not limited to, provider ordering diagnostic tests and medical equipment or supplies.	N/A	COT00003	CLAIM-LINE-RECORD-OT	X(30)	84	1200	1229	1. Value must be 30 characters or less 2. Conditional
COT271	COT.003.271	ORDERING-PROV-NPI-NUM	order Provider NPI Number	Conditional	The Medicaid provider ID of the Ordering Provider is the individual who requested the services or items being reported on this service line. Examples include, but are not limited to, provider ordering diagnostic tests and medical equipment or supplies.	N/A	COT00003	CLAIM-LINE-RECORD-OT	X(10)	85	1230	1239	1. Value must be 10 digits 2. Value must have an associated Provider Identifier Type equal to "2" 3. Value must exist in the NPPES NPI data file 4. Conditional
COT272	COT.003.272	SDP-ALLOWED-AMT	State Directed Payment Allowed Amount	Conditional	The component (in dollar and cents) of the allowed amount that represents the difference between what would have been the managed care plan's typical contractual allowed amount and the enhanced allowed amount for this specific claim as defined by the State's SPA, waiver, or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).	N/A	COT00003	CLAIM-LINE-RECORD-OT	S9(11)V99	86	1240	1252	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional

COT273	COT.003.273	SDP-PAID-AMT	State Directed Payment Paid Amount	Conditional	The component (in dollar and cents) of the paid amount that represents the difference between what would have been the managed care plan's typical contractual paid amount and the enhanced paid amount for this specific claim as defined by the State's SPA, waiver, or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).	N/A	COT00003	CLAIM-LINE-RECORD-OT	S9(11)V99	87	1253	1265	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
COT274	COT.004.274	RECORD-ID	Record ID	Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	COT00004	CLAIM-DX-OT	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "COT00004"
COT275	COT.004.275	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	COT00004	CLAIM-DX-OT	X(2)	2	9	10	1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (COT.001.007)
COT276	COT.004.276	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	COT00004	CLAIM-DX-OT	9(11)	3	11	21	1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory

COT277	COT.004.277	ICN-ORIG	Original ICN	Mandatory	A unique number assigned by the state's payment system that identifies an original or adjustment claim.	N/A	COT00004	CLAIM-DX-OT	X(50)	4	22	71	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
COT278	COT.004.278	ICN-ADJ	Adjustment ICN	Conditional	A unique claim number assigned by the state's payment system that identifies the adjustment claim for an original transaction.	N/A	COT00004	CLAIM-DX-OT	X(50)	5	72	121	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
COT279	COT.004.279	ADJUSTMENT-IND	Adjustment Indicator	Mandatory	Indicates the type of adjustment record.	ADJUSTMENT-IND	COT00004	CLAIM-DX-OT	X(1)	6	122	122	1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Value must be in [0,1,4] 4. Mandatory 5. If value equals "0", then associated Adjustment ICN must not be populated 6. Value must equal "1", when associated Claim Status equals "686" 7. Value must match the adjustment indicator in the header (COT.002.025)
COT280	COT.004.280	ADJUDICATION-DATE	Adjudication Date	Mandatory	The date on which the payment status of the claim was finally adjudicated by the state. For Encounter Records (Type of Claim = 3, C, W), use date the encounter was processed by the state.	N/A	COT00004	CLAIM-DX-OT	9(8)	7	123	130	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value should be on or before End of Time Period (COT.001.010) 3. Mandatory 4. Value should be on or after associated Admission Date value

COT281	COT.004.281	DIAGNOSIS-TYPE	Diagnosis Type	Mandatory	Indicates the context of the diagnosis code from the provider's claim (i.e., an 837I claim can have one principal diagnosis code, up to 12 external cause of injury diagnosis codes, and up to 24 other diagnosis codes; a UB-04 claim can have one principal diagnosis code, one admitting diagnosis code, and up to 17 other diagnosis codes; an 837P or CMS-1500 claim can have up to 12 diagnosis codes; an 837D or ADA claim can have up to 4 diagnosis codes). The type of diagnosis code (e.g., principal, external cause of injury, or other) is captured here. The order in which the diagnosis code was reported is captured in the Diagnosis Sequence Number.	DIAGNOSIS-TYPE	COT00004	CLAIM-DX-OT	X(1)	8	131	131	1. Value must be 1 character 2. Value must be in Diagnosis Type Code List (VVL) 3. Value must be in [P,A,E,O] 4. Mandatory
COT282	COT.004.282	DIAGNOSIS-SEQUENCE-NUMBER	Diagnosis Sequence Number	Mandatory	The order in which the diagnosis occurred on the provider's claim for a given type of diagnosis code (e.g., an 837P claim can have up to 12 external cause of injury diagnosis codes and up to 24 other diagnosis codes).	N/A	COT00004	CLAIM-DX-OT	9(2)	9	132	133	1. Value must be in [01-24] 2. Mandatory
COT283	COT.004.283	DIAGNOSIS-CODE-FLAG	Diagnosis Code Flag	Mandatory	Flag used to identify wither the associated Diagnosis Code value is a ICD-9 or ICD-10 code.	DIAGNOSIS-CODE-FLAG	COT00004	CLAIM-DX-OT	X(1)	10	134	134	1. Value must be 1 character 2. Value must be in Diagnosis Code Flag List (VVL) 3. Mandatory
COT284	COT.004.284	DIAGNOSIS-CODE	Diagnosis Code	Mandatory	ICD-9 or ICD-10 diagnosis codes used as a tool to group and identify diseases, disorders, symptoms, poisonings, adverse effects of drugs and chemicals, injuries and other reasons for patient encounters. Diagnosis codes should be passed through to T-MSIS exactly as they were submitted by the provider on their claim (with the exception of removing the decimal). For example: 210.5 is coded as '2105'.	DIAGNOSIS-CODE	COT00004	CLAIM-DX-OT	X(7)	11	135	141	1. Value must be a minimum of 3 characters 2. If associated Diagnosis Code Flag value equals "1" (ICD-9), then value must be in ICD-9 Diagnosis Code List (VVL) 3. If associated Diagnosis Code Flag value equals "2" (ICD-10), then value must be in ICD-10 Diagnosis Code List (VVL) 4. Value must not contain a decimal point 5. Mandatory

COT285	COT.004.285	STATE-NOTATION	State Notation	Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	COT00004	CLAIM-DX-OT	X(500)	12	142	641	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
COT287	COT.003.287	DIAGNOSIS-CODE-POINTER-2	Diagnosis Code Pointer 2	Conditional	A pointer to the diagnosis code in the order of importance to this service.	N/A	COT00003	CLAIM-LINE-RECORD-OT	9(2)	65	798	799	1. Value must be numeric 2. Value must not be more than 2 digits long 3. Value must be between 1 and 12 4. Conditional
COT288	COT.003.288	DIAGNOSIS-CODE-POINTER-3	Diagnosis Code Pointer 3	Conditional	A pointer to the diagnosis code in the order of importance to this service.	N/A	COT00003	CLAIM-LINE-RECORD-OT	9(2)	66	800	801	1. Value must be numeric 2. Value must not be more than 2 digits long 3. Value must be between 1 and 12 4. Conditional
COT289	COT.003.289	DIAGNOSIS-CODE-POINTER-4	Diagnosis Code Pointer 4	Conditional	A pointer to the diagnosis code in the order of importance to this service.	N/A	COT00003	CLAIM-LINE-RECORD-OT	9(2)	67	802	803	1. Value must be numeric 2. Value must not be more than 2 digits long 3. Value must be between 1 and 12 4. Conditional
COT290	COT.003.290	MBESCBES-FORM-GROUP	MBESCBES Form Group	Conditional	Indicates group of MBES/CBES forms that this payment applies to (e.g., the CMS-64.9 Base form is for Title XIX-funded Medicaid, the CMS-64.21 form is for Title XXI-funded Medicaid-expansion CHIP (M-CHIP), and the CMS-21 Base form is for Title XXI-funded separate CHIP (S-CHIP)).	MBESCBES-FORM-GROUP	COT00003	CLAIM-LINE-RECORD-OT	X(1)	69	880	880	1. Value must be 1 character 2. Value must be in MBESCBES Form Group List (VVL) 3. Conditional 4. If Type of Claim in [1,A,U], then value must be populated on all claim lines with a Medicaid Paid Amount greater than $0

T-MSIS Data Dictionary – CRX File Changes Between Versions 2.4.0 and 4.0.0

CRX001	CRX.001.001	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	CRX00001	FILE-HEADER-RECORD-RX	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "CRX00001"
CRX002	CRX.001.002	DATA-DICTIONARY-VERSION	Data Dictionary Version	Mandatory	A data element to capture the version of the T-MSIS data dictionary that was used to build the file.~~ Use the version number specified on the Cover Sheet of the data dictionary" to V2.4.~~	DATA-DICTIONARY-VERSION	CRX00001	FILE-HEADER-RECORD-RX	X(10)	2	9	18	1. Value must be 10 characters or less 2. Value must be in Data Dictionary Version List (VVL) 3. Value must not include the pipe ("|") symbol ~~3~~4. Mandatory
CRX003	CRX.001.003	SUBMISSION-TRANSACTION-TYPE	Submission Transaction Type	Mandatory	A data element to identify the whether the transactions in the file are original submissions of the data, a resubmission of a previously submitted file, or corrections of edit rejects.	SUBMISSION-TRANSACTION-TYPE	CRX00001	FILE-HEADER-RECORD-RX	X(1)	3	19	19	~~1.~~1. Value must be 1 character 2. Value must be in Submission Transaction Type List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory
CRX004	CRX.001.004	FILE-ENCODING-SPECIFICATION	File Encoding Specification	Mandatory	Denotes which supported file encoding standard was used to create the file.	FILE-ENCODING-SPECIFICATION	CRX00001	FILE-HEADER-RECORD-RX	X(3)	4	20	22	~~1.~~1. Value must be 3 characters 2. Value must be in File Encoding Specification List (VVL) ~~2. Value must be 3 characters~~ ~~3.~~3. Mandatory
CRX005	CRX.001.005	DATA-MAPPING-DOCUMENT-VERSION	Data Mapping Document Version	Mandatory	Identifies the version of the T-MSIS data mapping document used to build a state	N/A	CRX00001	FILE-HEADER-RECORD-RX	X(9)	5	23	31	1. Value must be 9 characters or less 2. Mandatory

					submission file. ~~Use the version number specified on the title page of the data mapping document.~~								
CRX006	CRX.001.006	FILE-NAME	File Name	~~Not Applicable~~ Mandatory	A code to identify the subject area to which the records in its file relate. Each T-MSIS submission file should only contain records for one subject area (i.e., Eligible, Third-party liability, Provider, Managed Care Plan Information, Inpatient, Long-Term Care, Other, ~~and~~ Pharmacy Claim, and Financial Transactions).	N/A	CRX00001	FILE-HEADER-RECORD-RX	X(8)	6	32	39	1. Value must equal ~~'CLAIM-RX'~~"CLAIM-RX" 2. Mandatory
CRX007	CRX.001.007	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	CRX00001	FILE-HEADER-RECORD-RX	X(2)	7	40	41	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ 3. Mandatory
CRX008	CRX.001.008	DATE-FILE-CREATED	Date File Created	Mandatory	The date on which the file was created.	N/A	CRX00001	FILE-HEADER-RECORD-RX	9(8)	8	42	49	~~1.~~1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" ~~2~~3. Value must be ~~8 characters in the form "CCYYMMDD"~~ ~~3. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~4.~~less than current date 4. Value must be equal to or after the value of associated End of Time Period 5. Mandatory
CRX009	CRX.001.009	START-OF-TIME-PERIOD	Start of Time Period	Mandatory	This value must be the first day of the reporting month, regardless of the actual date span of the data in the file.	N/A	CRX00001	FILE-HEADER-RECORD-RX	9(8)	9	50	57	~~1. Value of the CC component must be "20"~~ ~~2. Value must be 8 characters in the form "CCYYMMDD"~~ ~~3.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~4. Value must be less than current date~~ ~~5.~~in the form "CCYYMMDD" 2. Value must be equal to or earlier than

													associated Date File Created ~~6~~3. Value must be before associated End of Time Period ~~7~~4. Mandatory 5. Value of the CC component must be "20"
CRX010	CRX.001.010	END-OF-TIME-PERIOD	End of Time Period	Mandatory	This value must be the last day of the reporting month, regardless of the actual date span.	N/A	CRX00001	FILE-HEADER-RECORD-RX	9(8)	10	58	65	1. ~~Value~~The date must be ~~8 characters~~a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" 3. ~~The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~4.~~ Value must be equal to or earlier than associated Date File Created ~~5~~4. Value must be equal to or after associated Start of Time Period ~~6~~5. Mandatory
CRX011	CRX.001.011	FILE-STATUS-INDICATOR	File Status Indicator	Mandatory	A code to indicate whether the records in the file are test or production records.	FILE-STATUS-INDICATOR	CRX00001	FILE-HEADER-RECORD-RX	X(1)	11	66	66	~~1.~~1. Value must be 1 character 2. For production files, value must be equal to ~~'P'~~ ~~2. Value must be 1 character~~ "P" 3. Value must be in File Status Indicator List (VVL) 4. Mandatory
CRX012	CRX.001.012	SSN-INDICATOR	SSN Indicator	Mandatory	Indicates whether the state uses the eligible person's social security number instead of an MSIS Identification Number as the unique, unchanging eligible person identifier. A state's SSN/Non-SSN designation on the eligibility file should match on the claims and third party liability files.	SSN-INDICATOR	CRX00001	FILE-HEADER-RECORD-RX	X(1)	12	67	67	~~1.~~1. Value must be 1 character 2. Value must be in SSN Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory

CRX013	CRX.001.013	TOT-REC-CNT	Total Record Count	Mandatory	A count of all records in the file except for the file header record. This count will be used as a control total to help assure that the file did not become corrupted during transmission.	N/A	CRX00001	FILE-HEADER-RECORD-RX	9(11)	13	68	78	~~1.~~1. Value must be 11 digits or less 2. Value must be a positive integer ~~2~~3. Value must be between 0:99999999999 (inclusive) ~~3. Value must be 11 digits or less~~ ~~4.~~4. Value must equal the number of records included in the file submission except for the file header record. 5. Mandatory
CRX014	CRX.001.014	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	CRX00001	FILE-HEADER-RECORD-RX	X(500)	15	83	582	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
CRX016	CRX.002.016	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	CRX00002	CLAIM-HEADER-RECORD-RX	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~ 3. Value must be in Record ID List (VVL) 4. Value must equal "CRX00002"

CRX017	CRX.002.017	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	CRX00002	CLAIM-HEADER-RECORD-RX	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (CRX.001.007)
CRX018	CRX.002.018	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory
CRX019	CRX.002.019	ICN-ORIG	Original ICN	Mandatory	A unique number assigned by the state's payment system that identifies an original or adjustment claim.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(50)	4	22	71	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
CRX020	CRX.002.020	ICN-ADJ	Adjustment ICN	Conditional	A unique claim number assigned by the state's payment system that identifies the adjustment claim for an original transaction.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(50)	5	72	121	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value ~~is~~ equals "0~~,~~", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
CRX021	CRX.002.021	SUBMITTER-ID	Submitter ID	Mandatory	The Submitter Identification number is the value that identifies the provider/trading partner/clearing house organization to the state's claim adjudication system.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(12)	6	122	133	1. Value must be 12 characters or less 2. Mandatory

CRX022	CRX.002.022	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual ~~(except on service tracking payments).~~ . Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47572~~reporting-shared-msis-identification-numbers-eligibility/	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(20)	7	134	153	~~1. Mandatory~~ ~~2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN~~ ~~3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN~~ ~~4.~~1. Value must be 20 characters or less ~~5.~~2. Mandatory 3. The Prescription Fill Date (CRX.002.085) on the claim must fall between Enrollment Timespan Effective Date (ELG.021.253) and Enrollment Timespan End Date (ELG.021.253)
CRX023	CRX.002.023	CROSSOVER-INDICATOR	Crossover Indicator	~~Conditional~~ Mandatory	An indicator specifying whether the claim is a crossover claim where a portion is paid by Medicare.	CROSSOVER-INDICATOR	CRX00002	CLAIM-HEADER-RECORD-RX	X(1)	8	154	154	~~1.~~1. Value must be 1 character 2. Value must be in Crossover Indicator List (VVL) ~~2~~3. If Crossover Indicator value ~~is~~equals "1", then associated Dual Eligible Code (ELG.005.085) value must be in ~~"~~[01~~",~~ ",02~~",~~ ",04~~",~~ ",08~~",~~ ",09~~", or ~~",10~~"] for the same time period (by date of service) ~~3. Value must be 1 character~~ ~~4. Conditional~~ ~~5. If the TYPE OF CLAIM value is in ["1", "3", "A", "C"], then value is mandatory and must be reported.~~4. Mandatory

CRX024	CRX.002.024	1115A-DEMONSTRATION-IND	1115A Demonstration Indicator	Conditional	~~Indicates that~~In the claims files this data element indicates whether the claim or encounter was covered under the authority of an ~~1115(A)~~1115A demonstration. ~~1115(A) is a Center for Medicare and Medicaid Innovation~~In the Eligibility file, this data element indicates whether the individual participates in an 1115A demonstration.	1115A-DEMONSTRATION-IND	CRX00002	CLAIM-HEADER-RECORD-RX	X(1)	9	155	155	~~1.~~1. Value must be 1 character 2. Value must be in 1115A Demonstration Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Conditional 4. When value equals ~~'~~"0~~'~~", is invalid or not populated, then the associated 1115A Demonstration Indicator (ELG.018.2~~2~~33) must equal ~~'~~"0~~'~~", is invalid or not populated
CRX025	CRX.002.025	ADJUSTMENT-IND	Adjustment Indicator	Mandatory	Indicates the type of adjustment record.	ADJUSTMENT-IND	CRX00002	CLAIM-HEADER-RECORD-RX	X(1)	10	156	156	~~1.~~1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) ~~2. If associated Type of Claim value is in [1,~~ 3~~, 5, A, C, E, U, W, Y], then value must be in [0, 1, 4]~~ ~~3. If associated Type of Claim value is '4, D, X',~~ ~~then.~~ Value must be in [~~5, 6~~0,1,4] 4. ~~Value must be 1 character~~ ~~5.~~Mandatory 5. If value equals "0", then associated Adjustment ICN must not be populated 6. Value must equal "1", when associated Claim Status equals "686"
CRX026	CRX.002.026	ADJUSTMENT-REASON-CODE	Adjustment Reason Code	Conditional	Claim adjustment reason codes communicate why a claim was paid differently than it was billed. ~~If the amount paid is different from the amount billed you need an adjustment reason code.~~	ADJUSTMENT-REASON-CODE	CRX00002	CLAIM-HEADER-RECORD-RX	X(3)	11	157	159	~~1.~~1. Value must be 3 characters or less 2. Value must be in Adjustment Reason Code List (VVL) ~~2. Value must be 3 characters or less~~ ~~3.~~3. Conditional 4. Value must ~~not~~ be populated when ~~associated Adjustment Indicator equals "0"~~the total paid amount is different from the total billed amount

CRX027	CRX.002.027	ADJUDICATION-DATE	Adjudication Date	Mandatory	The date on which the payment status of the claim was finally adjudicated by the state. For Encounter Records (Type of Claim = 3, C, W), use date the encounter was processed by the state.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	9(8)	12	160	167	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value should be on or before End of Time Period ~~value found in~~(CIP.001.010) 3. Mandatory 4. Value should be on or after associated ~~T-MSIS File Header Record~~ ~~4. Mandatory~~Admission Date value
CRX028	CRX.002.028	MEDICAID-PAID-DATE	Medicaid Paid Date	Mandatory	The date Medicaid paid this claim or adjustment. For Encounter Records (Type of Claim = 3, C, W), the date the managed care organization paid the provider for the claim or adjustment.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	9(8)	13	168	175	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Must have an associated Total Medicaid Paid Amount ~~4~~3. Mandatory
CRX029	CRX.002.029	TYPE-OF-CLAIM	Type of Claim	Mandatory	A code to indicate what type of payment is covered in this claim. For sub-capitated encounters from a sub-capitated entity or sub-capitated network provider, report TYPE-OF-CLAIM = '3' for a Medicaid sub-capitated encounter record or “C” for an S-CHIP sub-capitated encounter record.	TYPE-OF-CLAIM	CRX00002	CLAIM-HEADER-RECORD-RX	X(1)	14	176	176	~~1.~~1. Value must be 1 character 2. Value must be in Type of Claim List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory ~~4. When value equals 'Z', claim denied indicator must equal '0'~~
CRX030	CRX.002.030	CLAIM-STATUS	Claim Status	Conditional	The health care claim status codes convey the status of an entire claim. status codes from the 277 transaction set. Only report the claim status for the final, adjudicated claim.	CLAIM-STATUS	CRX00002	CLAIM-HEADER-RECORD-RX	X(3)	15	177	179	~~1.~~1. Value must be 3 characters or less 2. Value must be in Claim Status List (VVL) ~~2. Value must be 3 characters or less~~ ~~3.~~3. Conditional 4. If value in [~~26, 87,~~542,585,654~~],~~], then Claim Denied Indicator must be ~~'0'~~"0" and Claim Status Category must be "F2"

CRX031	CRX.002.031	CLAIM-STATUS-CATEGORY	Claim Status Category	Mandatory	The ~~Claim Status Category conveys the status~~ general category of the ~~entire~~ claim ~~using the X12 Claim Status Category Codes~~status (accepted, rejected, pended, finalized, additional information requested, etc.) from the 277 transaction set which is then further detailed in the companion data element claim ~~adjudication process~~status.	CLAIM-STATUS-CATEGORY	CRX00002	CLAIM-HEADER-RECORD-RX	X(3)	16	180	182	~~1.~~1. Value must be 3 characters or less 2. Value must be in Claim Status Category List (VVL) ~~2~~3. (Denied Claim) if associated Claim Denied Indicator indicates the claim was denied, then value must be "F2" ~~3~~4. (Denied Claim) if associated ~~Type of Claim equals Z or associated~~ Claim Status is in [~~26, 87,~~ 542,~~8~~585,654], then value must be "F2" ~~4. Value must be 3 characters or less~~ 5. Mandatory
CRX032	CRX.002.032	SOURCE-LOCATION	Source Location	Mandatory	~~The field denotes the claims payment system from which the claim was extracted.~~The field denotes the claims payment system from which the claim was extracted. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report a SOURCE-LOCATION = '22' to indicate that the sub-capitated entity paid a provider for the service to the enrollee on a FFS basis. For sub-capitated encounters from a sub-capitated network provider that were submitted to sub-capitated entity, report a SOURCE-LOCATION = '23' to indicate that the sub-capitated network provider provided the service directly to the enrollee. For sub-capitated encounters from a sub-capitated network provider, report a SOURCE-LOCATION = “23” to indicate that the sub-capitated network provider provided the service directly to the enrollee.	SOURCE-LOCATION	CRX00002	CLAIM-HEADER-RECORD-RX	X(2)	17	183	184	~~1.~~1. Value must be 2 characters 2. Value must be in Source Location List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory

CRX033	CRX.002.033	CHECK-NUM	Check Number	Conditional	The check or electronic funds transfer number.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(15)	18	185	199	1. Value must be 15 characters or less 2. Value must have an associated Check Effective Date 3. Value must not contain a pipe or asterisk symbols 4. Conditional
CRX034	CRX.002.034	CHECK-EFF-DATE	Check Effective Date	Conditional	The date a check is issued to the payee. In the case of electronic funds transfer, it is the date the transfer is made.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	9(8)	19	200	207	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3. Value may be the same as associated Remittance Date~~ ~~4.~~ in the form "CCYYMMDD" 2. Must have an associated Check Number ~~5~~3. Conditional
CRX035	CRX.002.035	CLAIM-PYMT-REM-CODE-1	~~Claim Payment~~Remittance Advice Remark Code 1	Conditional	Remittance Advice Remark Codes are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Each Remittance Advice Remark Code identifies a specific message as shown in the Remittance Advice Remark Code List. It is a code set used by the health care industry to convey non-financial information critical to understanding the adjudication of a health care claim for payment. It is an external code set whose use is as mandated by the Administrative Simplification provisions of the Health Insurance Portability and Accountably Act of 1996 (P.L.104-191, commonly referred to as HIPAA).	CLAIM-PYMT-REM-CODE	CRX00002	CLAIM-HEADER-RECORD-RX	X(5)	20	208	212	~~1.~~1. Value must be 5 characters or less 2. Value must be in Claim Payment Remittance Code List (VVL) ~~2. Value must be 5 characters or less~~ ~~3.~~3. Conditional 4. When more than one ~~code~~occurrence of Claim Payment Remark Code 1 through Claim Payment Remark Code 4 is populated on a claim, all values must be unique

CRX036	CRX.002.036	CLAIM-PYMT-REM-CODE-2	~~Claim Payment~~Remittance Advice Remark Code 2	Conditional	Remittance Advice Remark Codes are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Each Remittance Advice Remark Code identifies a specific message as shown in the Remittance Advice Remark Code List. It is a code set used by the health care industry to convey non-financial information critical to understanding the adjudication of a health care claim for payment. It is an external code set whose use is as mandated by the Administrative Simplification provisions of the Health Insurance Portability and Accountably Act of 1996 (P.L.104-191, commonly referred to as HIPAA).	CLAIM-PYMT-REM-CODE	CRX00002	CLAIM-HEADER-RECORD-RX	X(5)	21	213	217	~~1.~~1. Value must be 5 characters or less 2. Value must be in Claim Payment Remittance Code List (VVL) ~~2. Value must be 5 characters or less~~ ~~3.~~3. Conditional 4. When more than one ~~code~~occurrence of Claim Payment Remark Code 1 through Claim Payment Remark Code 4 is populated on a claim, all values must be unique 5. Value must not be populated when ~~Claim Payment~~Remittance Advice Remark Code 1 (CRX.002.035) is not populated
CRX037	CRX.002.037	CLAIM-PYMT-REM-CODE-3	~~Claim Payment~~Remittance Advice Remark Code 3	Conditional	Remittance Advice Remark Codes are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Each Remittance Advice Remark Code identifies a specific message as shown in the Remittance Advice Remark Code List. It is a code set used by the health care industry to convey non-financial information critical to understanding the adjudication of a health care claim for payment. It is an external code set whose use is as mandated by the Administrative Simplification provisions of the Health Insurance Portability and Accountably Act of 1996 (P.L.104-191, commonly referred to as HIPAA).	CLAIM-PYMT-REM-CODE	CRX00002	CLAIM-HEADER-RECORD-RX	X(5)	22	218	222	1. Value must be in Claim Payment Remittance Code List (VVL) 2. Value must be 5 characters or less 3. Conditional 4. When more than one ~~code~~occurrence of Claim Payment Remark Code 1 through Claim Payment Remark Code 4 is populated on a claim, all values must be unique 5. Value must not be populated when ~~Claim Payment~~Remittance Advice Remark Code 2 (CRX.002.036) is not populated

CRX038	CRX.002.038	CLAIM-PYMT-REM-CODE-4	~~Claim Payment~~Remittance Advice Remark Code 4	Conditional	Remittance Advice Remark Codes are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Each Remittance Advice Remark Code identifies a specific message as shown in the Remittance Advice Remark Code List. It is a code set used by the health care industry to convey non-financial information critical to understanding the adjudication of a health care claim for payment. It is an external code set whose use is as mandated by the Administrative Simplification provisions of the Health Insurance Portability and Accountably Act of 1996 (P.L.104-191, commonly referred to as HIPAA).	CLAIM-PYMT-REM-CODE	CRX00002	CLAIM-HEADER-RECORD-RX	X(5)	23	223	227	1. Value must be in Claim Payment Remittance Code List (VVL) 2. Value must be 5 characters or less 3. Conditional 4. When more than one ~~code~~occurrence of Claim Payment Remark Code 1 through Claim Payment Remark Code 4 is populated on a claim, all values must be unique 5. Value must not be populated when ~~Claim Payment~~Remittance Advice Remark Code 3 (~~CRX~~CIP.002.~~037~~110) is not populated
CRX039	CRX.002.039	TOT-BILLED-AMT	Total Billed Amount	Conditional	The total amount billed for this claim at the claim header level as submitted by the provider. For encounter records, when Type of Claim value is ~~[~~in [3, C, ~~or~~ W], then value must equal amount the provider billed to the managed care plan. ~~Total Billed Amount~~For sub-capitated encounters from a sub-capitated entity that is not ~~expected on financial transactions~~a sub-capitated network provider, report the total amount that the provider billed the sub-capitated entity for the service. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11)V99	24	228	240	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Value must equal the sum of all Billed Amount instances for the associated claim 4. Conditional ~~5. Value should not be populated when associated Type of Claim is in [2, 4, 5, B, D-E or X]~~

CRX040	CRX.002.040	TOT-ALLOWED-AMT	Total Allowed Amount	Conditional	The claim header level maximum amount determined by the payer as being 'allowable' under the provisions of the contract prior to the determination of actual payment. On FFS claims the Allowed Amount is determined by the state's MMIS. On managed care encounters the Allowed Amount is determined by the managed care organization. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the total amount that the sub-capitated entity allowed for the service. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11) V99	25	241	253	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. When populated and Payment Level Indicator ~~= '2'~~equals "2", then value must equal the sum of all claim line Allowed Amount values 4. Conditional

CRX041	CRX.002.041	TOT-MEDICAID-PAID-AMT	Total Medicaid Paid Amount	Conditional	The total amount paid by Medicaid/CHIP or the managed care plan on this claim or adjustment at the claim header level, which is the sum of the amounts paid by Medicaid or the managed care plan at the detail level for the claim. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the total amount that the sub-capitated entity paid the provider for the service. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11) V99	26	254	266	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Must have an associated Medicaid Paid Date 4. If Total Medicare Coinsurance Amount and Total Medicare Deductible Amount is reported it must equal Total Medicaid Paid Amount 5. When Payment Level Indicator equals '2', value must equal the sum of line level Medicaid Paid Amounts. 6. Conditional 7. Value must be populated, when Type of Claim is in [1,A] 8. Value must not be populated or equal to "0.00" when associated Claim Status is in [542,585,654] 9. Value must not be greater than Total Allowed Amount (CRX.002.040)
~~CRX042~~	~~CRX.002.042~~	~~TOT-COPAY-AMT~~	~~Total Copayment Amount~~	~~Conditional~~	~~The total amount paid by Medicaid/CHIP enrollee for each office or emergency department visit or purchase of prescription drugs in addition to the amount paid by Medicaid/CHIP.~~	~~N/A~~	~~CRX00002~~	~~CLAIM-HEADER-RECORD-RX~~	~~S9(11) V99~~	~~27~~	~~267~~	~~279~~	~~1. Value must be between -99999999999.99 and 99999999999.99~~ ~~2. Value must be expressed as a number with 2-digit precision (e.g. 100.50)~~ ~~3. Conditional~~

CRX043	CRX.002.043	TOT-MEDICARE-DEDUCTIBLE-AMT	Total Medicare Deductible Amount	Conditional	The amount paid by Medicaid/CHIP, on this claim at the claim header level, toward the beneficiary's Medicare deductible. 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, code Medicare Combined Indicator a ~~"1"~~'1' and leave Total Medicare Coinsurance Amount unpopulated.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11) V99	~~28~~27	~~280~~267	279~~2~~	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Crossover Indicator value ~~is '0'~~equals "0" (not a crossover claim), then value should not be populated~~.~~ 4. (Medicare Enrolled) if associated Dual Eligible Code (ELG.005.085) value is in ~~["~~["01~~",~~ ~~"~~,02~~",~~ ~~"~~,03~~",~~ ~~"~~,04~~",~~ ~~"~~,05~~",~~ ~~"~~,06~~",~~ ~~"~~,08~~",~~ ~~"~~,09~~", or~~ ~~"~~,10~~"],],~~ then value is mandatory and must be provided 5. Conditional 6. When populated, value must be less than or equal to Total Billed Amount
CRX044	CRX.002.044	TOT-MEDICARE-COINS-AMT	Total Medicare Coinsurance Amount	Conditional	The total amount paid by the Medicaid/CHIP agency or a managed care plan towards the portion of the Medicare allowed charges that Medicare applied to coinsurance.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11) V99	~~29~~28	~~293~~280	~~305~~292	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Crossover Indicator value ~~is '0'~~equals "0" (not a crossover claim), then value should not be populated. 4. Conditional 5. If associated Medicare Combined Deductible Indicator ~~is '1'~~,equals "1", then value must not be populated 6. When populated, value must be less than or equal to Total Billed Amount

CRX045	CRX.002.045	TOT-TPL-AMT	Total ~~Third Party Liability~~TPL Amount	Conditional	Third-party liability refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a state plan. This is the total amount denoted at the claim header level paid by the third party.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11) V99	~~30~~29	~~306~~293	~~318~~305	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Value must be less than associated Total Billed Amount - (Total Medicare Coinsurance Amount + Total Medicare Deductible Amount) 4. Conditional
CRX047	CRX.002.047	TOT-OTHER-INSURANCE-AMT	Total Other Insurance Amount	Conditional	The amount paid by insurance other than Medicare or Medicaid on this claim.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11) V99	~~31~~30	~~319~~306	3~~3~~18	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CRX048	CRX.002.048	OTHER-INSURANCE-IND	Other Insurance Indicator	Conditional	The field denotes whether the insured party is covered under an other insurance plan other than Medicare or Medicaid.	OTHER-INSURANCE-IND	CRX00002	CLAIM-HEADER-RECORD-RX	X(1)	~~32~~31	~~332~~319	~~332~~319	~~1.~~1. Value must be 1 character 2. Value must be in Other Insurance Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Conditional
CRX049	CRX.002.049	OTHER-TPL-COLLECTION	Other TPL Collection	~~Conditional~~ Mandatory	This data element indicates that the claim is for a beneficiary for whom other third party resource development and collection activities are in progress, when the liability is not another health insurance plan for which the eligible is a beneficiary.	OTHER-TPL-COLLECTION	CRX00002	CLAIM-HEADER-RECORD-RX	X(3)	~~33~~32	~~333~~320	~~335~~322	1. Value must be in Other TPL Collection List (VVL) 2. Value must be 3 characters 3. ~~Conditional~~Mandatory
~~CRX050~~	~~CRX.002.050~~	~~SERVICE-TRACKING-TYPE~~	~~Service Tracking Type~~	~~Conditional~~	~~A code to categorize service tracking claims. A "service tracking claim" is used to report lump sum payments that cannot be attributed to a single enrollee.~~	~~SERVICE-TRACKING-TYPE~~	~~CRX00002~~	~~CLAIM-HEADER-RECORD-RX~~	~~X(2)~~	~~34~~	~~336~~	~~337~~	~~1. Value must be in Service Tracking Type List (VVL)~~ ~~2. (Service Tracking Claim) if associated Type of Claim is in ['4','D', 'X'] then value is mandatory and must be reported~~ ~~3. Value must be 2 characters~~ ~~4. Conditional~~

~~CRX051~~	~~CRX.002.051~~	~~SERVICE-TRACKING-PAYMENT-AMT~~	~~Service Tracking Payment Amount~~	~~Conditional~~	~~On service tracking claims, the payment amount is the lump sum that cannot be attributed to any one beneficiary paid to the provider.~~	~~N/A~~	~~CRX00002~~	~~CLAIM-HEADER-RECORD-RX~~	~~S9(11) V99~~	~~35~~	~~338~~	~~350~~	~~1. Value must be between -99999999999.99 and 99999999999.99~~ ~~2. Value must be expressed as a number with 2-digit precision (e.g. 100.50)~~ ~~3. If associated Type of Claim value is in [4, D, or X], then value is mandatory and must be provided~~ ~~4. Conditional~~ ~~5. When populated, Service Tracking Type must be populated~~ ~~6. When populated, Total Medicaid Amount must not be populated~~
CRX052	CRX.002.052	FIXED-PAYMENT-IND	Fixed Payment Indicator	Conditional	This indicator indicates that the reimbursement amount included on the claim is for a fixed payment. Fixed payments are made by the state to insurers or providers for premiums or eligible coverage, not for a particular service. For example, some states have Primary Care Case Management programs where the state pays providers a monthly patient management fee of $3.50 for each eligible participant under their care. This fee is considered a fixed payment. It is very important for states to correctly identify fixed payments. Fixed payments do not have a defined ~~"medical record".~~'medical record' associated with the payment; therefore, fixed payments are not subject to medical record request and medical record review.	FIXED-PAYMENT-IND	CRX00002	CLAIM-HEADER-RECORD-RX	X(1)	~~36~~33	~~351~~323	~~351~~323	~~1.~~1. Value must be 1 character 2. Value must be in Fixed Payment Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Conditional
CRX053	CRX.002.053	FUNDING-CODE	Funding Code	~~Mandatory~~Conditional	A code to indicate the source of non-federal share funds.	FUNDING-CODE	CRX00002	CLAIM-HEADER-RECORD-RX	X(2)	~~37~~34	3~~5~~24	325~~3~~	~~1.~~1. Value must be 1 character 2. Value must be in Funding Code List (VVL) ~~2.~~3. If Type of Claim is not in [3,C,W], then value must be ~~1 character~~ ~~3. Mandatory~~populated 4. Conditional

CRX054	CRX.002.054	FUNDING-SOURCE-NONFEDERAL-SHARE	Funding Source Non-Federal Share	~~Not Applicable~~Conditional	A code to indicate the type of non-federal share used by the state to finance its expenditure to the provider. In the event of two sources, states are to report the portion which represents the largest proportion not funded by the Federal government.	FUNDING-SOURCE-NONFEDERAL-SHARE	CRX00002	CLAIM-HEADER-RECORD-RX	X(2)	~~38~~35	~~354~~326	~~355~~327	~~1.~~1. Value must be 2 characters 2. Value must be in Funding Source Non-Federal Share List (VVL) ~~2.~~3. If Type of Claim is in [3,C,W], then value must be ~~2 characters~~ ~~3. Required~~populated 4. Conditional
CRX055	CRX.002.055	PROGRAM-TYPE	Program Type	Mandatory	A code to indicate special Medicaid program under which the service was provided.	PROGRAM-TYPE	CRX00002	CLAIM-HEADER-RECORD-RX	X(2)	~~39~~36	~~356~~328	~~357~~329	~~1.~~1. Value must be 2 characters 2. Value must be in Program Type List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. (Community First Choice) If value equals '11', then State Plan Option Type (ELG.011.163) must equal '01' for the same time period 5. If value equals '13', then State Plan Option Type (ELG.011.163) must equal '02' for the same time period

CRX056	CRX.002.056	PLAN-ID-NUMBER	Plan ID Number	Conditional	A unique number assigned by the state which represents a distinct comprehensive managed care plan, prepaid health plan, primary care case management program, a program for all-inclusive care for the elderly entity, or other approved plans.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(12)	~~40~~37	~~358~~330	~~369~~341	1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional 4. Value must match Managed Care Plan ID (ELG.014.192) 5. Value must match State Plan ID Number (MCR.002.019) 6. Value should be populated when Type of Claim (CRX.002.029) is in [3,C,W~~, 2, B, V~~] 7. When Type of Claim (CRX.002.029) in ~~{~~[3,C,W~~, 2, B, V)~~] value must have a Managed Care Enrollment (ELG.014) for the beneficiary where the Prescription Fill Date (CRX.002.085) occurs between the managed care plan enrollment eff/end dates (ELG.014.197/198) 8. When Type of Claim (CRX.002.029) in ~~{~~[3,C,W~~, 2, B, V)~~] value must have a Managed Care Main Record (MCR.002) for the plan where the Prescription Fill Date (CRX.002.085) occurs between the managed care contract eff/end dates (MCR.002.020/021)
~~CRX057~~	~~CRX.002.057~~	~~NATIONAL-HEALTH-CARE-ENTITY-ID~~	~~National Health Care Entity ID~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~CRX00002~~	~~CLAIM-HEADER-RECORD-RX~~	~~X(10)~~	~~41~~	~~370~~	~~379~~	~~1. Not Applicable~~

CRX058	CRX.002.058	PAYMENT-LEVEL-IND	Payment Level Indicator	Mandatory	~~The field denotes whether the payment amount was determined at the claim header or line/detail level.~~The field denotes whether the payment amount was determined at the claim header or line/detail level. For claims where payment is NOT determined at the individual line level (PAYMENT-LEVEL-IND = 1), the claim lines' associated allowed (ALLOWED-AMT) and paid (MEDICAID-PAID-AMT) amounts are left blank and the total allowed (TOT-ALLOWED-AMT) and total paid (TOT-MEDICAID-PAID-AMT) amount is reported at the header level only. For claims where payment/allowed amount is determined at the individual lines and when applicable, cost-sharing and/or coordination of benefits were deducted from one or more specific line-level payment/allowed amounts (PAYMENT-LEVEL-IND = 2), the allowed (ALLOWED-AMT) and paid (MEDICAID-PAID-AMT) amounts on the associated claim lines should sum to the total allowed (TOT-ALLOWED-AMT) and total paid (TOT-MEDICAID-PAID-AMT) amounts reported on the claim header. For claims where payment/allowed amount is determined at the individual lines but then cost sharing or coordination of benefits was deducted from the total paid/allowed amount at the header only (PAYMENT-LEVEL-IND = 3), then the line-level paid amount (MEDICAID-PAID-AMT) would be blank and line-level allowed (ALLOWED-AMT) and header level total allowed (TOT-ALLOWED-AMT) and total paid (TOT-MEDICAID-PAID-AMT) amounts must all be populated but the line level allowed amounts are not expected to sum exactly to the header level total allowed.	PAYMENT-LEVEL-IND	CRX00002	CLAIM-HEADER-RECORD-RX	X(1)	~~42~~38	~~380~~342	~~380~~342	~~1.~~1. Value must be 1 character 2. Value must be in Payment Level Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory

					For example, if a claim for an office visit and a procedure is assigned a separate line-level allowed amount for each line, but then at the header level a copy is deducted from the header-level total allowed and/or total paid amounts, then the sum of line-level allowed amounts may not be equal to the header-level total allowed amounts or correspond directly to the total paid amount. If the state cannot distinguish between the scenarios for value 1 and value 3, then value 1 can be used for all claims with only header-level total allowed/paid amounts.								
CRX059	CRX.002.059	MEDICARE-REIM-TYPE	Medicare Reimbursement Type	Conditional	A code to indicate the type of Medicare reimbursement.	MEDICARE-REIM-TYPE	CRX00002	CLAIM-HEADER-RECORD-RX	X(2)	~~43~~39	~~381~~343	~~382~~344	~~1.~~1. Value must be 2 characters 2. Value must be in Medicare Reimbursement Type List (VVL) ~~2. (Crossover Claim) if associated Crossover Indicator value indicates a crossover claim,~~3. Value is mandatory and must be provided ~~3. Value must be 2 characters~~ , when Crossover Indicator is equal to "1"

													(Crossover Claim) 4. Conditional
CRX060	CRX.002.060	CLAIM-LINE-COUNT	Claim Line Count	Mandatory	The total number of lines on the claim.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	9(4)	~~44~~40	~~383~~345	34~~8 6~~	1. Value must be 4 characters or less 2. Value must be a positive integer ~~2~~3. Value must be between ~~0~~0000:9999 (inclusive) ~~3~~4. Value must not include commas or other non-numeric characters ~~4~~5. Value must be equal to the number of claim lines (e.g. Original Claim Line Number or Adjustment Claim Line Number instances) reported in the associated claim record being reported ~~5. Value must be 4 characters or less~~ 6. Mandatory
CRX061	CRX.002.061	FORCED-CLAIM-IND	Forced Claim Indicator	Conditional	Indicates if the claim was processed by forcing it through a manual override process.	FORCED-CLAIM-IND	CRX00002	CLAIM-HEADER-RECORD-RX	X(1)	~~45~~41	~~387~~349	~~387~~349	~~1.~~1. Value must be 1 character 2. Value must be in Forced Claim Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Conditional
CRX062	CRX.002.062	PATIENT-CONTROL-NUM	Patient Control Number	Conditional	A patient's unique number assigned by the provider agency during claim submission, which identifies the client or the client's episode of service within the provider's system to facilitate retrieval of individual financial and clinical records and posting of payment~~.~~	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(20)	~~46~~42	~~388~~350	~~407~~369	1. Value must be 20 characters or less 2. Value must not contain a pipe or asterisk symbol 3. Conditional

CRX063	CRX.002.063	ELIGIBLE-LAST-NAME	Eligible Last Name	Conditional	The last name of the individual to whom the services were provided. (The patients name should be captured as it appears on the claim record, it does not need to be the same as it appears on the eligibility file. The MSIS Identification Number will be used to associate a claim record with the appropriate eligibility data.)	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(30)	~~47~~43	~~408~~370	~~437~~399	1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional
CRX064	CRX.002.064	ELIGIBLE-FIRST-NAME	Eligible First Name	Conditional	The first name of the individual to whom the services were provided.(The patients name should be captured as it appears on the claim record, it does not need to be the same as it appears on the eligibility file. The MSIS Identification Number will be used to associate a claim record with the appropriate eligibility data.)	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(30)	~~48~~44	~~438~~400	~~467~~429	1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional
CRX065	CRX.002.065	ELIGIBLE-MIDDLE-INIT	Eligible Middle Initial	Conditional	Individual's middle initial; middle initial component of full name (e.g. First Name, Middle Initial, Last Name).	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(1)	~~49~~45	~~468~~430	~~468~~430	1. ~~Value may include any alphanumeric characters, digits or symbols~~ ~~2.~~ Value must be 1 character ~~3~~2. Value must not contain a pipe or asterisk symbols ~~4~~3. Conditional
CRX066	CRX.002.066	DATE-OF-BIRTH	Date of Birth	Mandatory	An individual's date of birth.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	9(8)	~~50~~46	~~469~~431	~~476~~438	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Mandatory

CRX067	CRX.002.067	HEALTH-HOME-PROV-IND	Health Home Provider Indicator	Conditional	Indicates whether the claim is submitted by a provider or provider group enrolled in the Health Home care model~~.~~ to provide services for the beneficiary on the claim. Health home providers provide service for patients with chronic illnesses. ~~States should not submit claim records for an eligible individual that indicate the claim was submitted by a provider or provider group enrolled in a health home model if the eligible individual is not enrolled in the health home program.~~ States that do not specify an eligible individual's health home provider number, if applicable, should not report claims that indicate the claim is submitted by a provider or provider group enrolled in the health home model.	HEALTH-HOME-PROV-IND	CRX00002	CLAIM-HEADER-RECORD-RX	X(1)	~~51~~47	~~477~~439	~~477~~439	1. Value must be in Health Home Provider Indicator List (VVL) 2. Value must be 1 character 3. If there is an associated Health Home Entity Name value, then value must be "1" ~~3. Value must be 1 character~~ ~~4.~~4. Conditional
CRX068	CRX.002.068	WAIVER-TYPE	Waiver Type	Conditional	A code for specifying waiver type under which the eligible individual is covered during the month and receiving services/under which claim is submitted.	WAIVER-TYPE	CRX00002	CLAIM-HEADER-RECORD-RX	X(2)	~~52~~48	~~478~~440	~~479~~441	~~1.~~1. Value must be 2 characters 2. Value must be in Waiver Type List (VVL) ~~2. Value must be 2 characters~~ ~~3. Value must be in ['06', '07', '08', '09', '10', '11', '12', '13', '14', '15', '16', '17', '18', '19', '20', '33'] when associated Program Type equals "07"~~ ~~4.~~3. Value must match Eligible Waiver Type (ELG.012.173) for the enrollee for the same time period (by date of service) 4. Value must have a corresponding value in Waiver ID (CRX.002.069) 5. Conditional 6. Value must be in [06,07,08,09,10,11,12,13,14,15,16,17,18,19,20,33] when associated Program Type equals "07"

CRX069	CRX.002.069	WAIVER-ID	Waiver ID	Conditional	Field specifying the waiver or demonstration which authorized payment for a claim. These IDs must be the approved, full federal waiver ID number assigned during the state submission and CMS approval process. Waiver IDs should actually only be the "core" part of the waiver IDs, without including suffixes for renewals or amendments.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(20)	~~53~~49	~~480~~442	~~499~~461	~~1.~~1. Value must be 20 characters or less 2. Value must be associated with a populated Waiver Type ~~2. Value must be 20 characters or less~~ ~~3.~~3. (1115 demonstration ~~waivers~~) If value begins with "11-W-" or "21-W-", the associated Claim Waiver Type value must be 01 or in [21-30] 4. (1115 demonstration) If value begins with"11-W-" or "21-W-", then the value must include slash "/" in the 11th position followed by the last digit of the CMS Region [0-9] in the 12th position 5. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation followed by a period (.), the associated Claim Waiver Type value must be in [02-20,32,33] ~~5~~6. Conditional
CRX070	CRX.002.070	BILLING-PROV-NUM	Billing Provider Number	Conditional	A unique identification number assigned by the state to a provider or ~~capitation~~managed care plan. This data element should represent the entity billing for the service. For encounter records, if associated Type of Claim value equals 3, C, or W, then value must be the state identifier of the provider or entity (billing or reporting) to the managed care plan.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(30)	~~54~~50	~~500~~462	~~529~~491	1. Value must be 30 characters or less 2. ~~Value must be reported in Provider Identifier (PRV.005.080) with an associated Provider Identifier Type (PRV.005.081) equal to '1'~~ ~~3.~~ Conditional ~~4~~3. When Type of Claim not in ~~('Z','3','C','W","2","B","V"," 4","D","X")~~[3,C,W] then value may match (PRV.002.019) Submitting State Provider ID or 4. When Type of Claim not in ~~('Z','3','C','W","2","B","V"," 4","D","X")~~[3,C,W] then value may match (PRV.005.081) Provider Identifier where the Provider Identifier Type ~~=~~ ~~'1'~~(PRV.005.077) equals "1" 5. ~~Prescription Fill~~Discharge Date (~~CRX~~CIP.002.~~085~~096) may be between Provider Attributes Effective Date (PRV.002.020) and Provider Attributes End

													Date (PRV.002.021) or ~~Prescription Fill~~6. Discharge Date (~~CRX~~CIP.002.~~085~~096) may be between Provider Identifier Effective Date (PRV.005.079) and Provider Identifier End Date (PRV.005.080)
CRX071	CRX.002.071	BILLING-PROV-NPI-NUM	Billing Provider NPI Number	Conditional	~~A National Provider Identifier (NPI) is a unique 10-digit identification number issued to health care providers in the United States by CMS. Healthcare providers acquire their unique 10-digit NPIs to identify themselves in a standard way throughout their industry. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number).~~The National Provider ID (NPI) of the billing provider responsible for billing for the service on the claim. The billing provider can also be servicing, referring, or prescribing provider; can be admitting provider except for Long Term Care.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(10)	~~55~~51	~~530~~492	~~539~~501	1. Value must be 10 digits~~, consisting of 9 numeric digits followed by one check digit calculated using the Luhn formula (algorithm) 2.~~ 2. Value must have an associated Provider Identifier Type equal to ~~'2'~~"2" 3. Value must exist in the NPPES NPI data file 4. Conditional ~~4~~5. When ~~Type of Claim not in ('3','C','W') then~~populated, value must match Provider Identifier (PRV.005.081) and Facility Group Individual Code (PRV.002.~~081)~~028) must equal "01" 6. NPPES Entity Type Code associated with this NPI must equal "2" (Organization)
CRX072	CRX.002.072	BILLING-PROV-TAXONOMY	Billing Provider Taxonomy	Conditional	The taxonomy code for the provider billing for the service.	PROV-TAXONOMY	CRX00002	CLAIM-HEADER-RECORD-RX	X(12)	~~56~~52	540~~1~~2	5~~5~~13	~~1.~~1. Value must be 12 characters or less 2. Value must be in Provider Taxonomy List (VVL) ~~2. Value must be 12 characters or less~~ ~~3.~~3. Conditional

CRX073	CRX.002.073	BILLING-PROV-SPECIALTY	Billing Provider Specialty	Conditional	This code describes the area of specialty for the provider being reported.	PROV-SPECIALTY	CRX00002	CLAIM-HEADER-RECORD-RX	X(2)	~~57~~53	~~552~~514	515~~3~~	~~1.~~1. Value must be 2 characters 2. Value must be in Provider Specialty List (VVL~~).~~ ~~2. Value must be 2 characters~~) 3. Conditional
CRX074	CRX.002.074	PRESCRIBING-PROV-NUM	Prescribing Provider Number	Mandatory	A unique identification number assigned by the state to the provider who prescribed the drug, device, or supply. This must be the individual's ID number, not a group identification number. 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	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(30)	~~58~~54	~~554~~516	~~583~~545	1. Value must be 30 characters or less 2. ~~Value must be reported in Provider Identifier (PRV.005.080) with an associated Provider Identifier Type (PRV.005.081) equal to '1'~~ ~~3.~~ Mandatory
CRX075	CRX.002.075	PRESCRIBING-PROV-NPI-NUM	Prescribing Provider NPI Number	Mandatory	~~A National Provider Identifier (NPI) is a unique 10-digit identification number issued to health care providers in the United States by CMS. Healthcare providers acquire their unique 10-digit NPIs to identify themselves in a standard way throughout their industry. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number).~~The National Provider ID (NPI) of the provider who prescribed a medication to a patient.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(10)	~~59~~55	58~~4~~6	~~593~~555	1. Value must be 10 digits~~, consisting of 9 numeric digits followed by one check digit calculated using the Luhn formula (algorithm)~~ ~~2.~~ 2. Value must have an associated Provider Identifier Type equal to ~~'2'~~"2" 3. Mandatory 4. Value must exist in the NPPES NPI data file 5. NPPES Entity Type Code associate with this NPI must equal '1' (Individual)
~~CRX076~~	~~CRX.002.076~~	~~PRESCRIBING-PROV-TAXONOMY~~	~~Prescribing Provider Taxonomy~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~CRX00002~~	~~CLAIM-HEADER-RECORD-RX~~	~~X(12)~~	~~60~~	~~594~~	~~605~~	~~1. Not Applicable~~
~~CRX077~~	~~CRX.002.077~~	~~PRESCRIBING-PROV-TYPE~~	~~Prescribing Provider Type~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~PRESCRIPTION-ORIGIN-CODE~~	~~CRX00002~~	~~CLAIM-HEADER-RECORD-RX~~	~~X(2)~~	~~61~~	~~606~~	~~607~~	~~1. Not Applicable~~

~~CRX078~~	~~CRX.002.078~~	~~PRESCRIBING-PROV-SPECIALTY~~	~~Prescribing Provider Specialty~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~CRX00002~~	~~CLAIM-HEADER-RECORD-RX~~	~~X(2)~~	~~62~~	~~608~~	~~609~~	~~1. Not Applicable~~
CRX079	CRX.002.079	MEDICARE-HIC-NUM	Medicare HIC Number	Conditional	The Medicare HIC Number (HICN) is an identifier formerly used by SSA and CMS to identify all Medicare beneficiaries. For many beneficiaries, their SSN was a major component of their HICN. To prevent identify theft, among other reasons, HICN gradually were retired and replaced by the Medicare Beneficiary Identifier (MBI) over the course of 2018 and 2019. HICN continue to be used by Medicare for limited administrative purposes after 2019 but starting in 2020 the MBI became the primary identifier for Medicare beneficiaries. HICN consists of two components: SSN ~~&~~and alpha-suffix or (for Railroad IDs) prefix and ID (not always SSN based~~)~~).	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(12)	~~63~~56	~~610~~556	~~621~~567	1. ~~Conditional~~ ~~2.~~ Value must be 12 characters or less 2. Conditional 3. Value must not contain a pipe or asterisk symbols 4. (Not Dual Eligible) if Dual Eligible Code (ELG.DE.085) value ~~=~~equals "00", then value must not be populated~~.~~ 5. Value must be populated when Crossover Indicator (CRX.002.023) equals ~~'1'~~"1" and Medicare Beneficiary Identifier (CRX.002.105) ~~must~~is not ~~be~~ populated~~.~~
CRX081	CRX.002.081	REMITTANCE-NUM	Remittance Number	Mandatory	The Remittance Advice Number is a sequential number that identifies the current Remittance Advice (RA) produced for a provider. The number is incremented by one each time a new RA is generated. ~~The first five (5) positions are Julian date following a YYDDD format.~~ The RA is the detailed explanation of the reason for the payment amount.~~ The RA number is not the check number.~~	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(30)	~~64~~57	~~622~~568	~~651~~597	1. Value must be 30 characters or less 2. ~~First five (5) characters of the value must be a Julian date express in the form YYDDD (e.g. 19095, 95th day of 20(19))~~ ~~3.~~Value must not contain a pipe or asterisk symbols ~~4~~3. Mandatory
CRX082	CRX.002.082	BORDER-STATE-IND	Border State Indicator	Conditional	A code to indicate whether an individual received services or equipment across state borders. (The provider location is out of state, but for payment purposes the provider is treated as an in-state provider.)	BORDER-STATE-IND	CRX00002	CLAIM-HEADER-RECORD-RX	X(1)	~~65~~58	~~652~~598	~~652~~598	~~1.~~1. Value must be 1 character 2. Value must be in Border State Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Conditional

CRX084	CRX.002.084	DATE-PRESCRIBED	Date Prescribed	Mandatory	The date the drug, device, or supply was prescribed by the physician or other practitioner. This should not be confused with the Prescription ~~-FILL-~~ Fill Date, which represents the date the prescription was actually filled by the provider.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	9(8)	~~66~~59	~~653~~599	6~~6~~06	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be on or after associated eligible party's Date of Birth (ELG.002.024) ~~4~~3. Value must be on or before associated Prescription Fill Date (CRX.002.085) ~~5~~4. Value must be on or before associated Adjudication Date (CRX.002.027) ~~6~~5. Value must be on or before associated eligible party's Date of Death (ELG.002.025) ~~7~~6. Mandatory ~~8~~7. Value should be on or before End of Time Period (CRX.001.010)
CRX085	CRX.002.085	PRESCRIPTION-FILL-DATE	Prescription Fill Date	Mandatory	Date the drug, device, or supply was dispensed by the provider. ~~see Date (DT.001)~~	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	9(8)	~~67~~60	~~661~~607	~~668~~614	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be on or before associated End of Time Period (CRX.001.010) ~~4~~3. Value must be on or after associated Start of Time Period (CRX.001.009) ~~5~~4. Value must be on or after associated Date Prescribed (CRX.002.084) ~~6~~5. Value must be on or after associated eligible party's Date of Birth (ELG.002.024) ~~7~~6. Value must be on or before associated eligible party's Date of Death (ELG.002.025) ~~8~~7. Value must be populated when Adjustment Indicator (CRX.002.025) does not equal ~~'1' and Type of Claim (CRX.002.029) does not equal 'Z'~~

													~~9.~~"1" 8. Mandatory
CRX086	CRX.002.086	COMPOUND-DRUG-IND	Compound Drug Indicator	Conditional	Indicator to specify if the drug is compound or not. ~~see Compound Drug Indicator List (VVL.038)~~	COMPOUND-DRUG-IND	CRX00002	CLAIM-HEADER-RECORD-RX	X(1)	~~68~~61	~~669~~615	~~669~~615	~~1.~~1. Value must be 1 character 2. Value must be in Compound Drug Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Conditional
CRX087	CRX.002.087	TOT-BENEFICIARY-COINSURANCE-PAID-AMOUNT	Total Beneficiary Coinsurance Paid Amount	Conditional	The amount ~~of money~~ the beneficiary or his or her representative (e.g., their guardian) paid towards their coinsurance for the covered services on the claim. Do not include coinsurance payments made by a third party/s on behalf of the beneficiary.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11) V99	~~69~~62	~~670~~616	6~~8~~28	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. ~~Must have an associated Beneficiary Coinsurance Date Paid~~ ~~4.~~Conditional
CRX088	CRX.002.088	BENEFICIARY-COINSURANCE-DATE-PAID	Beneficiary Coinsurance Date Paid	Conditional	The date the beneficiary paid the coinsurance amount.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	9(8)	~~72~~63	~~704~~629	~~711~~636	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~in the form "CCYYMMDD"

													2. When populated, value must have an associated Beneficiary Coinsurance Amount ~~4~~3. Conditional
CRX089	CRX.002.089	TOT-BENEFICIARY-COPAYMENT-PAID-AMOUNT	Total Beneficiary Copayment Paid Amount	Conditional	The amount ~~of money~~ the beneficiary or his or her representative (e.g., their guardian) paid towards their copayment for the covered services on the claim. Do not include copayment payments made by a ~~co-payment~~third party/s on behalf of the beneficiary.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11) V99	~~70~~64	6~~8~~37	649~~5~~	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. ~~Must have an associated Beneficiary Copayment Date Paid~~ ~~4.~~Conditional
CRX090	CRX.002.090	BENEFICIARY-COPAYMENT-DATE-PAID	Beneficiary Copayment Date Paid	Conditional	The date the beneficiary paid the copayment amount.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	9(8)	~~71~~65	~~696~~650	~~703~~657	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~in the form "CCYYMMDD" 2. When populated, value must have an associated Beneficiary Copayment Amount ~~4~~3. Conditional
CRX092	CRX.002.092	TOT-BENEFICIARY-DEDUCTIBLE-PAID-AMOUNT	Total Beneficiary Deductible Paid Amount	Conditional	The amount ~~of money~~ the beneficiary or his or her representative (e.g., their guardian) paid towards ~~an annual~~their deductible for the covered services on the claim. Do not include deductible payments made by a third party/s on behalf of the beneficiary.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11) V99	~~73~~66	~~712~~658	~~724~~670	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. ~~Must have an associated Beneficiary Deductible Date Paid~~ ~~4.~~Conditional
CRX093	CRX.002.093	BENEFICIARY-DEDUCTIBLE-DATE-PAID	Beneficiary Deductible Date Paid	Conditional	The date the beneficiary paid the deductible amount.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	9(8)	~~74~~67	~~725~~671	~~732~~678	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~in the form "CCYYMMDD" 2. When populated, value must have an

													associated Beneficiary Deductible ~~Date Paid 4~~Amount 3. Conditional
CRX094	CRX.002.094	CLAIM-DENIED-INDICATOR	Claim Denied Indicator	Mandatory	An indicator to identify a claim that the state refused pay in its entirety.	CLAIM-DENIED-INDICATOR	CRX00002	CLAIM-HEADER-RECORD-RX	X(1)	~~75~~68	~~733~~679	~~733~~679	~~1.~~1. Value must be 1 character 2. Value must be in Claim Denied Indicator List (VVL) ~~2~~3. If value ~~is '0',~~equals "0", then Claim Status Category must equal "F2" ~~3. Value must be 1 character~~ ~~4.~~4. Mandatory
CRX095	CRX.002.095	COPAY-WAIVED-IND	Copayment Waived Indicator	~~Op~~Situational	An indicator signifying that the copay was discounted or waived by the provider (e.g., physician or hospital). Do not use to indicate administrative-level, Medicaid State Agency or Medicaid MCO copayment waived decisions.	COPAY-WAIVED-IND	CRX00002	CLAIM-HEADER-RECORD-RX	X(1)	~~76~~69	~~734~~680	~~734~~680	~~1.~~1. Value must be 1 character 2. Value must be in Copay Waived Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3. Optional~~3. Situational
CRX096	CRX.002.096	HEALTH-HOME-ENTITY-NAME	Health Home Entity Name	Conditional	A free-form text field to indicate the health home program that authorized payment for the service on the claim~~.~~ or to identify the health home SPA in which an individual is enrolled. The name entered should be the name that the state uses to uniquely identify the team. A "Health Home Entity" can be a designated provider (e.g., physician, clinic, behavioral health organization), a health team which links to a designated provider, or a health team (physicians, nurses, behavioral health professionals). Because an identification numbering schema has not been established, the entities' names are being used instead.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(50)	~~77~~70	~~735~~681	~~784~~730	~~1. Value must 50 characters or less~~ ~~2.~~1. Value must not contain a pipe or asterisk symbols 2. Value must 50 characters or less 3. Conditional

CRX098	CRX.002.098	THIRD-PARTY-COINSURANCE-AMOUNT-PAID	Third Party Coinsurance Amount Paid	~~Cond~~Situational	The amount of money paid by a third party on behalf of the beneficiary towards coinsurance.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11) V99	~~78~~71	~~785~~731	~~797~~743	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. ~~Cond~~Situational
CRX099	CRX.002.099	THIRD-PARTY-COINSURANCE-DATE-PAID	Third Party Coinsurance Date Paid	Conditional	The date ~~a Third Party~~the third party paid the coinsurance amount ~~was paid on this claim or adjustment.~~	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	9(8)	~~79~~72	~~798~~744	~~805~~751	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~in the form "CCYYMMDD" 2. When populated, value must have an associated Third Party Coinsurance Amount 3. Conditional
CRX100	CRX.002.100	THIRD-PARTY-COPAYMENT-AMOUNT-PAID	Third Party Copayment Amount Paid	~~Op~~Situational	The amount of money paid by a third ~~-~~party on behalf of the beneficiary ~~paid~~ towards ~~a~~ copayment.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11) V99	~~80~~73	~~806~~752	~~818~~764	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. ~~Op~~Situational
CRX101	CRX.002.101	THIRD-PARTY-COPAYMENT-DATE-PAID	Third Party Copayment Date Paid	~~Op~~Situational	The date ~~a Third Party~~the third party paid the copayment amount ~~was paid on a claim or adjustment~~.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	9(8)	~~81~~74	~~819~~765	~~826~~772	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~in the form "CCYYMMDD" 2. When populated, value must have an associated Third Party Copayment Amount 3. ~~Op~~Situational

CRX102	CRX.002.102	DISPENSING-PRESCRIPTION-DRUG-PROV-NPI	Dispensing Prescription Drug Provider NPI Number	Mandatory	~~A National Provider Identifier (NPI) is a unique 10-digit identification number issued to health care providers in the United States by CMS. Healthcare providers acquire their unique 10-digit NPIs to identify themselves in a standard way throughout their industry. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number).~~The National Provider ID (NPI) of the provider responsible for dispensing the prescription drug.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(10)	~~82~~75	~~827~~773	~~836~~782	1. Value must be 10 digits~~, consisting of 9 numeric digits followed by one check digit calculated using the Luhn formula (algorithm) 2.~~ 2. Value must have an associated Provider Identifier Type (PRV.005.007) equal to '2' 3. When Type of Claim not in ~~('3','C','W')~~[3,C,W], then value must match Provider Identifier (PRV.005.081) 4. Mandatory 5. Value must exist in the NPPES NPI data file 6. NPPES Entity Type Code associate with this NPI must equal "1" (Individual)
~~CRX103~~	~~CRX.002.103~~	~~DISPENSING-PRESCRIPTION-DRUG-PROV-TAXONOMY~~	~~Dispensing Prescription Drug Provider Taxonomy~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~CRX00002~~	~~CLAIM-HEADER-RECORD-RX~~	~~X(12)~~	~~83~~	~~837~~	~~848~~	~~1. Not Applicable~~
CRX104	CRX.002.104	HEALTH-HOME-PROVIDER-NPI	Health Home Provider NPI Number	Conditional	~~A National Provider Identifier (NPI) is a unique 10-digit identification number issued to health care providers in the United States by CMS. Healthcare providers acquire their unique 10-digit NPIs to identify themselves in a standard way throughout their industry. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number).~~The National Provider ID (NPI) of the health home provider.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(10)	~~84~~76	~~849~~783	~~858~~792	1. Value must be 10 digits~~, consisting of 9 numeric digits followed by one check digit calculated using the Luhn formula (algorithm) 2.~~ 2. Value must have an associated Provider Identifier, where Provider Identifier Type ~~equal to '2'~~(PRV.005.077) equals "2" 3. Value must exist in the NPPES NPI data file 4. Conditional

CRX105	CRX.002.105	MEDICARE-BENEFICIARY-IDENTIFIER	Medicare Beneficiary Identifier	Conditional	The Medicare Beneficiary Identifier (MBI) is a randomly generated identifier used to identify all Medicare beneficiaries. It replaced the previously-used SSN-based Medicare HIC Number (HICN). To prevent identify theft, among other reasons, HICN gradually were retired and replaced by the MBI over the course of 2018 and 2019. Starting in 2020, the MBI became the primary identifier for Medicare beneficiaries.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(12)	~~85~~77	~~859~~793	8~~7~~04	1. Conditional 2. Value must be an 11-character string 3. Character 1 must be numeric values 1 thru 9 4. Character 2 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 5. Character 3 must be alphanumeric values 0 thru 9 or A thru Z (minus S,L,O,I,B,Z) 6. Character 4 must be numeric values 0 thru 9 7. Character 5 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 8. Character 6 must be alphanumeric values 0 thru 9 or A thru Z (minus S,L,O,I,B,Z) 9. Character 7 must be numeric values 0 thru 9 10. Character 8 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 11. Character 9 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 12. Character 10 must be numeric values 0 thru 9 13. Character 11 must be numeric values 0 thru 9 14. Value must not contain a pipe or asterisk symbols
CRX106	CRX.002.106	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(500)	~~86~~92	~~871~~998	1~~3~~497~~0~~	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational

CRX108	CRX.003.108	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	CRX00003	CLAIM-LINE-RECORD-RX	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~ 3. Value must be in Record ID List (VVL) 4. Value must equal "CRX00003"
CRX109	CRX.003.109	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	CRX00003	CLAIM-LINE-RECORD-RX	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (CRX.001.007)
CRX110	CRX.003.110	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	CRX00003	CLAIM-LINE-RECORD-RX	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory

CRX111	CRX.003.111	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual ~~(except on service tracking payments).~~ . Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47572~~reporting-shared-msis-identification-numbers-eligibility/	N/A	CRX00003	CLAIM-LINE-RECORD-RX	X(20)	4	22	41	~~1. Mandatory~~ ~~2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN~~ ~~3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN~~ ~~4. Value must be 20 characters or less~~ ~~5. When TYPE-OF-CLAIM = 4, D or X (lump sum payment), value must begin with an '&'~~1. Value must be 20 characters or less 2. Mandatory
CRX112	CRX.003.112	ICN-ORIG	Original ICN	Mandatory	A unique number assigned by the state's payment system that identifies an original or adjustment claim.	N/A	CRX00003	CLAIM-LINE-RECORD-RX	X(50)	5	42	91	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
CRX113	CRX.003.113	ICN-ADJ	Adjustment ICN	Conditional	A unique claim number assigned by the state's payment system that identifies the adjustment claim for an original transaction.	N/A	CRX00003	CLAIM-LINE-RECORD-RX	X(50)	6	92	141	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value ~~is~~ equals "0~~,~~", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated

CRX114	CRX.003.114	LINE-NUM-ORIG	Original Line Number	Mandatory	A unique number to identify the transaction line number that is being reported on the original claim.	N/A	CRX00003	CLAIM-LINE-RECORD-RX	X(3)	7	142	144	1. Value must be 3 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory 4. ~~When populated,~~ Value must be one or greater
CRX115	CRX.003.115	LINE-NUM-ADJ	Adjustment Line Number	Conditional	A unique number to identify the transaction line number that identifies the line number on the adjustment claim.	N/A	CRX00003	CLAIM-LINE-RECORD-RX	X(3)	8	145	147	1. Value ~~of the CC component~~ must be ~~"20"~~3 characters or less 2. If associated Line Adjustment Indicator value equals "0", then value must not be ~~8 characters in the form "CCYYMMDD"~~ ~~3. The date~~populated 3. If associated Line Adjustment Indicator value equals "1", then value is mandatory and must be ~~a valid calendar date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~provided 4. Conditional 5. When populated, value must be ~~equal to~~one or ~~after the value of associated End of Time Period~~ ~~5. Mandatory~~greater
CRX116	CRX.003.116	LINE-ADJUSTMENT-IND	Line Adjustment Indicator	Conditional	A code to indicate the type of adjustment record claim/encounter represents at claim detail level.	LINE-ADJUSTMENT-IND	CRX00003	CLAIM-LINE-RECORD-RX	X(1)	9	148	148	~~1.~~1. Value must be 1 character 2. Value must be in Line Adjustment Indicator List (VVL) ~~2. If associated Type of Claim value is in [1,~~ 3~~, 5, A, C, E, U, W, Y], then value must be in [0, 1, 4]~~ ~~3. If associated Type of Claim value is in [4, D, X], then.~~ Value must be in [~~5, 6]~~ ~~4. Value must be 1 character~~ ~~5.~~0,1,4] 4. Conditional ~~6~~5. If associated Line Adjustment Number is populated, then value must be populated

CRX117	CRX.003.117	LINE-ADJUSTMENT-REASON-CODE	Line Adjustment Reason Code	Conditional	Claim adjustment reason codes communicate why a service line was paid differently than it was billed.	LINE-ADJUSTMENT-REASON-CODE	CRX00003	CLAIM-LINE-RECORD-RX	X(3)	10	149	151	~~1.~~1. Value must be 3 characters or less 2. Value must be in Line Adjustment Reason Code List (VVL) ~~2. Value must be 3 characters or less~~ ~~3.~~3. Conditional 4. ~~When populated, Line Adjustment Indicator~~Value must be populated when the total paid amount is different from the total billed amount
CRX118	CRX.003.118	SUBMITTER-ID	Submitter ID	Mandatory	The Submitter Identification number is the value that identifies the provider/trading partner/clearing house organization to the state's claim adjudication system.	N/A	CRX00003	CLAIM-LINE-RECORD-RX	X(12)	11	152	163	1. Value must be 12 characters or less 2. Mandatory
CRX119	CRX.003.119	CLAIM-LINE-STATUS	Claim Line Status	Conditional	The claim line status ~~conveys~~codes from the 277 transaction set identify the status of a specific ~~service~~detail claim line ~~using~~rather than the ~~X12 Claim Status Codes from~~entire claim. Only report the claim ~~adjudication process~~line for the final, adjudicated claim.	CLAIM-STATUS	CRX00003	CLAIM-LINE-RECORD-RX	X(3)	12	164	166	~~1.~~1. Value must be 3 characters or less 2. Value must be in Claim Status List (VVL) ~~2. Value must be 3 characters or less~~ ~~3.~~3. Conditional 4. If value in [545,585,654], then Claim Denied Indicator must be "0" and Claim Status Category must be"F2"
CRX120	CRX.003.120	NATIONAL-DRUG-CODE	National Drug Code	Mandatory	A code following the National Drug Code format indicating the drug, device, or medical supply covered by this claim.	N/A	CRX00003	CLAIM-LINE-RECORD-RX	X(12)	13	167	178	~~1. Characters 1-5 of value must be numeric~~ ~~2. Characters 6-9 of value must be numeric~~ ~~3. Characters 10-12 of value must be numeric or blank~~ ~~4.~~1. Value must be 12 digits or less ~~5~~2. Value must be a valid National Drug Code ~~6~~3. Mandatory ~~7~~4. Value must have an associated ~~DTL~~ Metric Decimal Quantity (CRX.003.144) ~~8~~5. Value must have an associated Unit of Measure (CRX.003.133)

CRX121	CRX.003.121	BILLED-AMT	Billed Amount	Conditional	The amount billed at the claim detail level as submitted by the provider. For encounter records, Type of Claim = 3, C, or W, this field should be populated with the amount that the provider billed the managed care plan. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the amount that the provider billed the sub-capitated entity at the claim line detail level. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.	N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11) V99	14	179	191	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional

CRX122	CRX.003.122	ALLOWED-AMT	Allowed Amount	Conditional	The maximum amount displayed at the claim line level as determined by the payer as being "'allowable"' under the provisions of the contract prior to the determination of actual payment. On Fee for Service claims the Allowed Amount is determined by the state's MMIS (or PBM). On managed care encounters the Allowed Amount is determined by the managed care organization. For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the amount that the sub-capitated entity allowed at the claim line detail level. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.	N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11)V99	15	192	204	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CRX123	CRX.003.123	~~COPAY-AMT~~BENEFICIARY-COPAYMENT-PAID-AMOUNT	Beneficiary Copayment Paid Amount	Conditional	~~The copayment amount paid by an enrollee for the service, which does not include the amount paid by the insurance company.~~The amount the beneficiary or his or her representative (e.g., their guardian) paid towards their copayment for the covered services on a claim line. Do not include copayment payments made by a third party/ies on behalf of the beneficiary. This is a copayment paid for a service in the corresponding claim line for OT and RX claim files. The Beneficiary Copayment Paid Amount is an optional line level data element reported for OT and RX claim file types, only. If the beneficiary copayment paid amount is not available at the claim line level, report the total	N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(5)V99	16	205	211	1. Value must be ~~5 digits or less left of the decimal i.e. 99999~~between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional

					copayment paid amount in the header level copayment data element.								
CRX124	CRX.003.124	TPL-AMT	Third Party Liability Amount	Conditional	Third-party liability refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a state plan. This is the total amount denoted at the claim detail level paid by the third party.	N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11) V99	17	212	224	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CRX125	CRX.003.125	MEDICAID-PAID-AMT	Medicaid Paid Amount	Conditional	The amount paid by Medicaid/CHIP agency or the managed care plan on this claim or adjustment at the claim detail level. ~~For claims where Medicaid payment is only available at the header level, report the entire payment amount on the T-MSIS record corresponding to the line item with the highest charge or the 1st detail. Zero fill Medicaid Amount Paid on all other MSIS records created from the original claim.~~For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the amount that the sub-capitated entity paid the provider at the claim line detail level. Report a null value in this field if the provider is a sub-capitated network provider. For sub-capitated encounters from a sub-	N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11) V99	18	225	237	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50~~)~~ ~~3. Conditional)~~ 3. Conditional 4. Value should not be populated or should be equal to zero, when associated Claim Line Status is in [542,585,654]

					capitated network provider, if the sub-capitated network provider directly employs the provider that renders the service to the enrollee, report a null value in this field.								
CRX126	CRX.003.126	MEDICAID-FFS-EQUIVALENT-AMT	Medicaid FFS Equivalent Amount	Conditional	The amount that would have been paid had the services been provided on a Fee for Service basis.	N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11)V99	19	238	250	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Type of Claim value ~~equals '3,~~ in [3,C,W~~']~~, then value is mandatory and must be provided 4. Conditional
CRX127	CRX.003.127	MEDICARE-DEDUCTIBLE-AMT	Medicare Deductible Amount	Conditional	The amount paid by Medicaid/CHIP on this claim at the claim line level toward the beneficiary's Medicare deductible. 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 Medicare- ~~COINSURANCE~~ Coinsurance Payment is not required.	N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11)V99	20	251	263	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50~~)~~ ~~3. Conditional)~~ 3. Conditional 4. Value should not be populated if associated Crossover Indicator value equals "0" (not a crossover claim) 5. If value is greater than "0", then Crossover Indicator must be "1"

CRX128	CRX.003.128	MEDICARE-COINS-AMT	Medicare Coinsurance Amount	Conditional	The amount paid by Medicaid/CHIP on this claim toward the recipient's Medicare coinsurance at the claim detail level. 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, populate the Medicare ~~DEDUCTIBLE-AMT. See US Dollar~~ Deductible Amount ~~(DT).~~	N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11) V99	21	264	276	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. ~~(payments can't be separated)~~If associated Medicare Combined Deductible Indicator equals "1", then value must not be populated (or must be 99998 ~~is an exception to the US Dollar~~) 4. Value must not be populated if Medicare Deductible Amount ~~requirements~~ ~~4.~~ is not populated 5. Conditional
CRX129	CRX.003.129	MEDICARE-PAID-AMT	Medicare Paid Amount	Conditional	The amount paid by Medicare on this claim. For claims where Medicare payment is only available at the header level, report the entire payment amount on the T-MSIS claim line with the highest charge or ~~adjustment~~the 1st non-denied line. Zero fill Medicare Paid Amount on all other claim lines.	N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11) V99	22	277	289	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. If associated Crossover Indicator value ~~is~~equals "0", then the ~~Medicare Paid Amount~~ value must not be populated~~.~~ 4. Conditional 5. If value is populated, Crossover Indicator must be equal to "1"
CRX131	CRX.003.131	~~OT-RX-CLAIM~~PRESCRIPTION-QUANTITY-ALLOWED	~~OT RX Claim~~Prescription Quantity Allowed	Conditional	The maximum allowable quantity of a drug or service that may be dispensed per prescription per date of service or per month. Quantity limits are applied to medications when the majority of appropriate clinical utilizations will be addressed within the quantity allowed. For use with CLAIMRX claims/encounters. For CLAIMOT claims/encounters, use the Service Quantity Allowed field. For CLAIMIP and CLAIMLT claims/encounters, use the Revenue Center Quantity Actual field. One prescription for 100	N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(~~6~~)~~V99~~9)V(9)	23	290	~~298~~307	1. Value may include up to ~~6~~9 digits to the left of the decimal point, and ~~3~~9 digits to the right e.g. ~~123456.789~~123456789.123456789 2. Conditional ~~3. If Type of Claim is in {1, 3, A, C, U, W}, then this value must be reported.~~

					250 milligram tablets results in Prescription Quantity Allowed =100.								
CRX132	CRX.003.132	~~OT-RX-CLAIM~~PRESCRIPTION-QUANTITY-ACTUAL	~~OT RX Claim~~Prescription Quantity Actual	~~Conditional~~ Mandatory	~~The quantity of a drug, service, or product that is rendered/dispensed for a prescription, specific date of service, or billing time span. 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.~~The quantity of a drug that is dispensed for a prescription as reported by National Drug Code on the claim line. For use with CLAIMRX claims/encounters. For CLAIMOT claims/encounters, use the Service Quantity Actual field. For CLAIMIP and CLAIMLT claims/encounter records, use the Revenue Center Quantity Actual field.	N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(~~6~~)V9~~99~~9)V(9)	24	~~299~~308	~~307~~325	1. Value may include up to ~~6~~9 digits to the left of the decimal point, and ~~3~~9 digits to the right e.g. ~~123456.789~~123456789.123456789 2. ~~Conditional~~ ~~3. If Type of Claim is in [1, 3, A, C, U, W], then this value must be reported.~~ ~~4. When populated, corresponding Unit of Measure must be populated~~Mandatory
CRX133	CRX.003.133	UNIT-OF-MEASURE	Unit of Measure	~~Conditional~~ Mandatory	A code to indicate the basis by which the quantity of the drug or supply is expressed.	NDC-UNIT-OF-MEASURE	CRX00003	CLAIM-LINE-RECORD-RX	X(2)	25	~~308~~326	~~309~~327	1. Value must be 2 characters 2. Value must be in ~~NDC~~ Unit of Measure List (VVL~~).~~ ~~2. Value must be 2 characters~~

													) 3. ~~Conditional~~Mandatory
CRX134	CRX.003.134	TYPE-OF-SERVICE	Type of Service	Mandatory	A code to categorize the services provided to a Medicaid or CHIP enrollee.	TYPE-OF-SERVICE-RX	CRX00003	CLAIM-LINE-RECORD-RX	X(3)	26	~~310~~328	~~312~~330	1. Value must be 3 characters 2. Mandatory 3. Value must ~~satisfy the requirements of~~be in Type of Service ~~(~~RX ~~Claim)~~ List (VVL)
CRX135	CRX.003.135	HCBS-SERVICE-CODE	HCBS Service Code	Conditional	A code to indicate that the service represents a long-term care home and community based service or support for an individual with chronic medical and/or mental conditions. The codes help to delineate between acute care and long-term care provided in the home and community setting (e.g. 1915(c), 1915(i), 1915(j), and 1915(k) services).	HCBS-SERVICE-CODE	CRX00003	CLAIM-LINE-RECORD-RX	X(1)	27	3~~1~~31	3~~1~~31	~~1.~~1. Value must be 1 character 2. Value must be in HCBS Service Code List (VVL~~).~~ ~~2. Value must be 1 character~~) 3. If value is in [1-7~~,~~], then HCBS Taxonomy must be populated~~.~~ 4. Conditional

CRX136	CRX.003.136	HCBS-TAXONOMY	HCBS Taxonomy	Conditional	~~A code to classify the home and community based services listed on the claim into the HCBS taxonomy.~~A code to classify the home and community based services listed on the claim into the HCBS taxonomy. The HCBS Taxonomic classification system was adopted by CMS in August 2012. To acknowledge state variation, services and categories are defined based on the minimum definition necessary to establish mutually distinct categories and services. Some services are defined in part by characteristics that are NOT in that service. For example, the difference between companion services and personal care is that companion services do not include assistance with activities of daily living (ADLs) such as bathing, dressing, eating, and toileting. Some of the services reflected by the HCBS Taxonomy including, but not limited to personal care, case management, home health aide, and physician services, may (and in some case, must) also be covered under the Medicaid State Plan. The definitions below only define these services for purposes of Section 1915(c) Waivers and the State Plan Home and Community-Based Services benefit authorized by Section 1915(i). States interested in reflecting services as “extended state plan” services must offer them in accordance with state plan service definitions. Consult with the CMS Division of Benefits and Coverage in those instances to ensure definition alignment. The services and categories are arranged in order of consideration for placing a particular	HCBS-TAXONOMY	CRX00003	CLAIM-LINE-RECORD-RX	X(5)	28	~~314~~332	~~318~~336	~~1.~~1. Value must be 5 characters or less 2. Value must be in HCBS Taxonomy Code List (VVL~~).~~ ~~2. Value must be 5 characters or less~~) 3. Conditional

					state service in the taxonomy. If one is not sure how to map a state's service to the taxonomy, one should first consider Case Management, then Round-the-Clock Services, then Supported Employment, etc. Documentation of the HCBS Taxonomy from the CMS Waiver Management System can be found here: https://wms-mmdl.cms.gov/WMS/help/TaxonomyCategoryDefinitions.pdf.								
CRX137	CRX.003.137	OTHER-TPL-COLLECTION	Other TPL Collection	~~Conditional~~ Mandatory	This data element indicates that the claim is for a beneficiary for whom other third party resource development and collection activities are in progress, when the liability is not another health insurance plan for which the eligible is a beneficiary.	OTHER-TPL-COLLECTION	CRX00003	CLAIM-LINE-RECORD-RX	X(3)	29	~~319~~337	~~321~~339	~~1.~~1. Value must be 3 characters 2. Value must be in Other TPL Collection List (VVL) ~~2. Value must be 3 characters~~ ~~3. Conditional~~3. Mandatory

CRX138	CRX.003.138	DAYS-SUPPLY	Days Supply	Mandatory	Number of days supply dispensed.	N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(5)	30	~~322~~340	~~326~~344	1. Value must be 5 digits or less 2. Mandatory 3. Value should be between -365 and 365
CRX139	CRX.003.139	NEW-REFILL-IND	New Refill Indicator	Mandatory	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.	NEW-REFILL-IND	CRX00003	CLAIM-LINE-RECORD-RX	X(2)	31	~~327~~345	~~328~~346	~~1.~~1. Value must be 2 characters 2. Value must be in New Refill Indicator List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory
CRX140	CRX.003.140	BRAND-GENERIC-IND	Brand Generic Indicator	Mandatory	Indicates whether the drug is a brand name, generic, single-source, or multi-source drug.	BRAND-GENERIC-IND	CRX00003	CLAIM-LINE-RECORD-RX	X(1)	32	~~329~~347	~~329~~347	1. Value must be 1 character 2. Value must be in Brand Generic Indicator List (VVL) 3. Mandatory
CRX141	CRX.003.141	DISPENSE-FEE-SUBMITTED	Dispense Fee Submitted	Mandatory	~~The charge to cover the cost of dispensing the prescription. Dispensing costs include overhead, supplies, and labor, etc. to fill the prescription. Dispense Fee reflects the amount billed by the provider towards the professional dispensing fee.~~ ~~If the provider does not break out the professional dispensing fee on the NCPDP transaction, this field should be left blank in T-MSIS.~~ ~~There is currently no specific field in T-MSIS to capture either the professional dispensing fee amount paid, or the amount billed or paid towards ingredient costs.~~The charge to cover the cost of the professional dispensing fee for the prescription.	N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(6)V99	33	~~330~~348	~~337~~355	~~1.~~1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Value may include up to 6 digits to the left of the decimal point, and ~~3~~2 digits to the right e.g. 123456.~~789~~ ~~2~~78 4. Mandatory
CRX142	CRX.003.142	PRESCRIPTION-NUM	Prescription Number	Mandatory	The unique identification number assigned by the pharmacy or supplier to the prescription.	N/A	CRX00003	CLAIM-LINE-RECORD-RX	X(12)	34	~~338~~356	~~349~~367	~~1.~~1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbol ~~2. Value must be 12 characters or less~~ ~~3.~~3. Mandatory

CRX143	CRX.003.143	DRUG-UTILIZATION-CODE	Drug Utilization Code	Mandatory	A code indicating the conflict, intervention and outcome of a prescription presented for fulfillment. The T-MSIS Drug Utilization Code data element is composite field comprised of three distinct NCPDP data elements: "'Reason for Service Code"' (439-E4); "'Professional Service ~~Code" (44~~Code' (440-E5); and "'Result of Service Code"' (441-E6). All 3 of these NCPDP fields are situationally required and independent of one another. Pharmacists may report none, one, two or all three. NCPDP situational rules call for one or more of these values in situations where the field(s) could result in different coverage, pricing, patient financial responsibility, drug utilization review outcome, or if the information affects payment for, or documentation of, professional pharmacy service. The NCPDP ~~"Results~~'Reasons of Service Code"' (bytes 1 ~~&~~and 2 of the T-MSIS DRUG ~~Utilization -~~UTILIZATION-CODE) explains whether the pharmacist filled the prescription, filled part of the prescription, etc. The NCPDP "'Professional Service Code"' (bytes 3 ~~&~~and 4 of the T-MSIS Drug Utilization Code) describes what the pharmacist did for the patient. The NCPDP "'Result of Service Code"' (bytes 5 ~~&~~and 6 of the T-MSIS Drug Utilization Code) describes the action the pharmacist took in response to a conflict or the result of a pharmacist's professional service. Because the T-MSIS Drug Utilization Code data element is a composite field, it is necessary for the state to populate all six bytes if any of the three NCPDP fields has a value. In such situations, use 'spaces' as placeholders for not applicable codes. ~~see Drug Utilization Professional Service Code List~~	DRUG-UTILIZATION-CODE-E4, DRUG-UTILIZATION-CODE-E5, DRUG-UTILIZATION-CODE-E6	CRX00003	CLAIM-LINE-RECORD-RX	X(6)	35	~~350~~368	~~355~~373	1. Value must be 6 characters or less 2. Characters 1 and 2 (2-character string) ~~may~~must be in Drug Utilization ~~Result of~~Reason for Service Code List (VVL~~), or spaces in cases where code is unused or not available 3.~~) 3. Characters 3 and 4 (2-character string) ~~may~~must be in Drug Utilization Professional Service Code List (VVL~~), or spaces in cases where code is unused or not available 4.~~) 4. Characters 5 and 6 (2-character string) ~~may~~must be in Drug Utilization ~~Reason For~~Result of Service Code List (VVL~~), or not populated in cases where code is unused or not available~~) 5. Mandatory

					~~(VVL.044)~~ ~~see Drug Utilization Reason For Service Code List (VVL.045)~~ ~~see Drug Utilization Result of Service Code List (VVL.046)~~								
CRX144	CRX.003.144	DTL-METRIC-DEC-QTY	Metric Decimal Quantity	Conditional	Metric decimal quantity of the product with the appropriate unit of measure (each, gram, or milliliter).	N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(7)V999	36	~~356~~374	~~365~~383	1. Value must be numeric 2. Value may include up to 7 digits to the left of the decimal point, and 3 digits to the right, e.g. 1234567.890 3. Value must be populated when Compound Drug Indicator (CRX.002.086) equals "1" 4. Conditional

CRX145	CRX.003.145	COMPOUND-DOSAGE-FORM	Compound Dosage Form	Conditional	The physical form of a dose of medication, such as a capsule or injection. ~~see Compound Dosage Form List (VVL.037)~~	COMPOUND-DOSAGE-FORM	CRX00003	CLAIM-LINE-RECORD-RX	X(2)	37	~~366~~384	~~367~~385	~~1.~~1. Value must be 2 characters 2. Value must be in Compound Dosage Form List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional
CRX146	CRX.003.146	REBATE-ELIGIBLE-INDICATOR	Rebate Eligible Indicator	Conditional	An indicator to identify claim lines with an NDC that is eligible for the drug rebate program.	REBATE-ELIGIBLE-INDICATOR	CRX00003	CLAIM-LINE-RECORD-RX	X(1)	38	3~~6~~86	3~~6~~86	~~1.~~1. Value must be 1 character 2. Value must be in Rebate Eligible Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Conditional
~~CRX147~~	~~CRX.003.147~~	~~IMMUNIZATION-TYPE~~	~~Immunization Type~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~CRX00003~~	~~CLAIM-LINE-RECORD-RX~~	~~X(2)~~	~~39~~	~~369~~	~~370~~	~~1. Not Applicable~~
~~CRX148~~	~~CRX.003.148~~	~~BENEFIT-TYPE~~	~~Benefit Type~~	~~Mandatory~~	~~The benefit category corresponding to the service reported on the claim or encounter record. Note: The code definitions in the valid value list originate from the Medicaid and CHIP Program Data System (MACPro) benefit type list. See Appendix H: Benefit Types~~	~~BENEFIT-TYPE~~	~~CRX00003~~	~~CLAIM-LINE-RECORD-RX~~	~~X(3)~~	~~40~~	~~371~~	~~373~~	~~1. Value must be in Benefit Type Code List (VVL)~~ ~~2. Value must be 3 characters~~ ~~3. Mandatory~~
CRX149	CRX.003.149	~~CMS-64-~~ CATEGORY-FOR-FEDERAL-REIMBURSEMENT	~~CMS-64~~ Category for Federal Reimbursement	Conditional	A code to indicate the Federal funding source for the payment.	~~CMS-64-~~ CATEGORY-FOR-FEDERAL-REIMBURSEMENT	CRX00003	CLAIM-LINE-RECORD-RX	X(2)	~~41~~39	38~~7~~4	~~375~~388	1. Value must be 2 characters 2. Value must be in ~~CMS-64~~ Category for Federal Reimbursement List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. (Federal Funding under Title XXI) if value equals ~~'~~'02~~'~~', then the eligible's CHIP Code (ELG.003.054) must be in [~~'2', '3'~~2,3] 4. (Federal Funding under Title XIX) if value equals ~~'~~'01~~'~~' then the eligible's CHIP Code (ELG.003.054) must be ~~'1'~~"1" 5. Conditional 6. If Type of Claim is in [~~'1','2','5','A','B','E','U','V','Y'~~1,A,U] and the Total Medicaid Paid Amount is populated on the

													corresponding claim header, then value must be reported~~.~~ ~~7. If Type of Claim is in ['4','D'] and the Service Tracking Payment Amount on the relevant record is populated, then value must be reported.~~
~~CRX150~~	~~CRX.003.150~~	~~XIX MBESCBES CATEGORY OF SERVICE~~	~~XIX MBESCBES Category of Service~~	~~Conditional~~	~~A code indicating the category of service for the paid claim. The category of service is the line item from the CMS-64 form that states use to report their expenditures and request federal financial participation.~~	~~XIX MBESCBES CATEGORY OF SERVICE~~	~~CRX00003~~	~~CLAIM LINE RECORD RX~~	~~X(4)~~	~~42~~	~~376~~	~~379~~	~~1. Value must be in XIX MBESCBES Category of Service List (VVL)~~ ~~2. Value must be 4 characters or less~~ ~~3. Conditional~~ ~~4. (Medicaid Claim) if the associated CMS-64 Category for Federal Reimbursement value is '1', then a valid value is mandatory and must be reported~~ ~~5. If value is in ['14', '35', '42' or '44'], then Sex (ELG.002.023) must not equals 'M'~~ ~~6. If XXI MBESCBES Category of Service is populated then must not be populated~~
~~CRX151~~	~~CRX.003.151~~	~~XXI MBESCBES CATEGORY OF SERVICE~~	~~XXI MBESCBES Category of Service~~	~~Conditional~~	~~A code to indicate the category of service for the paid claim. The category of service is the line item from the CMS-21 form that states use to report their expenditures and request federal financial participation.~~	~~XXI MBESCBES CATEGORY OF SERVICE~~	~~CRX00003~~	~~CLAIM LINE RECORD RX~~	~~X(3)~~	~~43~~	~~380~~	~~382~~	~~1. Value must be in XXI MBESCBES Category of Service List (VVL)~~ ~~2. Conditional~~ ~~3. (CHIP Claim) if the associated CMS-64 Category for Federal Reimbursement value is '2', then a valid value is mandatory and must be reported~~ ~~4. If XIX MBESCBES Category of Service is populated then value must not be populated~~ ~~5. Value must be 3 characters or less~~

CRX152	CRX.003.152	OTHER-INSURANCE-AMT	Other Insurance Amount	Conditional	The amount paid by insurance other than Medicare or Medicaid on this claim.	N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11) V99	~~44~~40	38~~3~~9	~~395~~401	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CRX153	CRX.003.153	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	CRX00003	CLAIM-LINE-RECORD-RX	X(500)	~~45~~68	~~396~~694	~~895~~1193	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
CRX155	CRX.001.155	SEQUENCE-NUMBER	Sequence Number	Mandatory	To enable states to sequentially number files, when related, follow-on files are necessary (i.e. update files, replace files). This should begin with 1 for the original Create submission type and be incremented by one for each Replacement or Update submission for the same reporting period and file type (subject area).	N/A	CRX00001	FILE-HEADER-RECORD-RX	X(4)	14	79	82	~~1.~~1. Value must be 4 characters or less 2. Value must between 1 and 9999 ~~2~~3. Value must be equal to the largest of any prior values for the same reporting period and file type, plus 1 (i.e. incremented by 1) ~~3~~4. Value must not contain a pipe symbol ~~4. Value must be 4 characters or less~~ 5. Mandatory
CRX156	CRX.002.156	DISPENSING-PRESCRIPTION-DRUG-PROV-NUM	Dispensing Prescription Drug Provider Number	Mandatory	The state-specific provider id of the provider who actually dispensed the prescription medication.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(30)	~~87~~78	~~1371~~805	~~1400~~834	1. Value must be 30 characters or less 2. ~~Value must be reported in Provider Identifier (PRV.005.080) with an associated Provider Identifier Type (PRV.005.081) equal to '1'~~ When Type of Claim not in [3~~. When Type of Claim not in ('Z','3','C','W","2","B","V"," 4","D","X"),C,W]~~ then value may match Submitting State Provider ID (PRV.002.019) or 3. When Type of Claim not in ~~('Z','3','C','W","2","B","V"," 4","D","X")~~[3,C,W] then value may match Provider Identifier (PRV.005.081) where the Provider Identifier Type (PRV.005.077) ~~= '1'~~ equals "1" 4. Mandatory

CRX157	CRX.003.157	ADJUDICATION-DATE	Adjudication Date	Mandatory	The date on which the payment status of the claim was finally adjudicated by the state. For Encounter Records (Type of Claim = 3, C, W), use date the encounter was processed by the state.	N/A	CRX00003	CLAIM-LINE-RECORD-RX	9(8)	4641	896402	903409	1. Value must be 8 characters in the form "CCYYMMDD" 2. 1. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st) 3. in the form "CCYYMMDD" 2. Value should be on or before End of Time Period value found in(CIP.001.010) 3. Mandatory 4. Value should be on or after associated T-MSIS File Header Record 4. MandatoryAdmission Date value
CRX158	CRX.003.158	SELF-DIRECTION-TYPE	Self Direction Type	Conditional Mandatory	This data element is not applicable to this file type.	SELF-DIRECTION-TYPE	CRX00003	CLAIM-LINE-RECORD-RX	X(3)	4742	904410	906412	1.1. Value must be 3 characters 2. Value must be in Self Direction Type List (VVL) 2. Value must be 3 characters 3. Conditional3. Mandatory
CRX159	CRX.003.159	PRE-AUTHORIZATION-NUM	Preauthorization Number	Conditional	A number, code or other value that indicates the services provided on this claim have been authorized by the payee or other service organization, or that a referral for services has been approved. (Also referred to as a Prior Authorization or Referral Number).	N/A	CRX00003	CLAIM-LINE-RECORD-RX	X(18)	4843	907413	924430	1. Value must be 18 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional
CRX160	CRX.002.160	MEDICARE-COMB-DED-IND	Medicare Combined Deductible Indicator	Conditional	Code indicating that the amount paid by Medicaid/CHIP on this claim toward the recipient's Medicare deductible was combined with their coinsurance amount because the amounts could not be separated.	MEDICARE-COMB-DED-IND	CRX00002	CLAIM-HEADER-RECORD-RX	X(1)	8879	1401835	1401835	1.1. Value must be 1 character 2. Value must be in Medicare Combined Deductible Indicator List (VVL) 2. Value must be 1 character 3.3. If value equals '1', then Total Medicare Coinsurance amount ismust not be populated. 4. Value must equal '0' if associated Type of Claim is '3', 'C' or 'W'If value equals "0", then Crossover Indicator must equals "0" 5. If value equals "1", then Crossover

													Indicator must equals "1" 6. Conditional
CRX161	CRX.002.161	PROV-LOCATION-ID	Provider Location ID	Mandatory	A code to uniquely identify the geographic location where the provider's services were performed. The Provider Location Identifier values reported on Inpatient, Long-Term Care, Other, and Pharmacy Claim Header Segments must correspond to an active Provider Location Identifier value on a Provider Location ~~&~~and Contact Info (~~PRV00003~~PRV.003) segment. If a particular license (e.g., a physician's medical license) or provider identifier (e.g., an individual provider's NPI or SSN) is applicable to all of their servicing locations, value "000" (a string of exactly three zeros) can be used in the ~~PRV00004~~PRV.004 or ~~PRV00005~~PRV.005, respectively, to represent all locations, however that location identifier must not be attributed to claims or provider bed type info.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(5)	~~89~~80	~~1402~~836	~~18~~40~~6~~	~~1.~~1. Value must be 5 characters or less 2. Value must not contain a pipe or asterisk symbols ~~2. Value must be 5 characters or less~~ ~~3.~~3. Mandatory
CRX162	CRX.002.162	PRESCRIPTION-ORIGIN-CODE	Prescription Origin Code	Conditional	How the prescription was sent to the pharmacy.	PRESCRIPTION-ORIGIN-CODE	CRX00002	CLAIM-HEADER-RECORD-RX	X(1)	81	841	841	1. Value must be one digit 2. Value must be in Prescription Origin Code List (VVL) 3. Conditional

CRX163	CRX.002.163	TOT-BENEFICIARY-COPAYMENT-LIABLE-AMOUNT	Total Beneficiary Copayment Liable Amount	Conditional	The total copayment amount on a claim that the beneficiary is obligated to pay for covered services. This is the total Medicaid or contract negotiated beneficiary copayment liability for covered service on the claim. Do not subtract out any payments made toward the copayment.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11) V99	82	842	854	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CRX164	CRX.002.164	TOT-BENEFICIARY-COINSURANCE-LIABLE-AMOUNT	Total Beneficiary Coinsurance Liable Amount	Conditional	The total coinsurance amount on a claim the beneficiary is obligated to pay for covered services. This amount is the total Medicaid or contract negotiated beneficiary coinsurance liability for covered services on the claim. Do not subtract out any payments made toward the coinsurance.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11) V99	83	855	867	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CRX165	CRX.002.165	TOT-BENEFICIARY-DEDUCTIBLE-LIABLE-AMOUNT	Total Beneficiary Deductible Liable Amount	Conditional	The total deductible amount on a claim the beneficiary is obligated to pay for covered services. This amount is the total Medicaid or contract negotiated beneficiary deductible liability minus previous beneficiary payments that went toward their deductible. Do not subtract out any payments for the given claim that went toward the deductible.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11) V99	84	868	880	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CRX166	CRX.002.166	COMBINED-BENE-COST-SHARING-PAID-AMOUNT	Combined Beneficiary Cost Sharing Paid Amount	Conditional	The combined amounts the beneficiary or his or her representative (e.g., their guardian) paid towards their copayment, coinsurance, and/or deductible for the covered services on the claim. Only report this data element when the claim does not differentiate among copayment, coinsurance, and/or deductible payments made by the beneficiary. Do not include beneficiary cost sharing payments made by a third party/ies on behalf of the beneficiary.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11) V99	85	881	893	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional

CRX167	CRX.003.167	INGREDIENT-COST-SUBMITTED	Ingredient Cost Submitted	Conditional	The charge to cover the cost of ingredients for the prescription or drug.	N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11)V99	44	431	443	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CRX168	CRX.003.168	INGREDIENT-COST-PAID-AMT	Ingredient Cost Paid Amount	Conditional	The amount paid by Medicaid or the managed care plan on this claim or adjustment at the claim detail level towards the cost of ingredients for the prescription or drug.	N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11)V99	45	444	456	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CRX169	CRX.003.169	DISPENSE-FEE-PAID-AMT	Dispense Fee Paid Amount	Conditional	The amount paid by Medicaid or the managed care plan on this claim or adjustment towards the cost of the pharmacy's professional dispensing fee for the prescription.	N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11)V99	46	457	469	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CRX170	CRX.003.170	PROFESSIONAL-SERVICE-FEE-SUBMITTED	Professional Service Fee Submitted	Conditional	The charge to cover the clinical services, not otherwise covered under the professional dispensing fee. (Example - not filling a prescription because of therapeutic duplication).	N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11)V99	47	470	482	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CRX171	CRX.003.171	PROFESSIONAL-SERVICE-FEE-PAID-AMT	Professional Service Fee Paid Amount	Conditional	The amount paid by Medicaid or the managed care plan on this claim or adjustment towards the costs of clinical services not otherwise covered under the professional dispensing fee.	N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11)V99	48	483	495	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional

CRX172	CRX.003.172	IHS-SERVICE-IND	IHS Service Indicator	Mandatory	To indicate Services received by Medicaid-eligible individuals who are American Indian or Alaska Native (AI/AN) through facilities of the Indian Health Service (IHS), whether operated by IHS or by Tribes.	IHS-SERVICE-IND	CRX00003	CLAIM-LINE-RECORD-RX	X(1)	49	496	496	1. Value must be 1 character 2. Value must be in the IHS Service Indicator List (VVL) 3. Mandatory
CRX173	CRX.002.173	LTC-RCP-LIAB-AMT	LTC RCP Liability Amount	Conditional	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.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11)V99	86	894	906	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CRX174	CRX.002.174	PROVIDER-CLAIM-FORM-CODE	Provider Claim Form Code	Mandatory	A code indicating the format in which the provider submitted their claim. Very few if any claims should be classified as "Other".	PROVIDER-CLAIM-FORM-CODE	CRX00002	CLAIM-HEADER-RECORD-RX	X(2)	87	907	908	1. Value must not be more than 2 characters 2. Value must be in Provider Claim Form Code List (VVL) 3. Mandatory
CRX175	CRX.002.175	PROVIDER-CLAIM-FORM-OTHER-TEXT	Provider Claim Form Other Text	Conditional	A free-form text field where a state can identify the "other" claim form used by the provider to submit their claim. Required when "Other" is reported to Provider Claim Form Code.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	X(50)	88	909	958	1. Value must not be more than 50 characters long 2. Conditional 3. Value must be provided when corresponding Provider Claim Form Code is "Other"
CRX176	CRX.002.176	TOT-GME-AMOUNT-PAID	Total GME Amount Paid	Conditional	The amount included in the Total Medicaid Amount (CRX.002.041) that is attributable to a Graduate Medical Education (GME) payment, when the state makes GME payments by claim.	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11)V99	89	959	971	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional

CRX177	CRX.002.177	TOT-SDP-ALLOWED-AMT	Total State Directed Payment Allowed Amount	Conditional	The component (in dollar and cents) of the total allowed amount that represents the difference between what would have been the managed care plan's typical contractual allowed amount and the enhanced allowed amount for this specific claim as defined by the State's SPA, waiver, or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11) V99	90	972	984	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CRX178	CRX.002.178	TOT-SDP-PAID-AMT	Total State Directed Payment Paid Amount	Conditional	The component (in dollar and cents) of the total paid amount that represents the difference between what would have been the managed care plan's typical contractual paid amount and the enhanced paid amount for this specific claim as defined by the State's SPA, waiver, or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).	N/A	CRX00002	CLAIM-HEADER-RECORD-RX	S9(11) V99	91	985	997	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CRX179	CRX.003.179	UNIQUE-DEVICE-IDENTIFIER	Unique Device Identifier	Conditional	An unique identifier assigned to every medical device that meets the requirements of 21 CFR 801 and 830.	N/A	CRX00003	CLAIM-LINE-RECORD-RX	X(76)	50	497	572	1. Value must not be more than 76 characters long 2. Conditional

CRX180	CRX.003.180	MBESCBES-CATEGORY-OF-SERVICE	MBESCBES Category of Service	Conditional	A code indicating the category of service for the paid claim. The category of service is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.) that states use to report their expenditures and request federal financial participation.	21.P-FORM, 21BASE-FORM, 64.21U-FORM, 64.10BASE-FORM, 64.9P-FORM, 64.9A-FORM, 64.9BASE-FORM, 64.21UP-FORM	CRX00003	CLAIM-LINE-RECORD-RX	X(5)	53	624	628	1. Value must be 5 characters or less 2. When MBESCBES Form equals "21.P", value must be in 21.P Form List (VVL) 3. When MBESCBES Form equals "21BASE", value must be in 21BASE Form List (VVL) 4. When MBESCBES Form equals "64.21U", value must be in 64.21U Form List (VVL) 5. When MBESCBES Form equals "64.10BASE", value must be in 64.10BASE Form List (VVL) 6. When MBESCBES Form equals "64.9P", value must be in 64.9P Form List (VVL) 7. When MBESCBES Form equals "64.9A", value must be in 64.9A Form List (VVL) 8. When MBESCBES Form equals "64.9BASE", value must be in 64.9BASE Form List (VVL) 9. When MBESCBES Form equals "64.21UP", value must be in 64.21UP Form List (VVL) 10. Conditional 11. If Type of Claim in [1,A,U], then value must be populated on all claim lines with a Medicaid Paid Amount greater than $0 12. When populated, an associated MBESCBES Form Group and MBESCBES Form must be populated

CRX181	CRX.003.181	MBESCBES-FORM	MBESCBES Form	Conditional	The MBES or CBES form to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.). This should be determined by the state's MBES/CBES reporting process. The MBES or CBES form reported here will determine what the meaning of the corresponding MBES/CBES category of service value is.	MBESCBES-FORMGP-1, MBESCBES-FORMGP-2, MBESCBES-FORMGP-3	CRX00003	CLAIM-LINE-RECORD-RX	X(50)	52	574	623	1. Value must be 50 characters or less 2. When MBESCBES Form Group equals "1", value must be in MBESCBES Form Group 1 List (VVL) 3. When MBESCBES Form Group equals "2", value must be in MBESCBES Form Group 2 List (VVL) 4. When MBESCBES Form Group equals "3", value must be in MBESCBES Form Group 3 List (VVL) 5. Conditional 6. If Type of Claim in [1,A,U], then value must be populated on all claim lines with a Medicaid Paid Amount greater than $0
CRX182	CRX.003.182	PROCEDURE-CODE	Procedure Code	Conditional	The procedure code (e.g., CPT, HCPCS, or other procedure code that is not an NDC or UDI) reported by a pharmacy on their NCPDP transaction.	PROCEDURE-CODE	CRX00003	CLAIM-LINE-RECORD-RX	X(6)	54	629	634	1. Value must not be more than 6 characters 2. Value must be in Procedure Code List (VVL) 3. Conditional
CRX183	CRX.003.183	PROCEDURE-CODE-MOD-1	Procedure Code Modifier 1	Conditional	The first modifier associated with the procedure code (or if procedure code is missing, then the modifier may be associated with an NDC or Unique Device Identifier).	PROCEDURE-CODE-MOD	CRX00003	CLAIM-LINE-RECORD-RX	X(2)	55	635	636	1. Value must be 2 characters 2. Value must be in Procedure Code Mod List (VVL) 3. Must be associated with a Procedure Code 4. Conditional
CRX184	CRX.003.184	PROCEDURE-CODE-MOD-2	Procedure Code Modifier 2	Conditional	The second modifier associated with the procedure code (or if procedure code is missing, then the modifier may be associated with an NDC or Unique Device Identifier).	PROCEDURE-CODE-MOD	CRX00003	CLAIM-LINE-RECORD-RX	X(2)	56	637	638	1. Value must be 2 characters 2. Value must be in Procedure Code Mod List (VVL) 3. Must be associated with a Procedure Code 4. Conditional
CRX185	CRX.003.185	PROCEDURE-CODE-MOD-3	Procedure Code Modifier 3	Conditional	The third modifier associated with the procedure code (or if procedure code is missing, then the modifier may be associated with an NDC or Unique Device Identifier).	PROCEDURE-CODE-MOD	CRX00003	CLAIM-LINE-RECORD-RX	X(2)	57	639	640	1. Value must be 2 characters 2. Value must be in Procedure Code Mod List (VVL) 3. Must be associated with a Procedure Code 4. Conditional

CRX186	CRX.003.186	PROCEDURE-CODE-MOD-4	Procedure Code Modifier 4	Conditional	The fourth modifier associated with the procedure code (or if procedure code is missing, then the modifier may be associated with an NDC or Unique Device Identifier).	PROCEDURE-CODE-MOD	CRX00003	CLAIM-LINE-RECORD-RX	X(2)	58	641	642	1. Value must be 2 characters 2. Value must be in Procedure Code Mod List (VVL) 3. Must be associated with a Procedure Code 4. Conditional
CRX187	CRX.003.187	PROCEDURE-CODE-MOD-5	Procedure Code Modifier 5	Conditional	The fifth modifier associated with the procedure code (or if procedure code is missing, then the modifier may be associated with an NDC or Unique Device Identifier).	PROCEDURE-CODE-MOD	CRX00003	CLAIM-LINE-RECORD-RX	X(2)	59	643	644	1. Value must be 2 characters 2. Value must be in Procedure Code Mod List (VVL) 3. Must be associated with a Procedure Code 4. Conditional
CRX188	CRX.003.188	PROCEDURE-CODE-MOD-6	Procedure Code Modifier 6	Conditional	The sixth modifier associated with the procedure code (or if procedure code is missing, then the modifier may be associated with an NDC or Unique Device Identifier).	PROCEDURE-CODE-MOD	CRX00003	CLAIM-LINE-RECORD-RX	X(2)	60	645	646	1. Value must be 2 characters 2. Value must be in Procedure Code Mod List (VVL) 3. Must be associated with a Procedure Code 4. Conditional
CRX189	CRX.003.189	PROCEDURE-CODE-MOD-7	Procedure Code Modifier 7	Conditional	The seventh modifier associated with the procedure code (or if procedure code is missing, then the modifier may be associated with an NDC or Unique Device Identifier).	PROCEDURE-CODE-MOD	CRX00003	CLAIM-LINE-RECORD-RX	X(2)	61	647	648	1. Value must be 2 characters 2. Value must be in Procedure Code Mod List (VVL) 3. Must be associated with a Procedure Code 4. Conditional
CRX190	CRX.003.190	PROCEDURE-CODE-MOD-8	Procedure Code Modifier 8	Conditional	The eighth modifier associated with the procedure code (or if procedure code is missing, then the modifier may be associated with an NDC or Unique Device Identifier).	PROCEDURE-CODE-MOD	CRX00003	CLAIM-LINE-RECORD-RX	X(2)	62	649	650	1. Value must be 2 characters 2. Value must be in Procedure Code Mod List (VVL) 3. Must be associated with a Procedure Code 4. Conditional
CRX191	CRX.003.191	PROCEDURE-CODE-MOD-9	Procedure Code Modifier 9	Conditional	The ninth modifier associated with the procedure code (or if procedure code is missing, then the modifier may be associated with an NDC or Unique Device Identifier).	PROCEDURE-CODE-MOD	CRX00003	CLAIM-LINE-RECORD-RX	X(2)	63	651	652	1. Value must be 2 characters 2. Value must be in Procedure Code Mod List (VVL) 3. Must be associated with a Procedure Code 4. Conditional

CRX192	CRX.003.192	PROCEDURE-CODE-MOD-10	Procedure Code Modifier 10	Conditional	The tenth modifier associated with the procedure code (or if procedure code is missing, then the modifier may be associated with an NDC or Unique Device Identifier).	PROCEDURE-CODE-MOD	CRX00003	CLAIM-LINE-RECORD-RX	X(2)	64	653	654	1. Value must be 2 characters 2. Value must be in Procedure Code Mod List (VVL) 3. Must be associated with a Procedure Code 4. Conditional
CRX193	CRX.003.193	GME-AMOUNT-PAID	GME Amount Paid	Conditional	The amount included in the Medicaid Amount (CRX.003.125) that is attributable to a Graduate Medical Education (GME) payment, when the state makes GME payments by claim.	N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11)V99	65	655	667	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CRX194	CRX.003.194	SDP-ALLOWED-AMT	State Directed Payment Allowed Amount	Conditional	The component (in dollar and cents) of the allowed amount that represents the difference between what would have been the managed care plan's typical contractual allowed amount and the enhanced allowed amount for this specific claim as defined by the State's SPA, waiver, or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).	N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11)V99	66	668	680	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
CRX195	CRX.003.195	SDP-PAID-AMT	State Directed Payment Paid Amount	Conditional	The component (in dollar and cents) of the paid amount that represents the difference between what would have been the managed care plan's typical contractual paid amount and the enhanced paid amount for this specific claim as defined by the State's SPA, waiver, or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).	N/A	CRX00003	CLAIM-LINE-RECORD-RX	S9(11)V99	67	681	693	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional

CRX196	CRX.004.196	RECORD-ID	Record ID	Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	CRX00004	CLAIM-DX-RX	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "CRX00004"
CRX197	CRX.004.197	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	CRX00004	CLAIM-DX-RX	X(2)	2	9	10	1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (CRX.001.007)
CRX198	CRX.004.198	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	CRX00004	CLAIM-DX-RX	9(11)	3	11	21	1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
CRX199	CRX.004.199	ICN-ORIG	Original ICN	Mandatory	A unique number assigned by the state's payment system that identifies an original or adjustment claim.	N/A	CRX00004	CLAIM-DX-RX	X(50)	4	22	71	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory

CRX200	CRX.004.200	ICN-ADJ	Adjustment ICN	Conditional	A unique claim number assigned by the state's payment system that identifies the adjustment claim for an original transaction.	N/A	CRX00004	CLAIM-DX-RX	X(50)	5	72	121	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
CRX201	CRX.004.201	ADJUSTMENT-IND	Adjustment Indicator	Mandatory	Indicates the type of adjustment record.	ADJUSTMENT-IND	CRX00004	CLAIM-DX-RX	X(1)	6	122	122	1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Value must be in [0,1,4] 4. Mandatory 5. If value equals "0", then associated Adjustment ICN must not be populated 6. If value is in [4,1] then Adjustment ICN must be populated 7. Value must equal "1", when associated Claim Status equals "686" 8. Value must match the adjustment indicator in the header (CRX.002.025)
CRX202	CRX.004.202	ADJUDICATION-DATE	Adjudication Date	Mandatory	The date on which the payment status of the claim was finally adjudicated by the state. For Encounter Records (Type of Claim = 3, C, W), use date the encounter was processed by the state.	N/A	CRX00004	CLAIM-DX-RX	9(8)	7	123	130	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value should be on or before End of Time Period (CRX.001.010) 3. Mandatory 4. Value should be on or after associated Admission Date value

CRX203	CRX.004.203	DIAGNOSIS-TYPE	Diagnosis Type	Mandatory	Indicates the context of the diagnosis code from the provider's claim (i.e., an NCPDP claim can have up to 5 diagnosis codes). The type of diagnosis code (e.g., principal, admitting, external cause of injury, or other) is captured here. The order in which the diagnosis code was reported is captured in the Diagnosis Sequence Number.	DIAGNOSIS-TYPE	CRX00004	CLAIM-DX-RX	X(1)	8	131	131	1. Value must be 1 character 2. Value must be in Diagnosis Type Code List (VVL) 3. Value must be "D" 4. Mandatory
CRX204	CRX.004.204	DIAGNOSIS-SEQUENCE-NUMBER	Diagnosis Sequence Number	Mandatory	The order in which the diagnosis occurred on the provider's claim for a given type of diagnosis code (e.g., an NCPDP claim can have up to 5 diagnosis codes).	N/A	CRX00004	CLAIM-DX-RX	9(2)	9	132	133	1. Value must be in [01-24] 2. Mandatory
CRX205	CRX.004.205	DIAGNOSIS-CODE-FLAG	Diagnosis Code Flag	Mandatory	Flag used to identify wither the associated Diagnosis Code value is a ICD-9 or ICD-10 code.	DIAGNOSIS-CODE-FLAG	CRX00004	CLAIM-DX-RX	X(1)	10	134	134	1. Value must be 1 character 2. Value must be in Diagnosis Code Flag List (VVL) 3. Mandatory
CRX206	CRX.004.206	DIAGNOSIS-CODE	Diagnosis Code	Mandatory	ICD-9 or ICD-10 diagnosis codes used as a tool to group and identify diseases, disorders, symptoms, poisonings, adverse effects of drugs and chemicals, injuries and other reasons for patient encounters. Diagnosis codes should be passed through to T-MSIS exactly as they were submitted by the provider on their claim (with the exception of removing the decimal). For example: 210.5 is coded as '2105'.	DIAGNOSIS-CODE	CRX00004	CLAIM-DX-RX	X(7)	11	135	141	1. Value must be a minimum of 3 characters 2. If associated Diagnosis Code Flag value equals "1" (ICD-9), then value must be in ICD-9 Diagnosis Code List (VVL) 3. If associated Diagnosis Code Flag value equals "2" (ICD-10), then value must be in ICD-10 Diagnosis Code List (VVL) 4. Value must not contain a decimal point 5. Mandatory
CRX207	CRX.004.207	STATE-NOTATION	State Notation	Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	CRX00004	CLAIM-DX-RX	X(500)	12	142	641	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational

CRX209	CRX.003.209	MBESCBES-FORM-GROUP	MBESCBES Form Group	Conditional	Indicates group of MBES/CBES forms that this payment applies to (e.g., the CMS-64.9 Base form is for Title XIX-funded Medicaid, the CMS-64.21 form is for Title XXI-funded Medicaid-expansion CHIP (M-CHIP), and the CMS-21 Base form is for Title XXI-funded separate CHIP (S-CHIP)).	MBESCBES-FORM-GROUP	CRX00003	CLAIM-LINE-RECORD-RX	X(1)	51	573	573	1. Value must be 1 character 2. Value must be in MBESCBES Form Group List (VVL) 3. Conditional 4. If Type of Claim in [1,A,U], then value must be populated on all claim lines with a Medicaid Paid Amount greater than $0

T-MSIS Data Dictionary – ELG File Changes Between Versions 2.4.0 and 4.0.0

ELG001	ELG.001.001	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	ELG00001	FILE-HEADER-RECORD-ELIGIBILITY	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00001"
ELG002	ELG.001.002	DATA-DICTIONARY-VERSION	Data Dictionary Version	Mandatory	A data element to capture the version of the T-MSIS data dictionary that was used to build the file. ~~Use the version number specified on the Cover Sheet of the data dictionary" to V2.4.~~	DATA-DICTIONARY-VERSION	ELG00001	FILE-HEADER-RECORD-ELIGIBILITY	X(10)	2	9	18	1. Value must be 10 characters or less 2. Value must be in Data Dictionary Version List (VVL) 3. Value must not include the pipe ("|") symbol ~~3~~4. Mandatory
ELG003	ELG.001.003	SUBMISSION-TRANSACTION-TYPE	Submission Transaction Type	Mandatory	A data element to identify the whether the transactions in the file are original submissions of the data, a resubmission of a previously submitted file, or corrections of edit rejects.	SUBMISSION-TRANSACTION-TYPE	ELG00001	FILE-HEADER-RECORD-ELIGIBILITY	X(1)	3	19	19	~~1.~~1. Value must be 1 characters 2. Value must be in Submission Transaction Type List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory
ELG004	ELG.001.004	FILE-ENCODING-SPECIFICATION	File Encoding Specification	Mandatory	Denotes which supported file encoding standard was used to create the file.	FILE-ENCODING-SPECIFICATION	ELG00001	FILE-HEADER-RECORD-ELIGIBILITY	X(3)	4	20	22	~~1.~~1. Value must be 3 characters 2. Value must be in File Encoding Specification List (VVL) ~~2. Value must be 3 characters~~ ~~3.~~3. Mandatory
ELG005	ELG.001.005	DATA-MAPPING-DOCUMENT-VERSION	Data Mapping Document Version	Mandatory	Identifies the version of the T-MSIS data mapping document used to build a state	N/A	ELG00001	FILE-HEADER-RECORD-ELIGIBILITY	X(9)	5	23	31	1. Value must be 9 characters or less 2. Mandatory

					submission file. ~~Use the version number specified on the title page of the data mapping document~~								
ELG006	ELG.001.006	FILE-NAME	File Name	~~Not Applicable~~ Mandatory	A code to identify the subject area to which the records in its file relate. Each T-MSIS submission file should only contain records for one subject area (i.e., Eligible, Third-party liability, Provider, Managed Care Plan Information, Inpatient, Long-Term Care, Other, ~~and~~ Pharmacy Claim, and Financial Transactions).	N/A	ELG00001	FILE-HEADER-RECORD-ELIGIBILITY	X(8)	6	32	39	1. Value must equal ~~'ELIGIBLE'~~"ELIGIBLE" 2. Mandatory
ELG007	ELG.001.007	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	ELG00001	FILE-HEADER-RECORD-ELIGIBILITY	X(2)	7	40	41	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same for all records
ELG008	ELG.001.008	DATE-FILE-CREATED	Date File Created	Mandatory	The date on which the file was created.	N/A	ELG00001	FILE-HEADER-RECORD-ELIGIBILITY	9(8)	8	42	49	~~1.~~1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" ~~2~~3. Value must be ~~8 characters in the form "CCYYMMDD"~~ ~~3. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~4.~~less than current date 4. Value must be equal to or after the value of associated End of Time Period 5. Mandatory
ELG009	ELG.001.009	START-OF-TIME-PERIOD	Start of Time Period	Mandatory	This value must be the first day of the reporting month, regardless of the actual date span of the data in the file.	N/A	ELG00001	FILE-HEADER-RECORD-ELIGIBILITY	9(8)	9	50	57	~~1. Value of the CC component must be "20"~~ ~~2. Value must be 8 characters in the form "CCYYMMDD"~~ ~~3.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~4. Value must be less than current date~~ ~~5.~~in the form "CCYYMMDD"

													2. Value must be equal to or earlier than associated Date File Created ~~6~~3. Value must be before associated End of Time Period ~~7~~4. Mandatory 5. Value of the CC component must be "20"
ELG010	ELG.001.010	END-OF-TIME-PERIOD	End of Time Period	Mandatory	This value must be the last day of the reporting month, regardless of the actual date span.	N/A	ELG00001	FILE-HEADER-RECORD-ELIGIBILITY	9(8)	10	58	65	1. ~~Value~~The date must be ~~8 characters~~a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" 3. ~~The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~4.~~ Value must be equal to or earlier than associated Date File Created ~~5~~4. Value must be equal to or after associated Start of Time Period ~~6~~5. Mandatory
ELG011	ELG.001.011	FILE-STATUS-INDICATOR	File Status Indicator	Mandatory	A code to indicate whether the records in the file are test or production records.	FILE-STATUS-INDICATOR	ELG00001	FILE-HEADER-RECORD-ELIGIBILITY	X(1)	11	66	66	~~1.~~1. Value must be 1 character 2. For production files, value must be equal to ~~'P'~~ ~~2. Value must be 1 character~~ "P" 3. Value must be in File Status Indicator List (VVL) 4. Mandatory
ELG012	ELG.001.012	SSN-INDICATOR	SSN Indicator	Mandatory	Indicates whether the state uses the eligible person's social security number instead of an MSIS Identification Number as the unique, unchanging eligible person identifier. A state's SSN/Non-SSN designation on the eligibility file should match on the claims and third party liability files.	SSN-INDICATOR	ELG00001	FILE-HEADER-RECORD-ELIGIBILITY	X(1)	12	67	67	~~1.~~1. Value must be 1 character 2. Value must be in SSN Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory

ELG013	ELG.001.013	TOT-REC-CNT	Total Record Count	Mandatory	A count of all records in the file except for the file header record. This count will be used as a control total to help assure that the file did not become corrupted during transmission.	N/A	ELG00001	FILE-HEADER-RECORD-ELIGIBILITY	9(11)	13	68	78	~~1.~~1. Value must be 11 digits or less 2. Value must be a positive integer ~~2~~3. Value must be between 0:99999999999 (inclusive) ~~3. Value must be 11 digits or less~~ ~~4.~~4. Value must equal the number of records included in the file submission except for the file header record. 5. Mandatory
ELG014	ELG.001.014	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	ELG00001	FILE-HEADER-RECORD-ELIGIBILITY	X(500)	~~15~~16	~~83~~85	58~~24~~	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
ELG016	ELG.002.016	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	ELG00002	PRIMARY-DEMOGRAPHICS-ELIGIBILITY	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00002"
ELG017	ELG.002.017	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	ELG00002	PRIMARY-DEMOGRAPHICS-ELIGIBILITY	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)

ELG018	ELG.002.018	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	ELG00002	PRIMARY-DEMOGRAPHICS-ELIGIBILITY	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory
ELG019	ELG.002.019	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual ~~(except on service tracking payments). .~~ Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47572~~reporting-shared-msis-identification-numbers-eligibility/	N/A	ELG00002	PRIMARY-DEMOGRAPHICS-ELIGIBILITY	X(20)	4	22	41	~~1. Mandatory~~ ~~2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN~~ ~~3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN~~ ~~4.~~1. Value must be 20 characters or less 2. Mandatory
ELG020	ELG.002.020	ELIGIBLE-FIRST-NAME	Eligible First Name	Mandatory	Individual's first name; first name component of full name (e.g. First Name, Middle Initial, Last Name).	N/A	ELG00002	PRIMARY-DEMOGRAPHICS-ELIGIBILITY	X(30)	5	42	71	1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
ELG021	ELG.002.021	ELIGIBLE-LAST-NAME	Eligible Last Name	Mandatory	Individual's last name; last name component of full name (e.g. First Name, Middle Initial, Last Name).	N/A	ELG00002	PRIMARY-DEMOGRAPHICS-ELIGIBILITY	X(30)	6	72	101	1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory

ELG022	ELG.002.022	ELIGIBLE-MIDDLE-INIT	Eligible Middle Initial	Conditional	Individual's middle initial; middle initial component of full name (e.g. First Name, Middle Initial, Last Name).	N/A	ELG00002	PRIMARY-DEMOGRAPHICS-ELIGIBILITY	X(1)	7	102	102	1. ~~Value may include any alphanumeric characters, digits or symbols~~ ~~2.~~ Value must be 1 character ~~3~~2. Value must not contain a pipe or asterisk symbols ~~4~~3. Conditional
ELG023	ELG.002.023	SEX	Sex	Mandatory	Either individual's biological sex or their self-identified sex.	SEX	ELG00002	PRIMARY-DEMOGRAPHICS-ELIGIBILITY	X(1)	8	103	103	~~1.~~1. Value must be 1 character 2. Value must be in Sex List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. (Pregnancy) if value equals "M", then associated Pregnancy Indicator (ELG.003.049) value must not equal ~~'1'~~"1" 4. Mandatory
ELG024	ELG.002.024	DATE-OF-BIRTH	Date of Birth	Mandatory	An individual's date of birth.	N/A	ELG00002	PRIMARY-DEMOGRAPHICS-ELIGIBILITY	9(8)	9	104	111	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~in the form "CCYYMMDD" 2. Children enrolled in the Separate CHIP prenatal program option should have a date of birth missing or a date of birth equal to the pregnant mother~~'~~s date of birth ~~4~~3. When Conception to Birth Indicator (ELG.005.094) does not equal ~~'1'~~"1" and Eligibility Group (ELG.005.087) does not equal ~~'~~"64~~'~~" value must be less than or equal to associated End of Time Period value ~~5~~4. Value must be less than or equal to associated Date File Created (ELG.001.008) value ~~6~~5. Mandatory ~~7~~6. When Conception to Birth Indicator (ELG.005.094) does not equal ~~'1'~~"1" and Eligibility Group (ELG.005.087) does not equal

													'"_64-'" value minus Start of Time Period (ELG.001.10) must be less than 125 years

ELG025	ELG.002.025	DATE-OF-DEATH	Date of Death	Conditional	The date an individual died on.	~~DATE-OF-DEATH~~N/A	ELG00002	PRIMARY-DEMOGRAPHICS-ELIGIBILITY	9(8)	10	112	119	~~1. Value must be in Eligibility Group List (VVL)~~ ~~2. If value is "26", then Dual Eligible Code value must be "06"~~ ~~3. Conditional~~ ~~4. Value is mandatory and must be provided when associated Eligibility Determinant Effective Date value is on or after 1 January, 2014.~~ ~~5. If value is in ["72", "73", "74", "75"], then associated Restricted Benefits Code value must equal "7" and State Plan Option Type must equal "06"~~ ~~6. If associated CHIP Code value is "2", then value must be in ["07", 31", "61"]~~ ~~7. If associated CHIP Code value is "3", then value must be in ["61", "62", "63", "64", "65", "66", "67", "68"]~~ ~~8. Value must be 2 characters~~ ~~9. If value is "23", then Dual Eligible Code value must be in ["01", "02"]~~ ~~10. If value is "25", then Dual Eligible Code value must be in ["03", "04"]~~ ~~11. If value is "24", then Dual Eligible Code value must be "05"~~ ~~12. Value must be in Level of Care Status List (VVL)~~1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Conditional 3. If populated, value must be on or after individual's Date of Birth 4. Value must be less than or equal to associated Date File Created (ELG.001.008) value 5. There must never be more than one Date of Death value reported across Primary Demographic segments that have the same MSIS Identification number 6. When populated, Procedure Code Dates on a claim must be less than or equal to this value

													7. When populated, Admission Date on a claim must be less than or equal to this value 8. When populated, Discharge Date on a claim must be less than or equal to this value 9. When populated, Ending Date of Service on a claim must be less than or equal to this value 10. When populated, value must be less than or equal to Enrollment End Date (ELG.021.254) 11. When populated, value minus Date of Birth (ELG.002.024) is less than or equal to 125 years
ELG026	ELG.002.026	PRIMARY-DEMOGRAPHIC-ELEMENT-EFF-DATE	Primary Demographic Element Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00002	PRIMARY-DEMOGRAPHICS-ELIGIBILITY	9(8)	11	120	127	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~19,20,99]

ELG027	ELG.002.027	PRIMARY-DEMOGRAPHIC-ELEMENT-END-DATE	Primary Demographic Element End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00002	PRIMARY-DEMOGRAPHICS-ELIGIBILITY	9(8)	12	128	135	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be greater than or equal to associated Segment Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~19,20,99]
ELG028	ELG.002.028	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	ELG00002	PRIMARY-DEMOGRAPHICS-ELIGIBILITY	X(500)	13	136	635	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
ELG030	ELG.003.030	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~ 3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00003"

ELG031	ELG.003.031	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
ELG032	ELG.003.032	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory
ELG033	ELG.003.033	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual ~~(except on service tracking payments). .~~ Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47572~~reporting-shared-msis-identification-numbers-eligibility/	N/A	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(20)	4	22	41	~~1. Mandatory~~ ~~2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN~~ ~~3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN~~ ~~4.~~1. Value must be 20 characters or less 2. Mandatory

ELG034	ELG.003.034	MARITAL-STATUS	Marital Status	~~Mandatory~~Conditional	A code to classify eligible individual's marital/domestic-relationship status. ~~An eligible individual who is younger than 12 years should have a marital status of never married or unknown.~~ This element should be reported by the state when the information is material to eligibility (i.e., institutionalization). Because there is no specific statutory or regulatory basis for defining marital status codes, they are being defined in a way that is as flexible for states and data users as possible. States can report at whatever level of granularity is available to them in their system and a data user can choose to use them as-is or roll the values up in broader categories depending on whichever approach best meets their needs. CMS periodically reviews the values reported to MARITAL-STATUS-OTHER-EXPLANATION to determine if states are appropriately using it only when there is no existing MARITAL-STATUS value that reflects the state's marital status description for an individual AND to determine whether it is necessary to add additional T-MSIS MARITAL-STATUS values to reflect commonly used state martial status descriptions for which there is no existing T-MSIS MARITAL-STATUS value.	MARITAL-STATUS	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(2)	5	42	43	~~1.~~1. Value must be 2 characters 2. Value must be in Marital Status List (VVL) ~~2. Value must be 2 characters~~ ~~3. Mandatory~~3. Conditional
ELG035	ELG.003.035	MARITAL-STATUS-OTHER-EXPLANATION	Marital Status Other Explanation	Conditional	A free-text field to capture the description of the marital/domestic-relationship status when Marital Status =14 (Other) is selected.	N/A	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(50)	6	44	93	1. If associated Marital Status (ELG.003.035) equals '14' (Other), then value is mandatory and must be provided 2. Value must be 50 characters or less 3. Value must not contain a pipe or asterisk symbol 4. Conditional

ELG036	ELG.003.036	SSN	SSN	Conditional	The eligible individual's social security number. For newborns when value is unknown it is not required. For SSN states, in instances where the social security number is not known and a temporary MSIS Identification Number is used, the MSIS Identification Number field should be populated with the temporary MSIS Identification Number and the SSN field should be space-filled, or blank. When the SSN becomes known, the MSIS Identification Number field should continue to be populated with the temporary MSIS Identification Number and the SSN field should be populated with the newly acquired SSN for at least one monthly submission of the Eligible File so that T-MSIS can associated the temporary MSIS Identification Number and the social security number.	N/A	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(9)	7	94	102	1. Value must be 9-digit number 2. For any individual, the value must be the same over all segment effective and end dates 3. (SSN State) if associated SSN Indicator (ELG.001.012) value is coded as "1", then value must equal MSIS Identification Number (ELG.002.019) value 4. Value can only be reported with one MSIS Identification Number (ELG.002.019) 5. Conditional 6. (Non-SSN State) if associated SSN Indicator (ELG.001.012) value is coded as "0", then value must not equal MSIS Identification Number (ELG.002.019)
ELG037	ELG.003.037	SSN-VERIFICATION-FLAG	SSN Verification Flag	Mandatory	A code describing whether the state has verified the social security number (SSN) with the Social Security Administration (SSA).	SSN-VERIFICATION-FLAG	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(1)	8	103	103	~~1.~~1. Value must be 1 character 2. Value must be in SSN Verification Flag List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory

ELG038	ELG.003.038	INCOME-CODE	Income Code	~~Mandatory~~Conditional	~~A code indicating the family income level.~~A code indicating the federal poverty level range in which the family income falls. If the beneficiary's income was assessed using multiple methodologies (MAGI and Non-MAGI), report the income that applies to their primary eligibility group. A beneficiary's income is applicable unless it is not required by the eligibility group for which they were determined eligible. For example, the eligibility groups for children with adoption assistance, foster care, or guardianship care under title IV-E and optional eligibility for individuals needing treatment for breast or cervical cancer do not have a Medicaid income test. Additionally, for individuals receiving SSI, states with section 1634 agreements with the Social Security Administration (SSA) and states that use SSI financial methodologies for Medicaid determinations do not conduct separate Medicaid financial eligibility for this group.	INCOME-CODE	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(2)	9	104	105	~~1.~~1. Value must be 2 characters 2. Value must be in Income Code List (VVL) ~~2. Value must be 2 characters~~ ~~3. Mandatory~~3. Conditional
ELG039	ELG.003.039	VETERAN-IND	Veteran Indicator	Conditional	A flag indicating if a non-citizen is exempt from the 5-year bar on benefits because they are a veteran or an active member of the military, naval or air service.	VETERAN-IND	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(1)	10	106	106	~~1.~~1. Value must be 1 character 2. Value must be in Veteran Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Conditional 4. Value must be populated when Immigration Status (ELG.003.042) is in [~~'1', '2', '3'~~1,2,3]

ELG040	ELG.003.040	CITIZENSHIP-IND	Citizenship Indicator	Mandatory	Indicates if the individual is identified as a U.S. Citizen.	CITIZENSHIP-IND	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(1)	11	107	107	~~1.~~1. Value must be 1 character 2. Value must be in [0,1,2] 3. Value must be in Citizenship Indicator List (VVL) ~~2~~4. If value ~~is coded as '0',~~equals "0", then associated Immigration Status (ELG.003.042) value must be in [1,2,~~3~~] 3] 5. If value is coded as ~~'~~"1~~'~~", then associated Immigration Status (ELG.003.042) value must equal ~~'8'~~ ~~4. Value must be 1 character~~ ~~5.~~"8" 6. Mandatory
ELG041	ELG.003.041	CITIZENSHIP-VERIFICATION-FLAG	Citizenship Verification Flag	Conditional	Indicates the individual is enrolled in Medicaid pending citizenship verification.	CITIZENSHIP-VERIFICATION-FLAG	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(1)	12	108	108	~~1.~~1. Value must be 1 character 2. Value must be in Citizenship Verification Flag List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Value must be populated when Citizenship Indicator (ELG.003.040) equals ~~'1'~~ ~~(Yes~~"1" (US Citizen) 4. Conditional
ELG042	ELG.003.042	IMMIGRATION-STATUS	Immigration Status	Mandatory	The immigration status of the individual.	IMMIGRATION-STATUS	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(1)	13	109	109	~~1.~~1. Value must be 1 character 2. Value must be in Immigration Status List (VVL) ~~2~~3. If associated Citizenship Indicator (ELG.003.040) value ~~is coded as '0',~~equals "0", then value must be in [1,2,~~3~~] 3] 4. If associated Citizenship Indicator (ELG.003.040) value ~~is coded as '1',~~equals "1", then value must equal ~~'8'~~ ~~4. Value must be 1 character~~ "8" 5. Mandatory

ELG043	ELG.003.043	IMMIGRATION-VERIFICATION-FLAG	Immigration Verification Flag	Conditional	Indicates the individual is enrolled in Medicaid pending immigration verification.	IMMIGRATION-VERIFICATION-FLAG	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(1)	14	110	110	~~1.~~1. Value must be 1 character 2. Value must be in Immigration Verification Flag List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Conditional
ELG044	ELG.003.044	IMMIGRATION-STATUS-FIVE-YEAR-BAR-END-DATE	Immigration Status Five Year Bar End Date	Conditional	The date the five-year bar for an individual ends. Section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) provides that certain immigrants who enter the United States on or after August 22, 1996 are not eligible to receive federally-funded benefits, including Medicaid and the State Children's Health Insurance Program (Separate CHIP), for five years from the date they enter the country with a status as a "qualified alien."	N/A	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	9(8)	15	111	118	1. ~~(U.S. Citizen) if associated Citizenship Indicator (ELG.003.040) value is '1', then value should not be populated~~The date must be a valid calendar date in the form "CCYYMMDD" 2. ~~(Non U.S. Citizen) if associated Citizenship Indicator (ELG.003.040) value is '0', then value should be populated~~ ~~3.~~ Conditional ~~4. (U.S. Citizen) value should not be populated when~~3. If Immigration Status (ELG.003.042) equals ~~'8'~~"8" (U.S. Citizen), then value should not be populated
ELG045	ELG.003.045	~~PRIMARY-LANGUAGE-~~ENGL-PROF-CODE	~~Primary Language~~ English Proficiency Code	Conditional	A code indicating the level of spoken English proficiency by the individual.	~~PRIMARY-LANGUAGE-~~ENGL-PROF-CODE	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(1)	16	119	119	~~1.~~1. Value must be 1 character 2. Value must be in Primary Language English Proficiency Code List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Conditional
ELG046	ELG.003.046	~~PRIMARY~~PREFERRED-LANGUAGE-CODE	Primary Language Code	Conditional	A code indicating the language that is the ~~individual speaks other than English at home~~individuals' preferred spoken or written language.	~~PRIMARY~~PREFERRED-LANGUAGE-CODE	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(3)	17	120	122	~~1.~~1. Value must be 3 characters 2. Value must be in Primary Language Code List (VVL) ~~2. Value must be 3 characters~~ ~~3.~~3. Conditional
ELG047	ELG.003.047	HOUSEHOLD-SIZE	Household Size	Mandatory	Household Size used in the Medicaid or CHIP eligibility determination process.	HOUSEHOLD-SIZE	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(2)	18	123	124	~~1.~~1. Value must be 2 characters 2. Value must be in Household Size List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory

ELG049	ELG.003.049	PREGNANCY-IND	Pregnancy Indicator	Conditional	A flag indicating the individual is pregnant at the time of application based on self-attestation.	PREGNANCY-IND	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(1)	19	125	125	~~1.~~1. Value must be 1 character 2. Value must be in Pregnancy Indicator List (VVL) ~~2. If value equals '1', then Sex (ELG.002.023) value must equal 'F"~~ ~~3. Value must be 1 character~~ ~~4.~~3. Conditional
ELG050	ELG.003.050	MEDICARE-HIC-NUM	Medicare HIC Number	Conditional	The Medicare HIC Number (HICN) is an identifier formerly used by SSA and CMS to identify all Medicare beneficiaries. For many beneficiaries, their SSN was a major component of their HICN. To prevent identify theft, among other reasons, HICN gradually were retired and replaced by the Medicare Beneficiary Identifier (MBI) over the course of 2018 and 2019. HICN continue to be used by Medicare for limited administrative purposes after 2019 but starting in 2020 the MBI became the primary identifier for Medicare beneficiaries. HICN consists of two components: SSN ~~&~~and alpha-suffix or (for Railroad IDs) prefix and ID (not always SSN based~~)~~).	N/A	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(12)	20	126	137	1. ~~Conditional~~ ~~2.~~ Value must be 12 characters or less 2. Conditional 3. Value must not contain a pipe or asterisk symbols 4. (Not Dual Eligible) if Dual Eligible Code (ELG.DE.085) value ~~=~~is "00", then value must not be populated. 5. (Medicare Enrolled) if associated Dual Eligible Code (ELG.005.085) value is in [~~"~~01~~",~~ ~~"~~¿02~~",~~ ~~"~~¿03~~",~~ ~~"~~¿04~~",~~ ~~"~~¿05~~",~~ ~~"~~¿06~~",~~ ~~"~~¿08~~",~~ ~~"~~¿09~~", or~~ ~~"~~¿10~~"~~], then value for either HICN or MBI is mandatory and must be provided

ELG051	ELG.003.051	MEDICARE-BENEFICIARY-IDENTIFIER	Medicare Beneficiary Identifier	Conditional	The Medicare Beneficiary Identifier (MBI) is a randomly generated identifier used to identify all Medicare beneficiaries. It replaced the previously-used SSN-based Medicare HIC Number (HICN). To prevent identify theft, among other reasons, HICN gradually were retired and replaced by the MBI over the course of 2018 and 2019. Starting in 2020, the MBI became the primary identifier for Medicare beneficiaries.	N/A	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(12)	21	138	149	1. Conditional 2. Value must be an 11-character string 3. Character 1 must be numeric values 1 thru 9 4. Character 2 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 5. Character 3 must be alphanumeric values 0 thru 9 or A thru Z (minus S,L,O,I,B,Z) 6. Character 4 must be numeric values 0 thru 9 7. Character 5 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 8. Character 6 must be alphanumeric values 0 thru 9 or A thru Z (minus S,L,O,I,B,Z) 9. Character 7 must be numeric values 0 thru 9 10. Character 8 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 11. Character 9 must be alphabetic values A thru Z (minus S,L,O,I,B,Z) 12. Character 10 must be numeric values 0 thru 9 13. Character 11 must be numeric values 0 thru 9 14. Value must not contain a pipe or asterisk symbols 15. When Dual Eligible Code (ELG.005.085) equals '00' and End of Time Period (ELG.001.010) greater than or equal to '2015-11-01', value should not be populated 16. (Medicare Enrolled) if associated Dual Eligible Code value (ELG.005.085) is in ["01", "02", "03", "04", "05", "06", "08", "09", or "10"], then the value for either HICN or MBI is mandatory and must be provided

ELG054	ELG.003.054	CHIP-CODE	CHIP Code	Mandatory	A code used to distinguish among Medicaid, Medicaid Expansion CHIP, and Separate CHIP populations.	CHIP-CODE	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(1)	22	150	150	1. Value must be in CHIP Code List (VVL) 2. If value is in [2,3], then associated Eligibility Group (ELG.005.087) value must be in [~~"~~07~~",~~ ~~",~~31~~",~~ ~~",~~61~~",~~ ~~",~~62~~",~~ ~~",~~63~~",~~ ~~",~~64~~",~~ ~~",~~65~~",~~ ~~",~~66~~",~~ ~~",~~67~~", or "~~,68~~"~~] 3. If value ~~is~~equals "1", then associated Eligibility Group (ELG.005.087) value must not be in [~~"~~61~~",~~ 62~~",~~ ~~",~~63~~",~~ ~~",~~64~~",~~ ~~",~~65~~",~~ ~~",~~66~~",~~ ~~",~~67~~", or "~~,68~~"~~] 4. Value must be 1 character 5. Mandatory
ELG057	ELG.003.057	VARIABLE-DEMOGRAPHIC-ELEMENT-EFF-DATE	Variable Demographic Element Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	9(8)	23	151	158	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~]19,20,99]\
ELG058	ELG.003.058	VARIABLE-DEMOGRAPHIC-ELEMENT-END-DATE	Variable Demographic Element End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	9(8)	24	159	166	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be greater than or equal to associated Segment Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~18,19,20,99]

ELG059	ELG.003.059	STATE-NOTATION	State Notation	~~Op~~Situati nal	A free text field for the submitting state to enter whatever information it chooses.	N/A	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	X(500)	~~25~~27	1~~6~~78	~~666~~677	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
ELG061	ELG.004.061	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	ELG00004	ELIGIBLE-CONTACT-INFORMATION	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00004"
ELG062	ELG.004.062	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	ELG00004	ELIGIBLE-CONTACT-INFORMATION	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
ELG063	ELG.004.063	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	ELG00004	ELIGIBLE-CONTACT-INFORMATION	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory

ELG064	ELG.004.064	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual ~~(except on service tracking payments).~~ . Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47572~~reporting-shared-msis-identification-numbers-eligibility/	N/A	ELG00004	ELIGIBLE-CONTACT-INFORMATION	X(20)	4	22	41	~~1. Mandatory~~ ~~2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN~~ ~~3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN~~ ~~4.~~1. Value must be 20 characters or less 2. Mandatory
ELG065	ELG.004.065	ELIGIBLE-ADDR-TYPE	Eligible Address Type	Mandatory	The type of address and contact information for the eligible submitted in the record segment.	ELIGIBLE-ADDR-TYPE	ELG00004	ELIGIBLE-CONTACT-INFORMATION	X(2)	5	42	43	~~1.~~1. Value must be 2 characters 2. Value must be in Eligible Address Type List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory
ELG066	ELG.004.066	ELIGIBLE-ADDR-LN1	Eligible Address Line 1	Mandatory	The first line of a potentially multi-line physical street or mailing address for a given entity (e.g. person, organization, agency, etc.).	N/A	ELG00004	ELIGIBLE-CONTACT-INFORMATION	X(60)	6	44	103	1. Value must be 60 characters or less 2. Value must not be equal to associated Address Line 2 or Address Line 3 value(s) 3. Value must not contain a pipe or asterisk symbols 4. ~~When populated, the associated Address Type is required~~ ~~5. Mandatory~~Mandatory

ELG067	ELG.004.067	ELIGIBLE-ADDR-LN2	Eligible Address Line 2	Conditional	The second line of a multi-line physical street or mailing address for a given entity (e.g. person, organization, agency, etc.).	N/A	ELG00004	ELIGIBLE-CONTACT-INFORMATION	X(60)	7	104	163	1. Value must be 60 characters or less 2. Value must not be equal to associated Address Line 1 or Address Line 3 value(s) 3. There must be an Address Line 1 in order to have an Address Line 2 4. Value must not contain a pipe or asterisk symbols 5. Conditional
ELG068	ELG.004.068	ELIGIBLE-ADDR-LN3	Eligible Address Line 3	Conditional	The third line of a multi-line physical street or mailing address for a given entity (e.g. person, organization, agency, etc.).	N/A	ELG00004	ELIGIBLE-CONTACT-INFORMATION	X(60)	8	164	223	1. Value must be 60 characters or less 2. Value must not be equal to associated Address Line 1 or Address Line 2 value(s) 3. If Address Line 2 is not populated, then value should not be populated 4. Value must not contain a pipe or asterisk symbols 5. Conditional
ELG069	ELG.004.069	ELIGIBLE-CITY	Eligible City	Mandatory	The city component of an address associated with a given entity (e.g. person, organization, agency, etc.).	N/A	ELG00004	ELIGIBLE-CONTACT-INFORMATION	X(28)	9	224	251	1. Value must be 28 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
ELG070	ELG.004.070	ELIGIBLE-STATE	Eligible State	Mandatory	The ANSI state numeric code for the U.S. state, Territory, or the District of Columbia code for where the individual eligible to receive healthcare services resides. (The state for the type of address indicated in Address Type.)	STATE	ELG00004	ELIGIBLE-CONTACT-INFORMATION	X(2)	10	252	253	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ 3. Mandatory
ELG071	ELG.004.071	ELIGIBLE-ZIP-CODE	Eligible ZIP Code	Mandatory	U.S. ZIP Code component of an address associated with a given entity (e.g. person, organization, agency, etc.)	ZIP-CODE	ELG00004	ELIGIBLE-CONTACT-INFORMATION	X(9)	11	254	262	1. Value may only be 5 digits (0-9) (Example: 91320) or 9 digits (0-9) (Example: 913200011) 2. Value must be in ZIP Code List (VVL) 3. Mandatory
ELG072	ELG.004.072	ELIGIBLE-COUNTY-CODE	Eligible County Code	Mandatory	Standard ANSI code used to identify a specific U.S. County.	COUNTY	ELG00004	ELIGIBLE-CONTACT-INFORMATION	X(3)	12	263	265	~~1.~~1. Value must be 3 characters 2. Value must be in US County Code List (VVL) ~~2. Value must be 3 characters~~ ~~3.~~3. Mandatory

ELG073	ELG.004.073	ELIGIBLE-PHONE-NUM	Eligible Phone Number	~~Op~~Conditional	Phone number for a given entity (e.g. person, organization, agency).	N/A	ELG00004	ELIGIBLE-CONTACT-INFORMATION	X(10)	13	266	275	1. Value must be 10 ~~characters, digits (0-9) only~~ digit number 2. ~~Op~~Conditional
ELG074	ELG.004.074	TYPE-OF-LIVING-ARRANGEMENT	Type Of Living Arrangement	Conditional	A free-form text field to describe the type of living arrangement used for the eligibility determination process. ~~The field will remain a free-form text data element until MACPro develops a list of valid values. When it becomes available, T-MSIS will align with MACPro valid value lists.~~	N/A	ELG00004	ELIGIBLE-CONTACT-INFORMATION	X(100)	14	276	375	1. Value must not contain a pipe or asterisk symbol 2. Value must be 100 characters or less 3. Conditional
ELG075	ELG.004.075	ELIGIBLE-ADDR-EFF-DATE	Eligible Address Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00004	ELIGIBLE-CONTACT-INFORMATION	9(8)	15	376	383	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~19,20,99]
ELG076	ELG.004.076	ELIGIBLE-ADDR-END-DATE	Eligible Address End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00004	ELIGIBLE-CONTACT-INFORMATION	9(8)	16	384	391	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on~~ in the form "CCYYMMDD" 2. Value must be after or the ~~leap year, never April 31st or Sept 31st)~~ ~~3. Value must be greater than or equal to~~ same as the associated Segment Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~19,20,99]
ELG077	ELG.004.077	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	ELG00004	ELIGIBLE-CONTACT-INFORMATION	X(500)	17	392	891	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk

													symbols 3. ~~Op~~Situational
ELG079	ELG.005.079	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	ELG00005	ELIGIBILITY-DETERMINANTS	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~ 3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00005"
ELG080	ELG.005.080	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	ELG00005	ELIGIBILITY-DETERMINANTS	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
ELG081	ELG.005.081	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	ELG00005	ELIGIBILITY-DETERMINANTS	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory

ELG082	ELG.005.082	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual ~~(except on service tracking payments).~~ . Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47572~~reporting-shared-msis-identification-numbers-eligibility/	N/A	ELG00005	ELIGIBILITY-DETERMINANTS	X(20)	4	22	41	~~1. Mandatory~~ ~~2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN~~ ~~3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN~~ ~~4.~~1. Value must be 20 characters or less 2. Mandatory
ELG083	ELG.005.083	MSIS-CASE-NUM	MSIS Case Num	Mandatory	The state-assigned number which uniquely identifies the Medicaid case to which the enrollee belongs. The definition of a case varies. There are single-person cases (mostly aged and blind/disabled) and multi-person cases (mostly TANF) in which all members of the case have the same case number, but a unique identification number. A warning for longitudinal research efforts: a case numbers associated with an individual may change over time.	N/A	ELG00005	ELIGIBILITY-DETERMINANTS	X(12)	5	42	53	~~1.~~1. Value must be 12 characters or less 2. Value must not contain a pipe symbol ~~2. Value must be 12 characters or less~~ 3. Mandatory
~~ELG084~~	~~ELG.005.084~~	~~MEDICAID-BASIS-OF-ELIGIBILITY~~	~~Medicaid Basis Of Eligibility~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~ELG00005~~	~~ELIGIBILITY-DETERMINANTS~~	~~X(2)~~	~~6~~	~~54~~	~~55~~	~~1. Not Applicable~~

ELG085	ELG.005.085	DUAL-ELIGIBLE-CODE	Dual Eligible Code	~~Conditional~~ Mandatory	Indicates coverage for individuals entitled to Medicare (Part A and/or B benefits) and eligible for some category of Medicaid benefits.	DUAL-ELIGIBLE-CODE	ELG00005	ELIGIBILITY-DETERMINANTS	X(2)	~~7~~6	~~56~~54	~~57~~55	~~1. Mandatory~~ ~~2. Value must be 8 characters in the form "CCYYMMDD"~~ ~~3. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~4. Value must be before or the same as the associated Segment End Date value~~ ~~5. Mandatory~~ ~~6. Value of the CC component must be in ['18', '19', '20']~~ ~~7. Value must be 8 characters in the form "CCYYMMDD"~~ ~~8. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~9. Value must be greater than or equal to associated Segment Effective Date value~~ ~~10. Mandatory~~ ~~11. Value of the CC component must be in ['18', '19', '20', '99']~~ ~~12. Value must not contain a pipe or asterisk symbol~~ ~~13. Value must be 100 characters or less~~1. Value must be 2 characters 2. Value must be in Dual Eligible Code List (VVL) 3. If value equals "05", then Eligibility Group (ELG.005.087) must be "24" 4. If value equals "06", then Eligibility Group (ELG.005.087) must be "26" 5. If Dual Eligible Code (ELG.005.085) is in [01,02,03,04,05,06,08,09,10], then Primary Eligibility Group Indicator (ELG.005.086) must be "1" (Yes) 6. Mandatory 7. A partial dual eligible (values="01", "03", "05" or "06") then Restricted Benefits Code (ELG.005.097) must be "3"

													8. (Not Dual Eligible) if value = "00", then associated Medicare Beneficiary Identifier (ELG.003.051) value must not be populated. 9. Value must be 2 characters 10. If value is in [08,10] then Restricted Benefits Code (ELG.005.097) must be "1" 11. If value equals "09", then Eligibility Group (ELG.005.087) and Restricted Benefits Code (ELG.005.097) must not be populated 12. If value equals "10", then CHIP Code (ELG.003.054) must be "03" (S-CHIP) and Medicare Beneficiary Identifier (ELG.003.051) must be populated 13. If value equals "01", then Eligibility Group (ELG.005.087) must be "23" 14. If value equals "03", then Eligibility Group (ELG.005.087) must be "25"

ELG086	ELG.005.086	PRIMARY-ELIGIBILITY-GROUP-IND	Primary Eligibility Group Indicator	Mandatory	~~A flag indicating the eligibility record is the primary eligibility in cases where there are multiple eligibility records submitted with overlapping or concurrent eligibility determinant effective and end dates.~~A flag indicating the eligibility record is the primary eligibility in cases where there are multiple eligibility records submitted with overlapping or concurrent eligibility determinant effective and end dates. It is expected that an enrollees' eligibility group assignment (ELG087 - ELIGIBILITY-GROUP) will change over time as his/her situation changes. Whenever the eligibility group assignment changes (i.e., ELG087 has a different value), a separate ELIGIBILITY-DETERMINANTS record segment must be created. In such situations, there would be multiple ELIGIBILITY-DETERMINANTS record segments, each covering a different effective time span. In such situations, the value in ELG087 would be the primary eligibility group for the effective date span of its respective ELIGIBILITY-DETERMINANTS record segment, and the PRIMARY-ELIGIBILITY-GROUP-IND data element on each of these segments would be set to '1' (YES). Should a situation arise where a Medicaid/CHIP enrollee has been assigned both a primary and one or more secondary eligibility groups, there would be two or more ELIGIBILITY-DETERMINANTS record segments with overlapping effective time spans - one segment containing the primary eligibility group and the other(s) for the secondary eligibility group(s). To differentiate the primary eligibility group from the secondary group(s), only one segment should be assigned as the primary group using PRIMARY-ELIGIBILITY-GROUP-IND = 1; the others	PRIMARY-ELIGIBILITY-GROUP-IND	ELG00005	ELIGIBILITY-DETERMINANTS	X(1)	~~8~~7	~~58~~56	~~58~~56	~~1.~~1. Value must be 1 character 2. Value must be in Primary Eligibility Group Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory

					should be assigned PRIMARY-ELIGIBILITY-GROUP-IND = 0.									

ELG087	ELG.005.087	ELIGIBILITY-GROUP	Eligibility Group	Conditional	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).	ELIGIBILITY-GROUP	ELG00005	ELIGIBILITY-DETERMINANTS	X(2)	~~9~~8	~~59~~57	~~60~~58	~~1.~~1. Value must be 2 characters 2. Value must be in Eligibility Group List (VVL) ~~2~~3. If value is "26", then Dual Eligible Code value must be "06" ~~3~~4. Conditional ~~4~~5. Value is mandatory and must be provided when associated Eligibility Determinant Effective Date value is on or after 1 January, 2014. ~~5~~6. If value is in [~~"~~72~~",~~ ~~"~~,73~~",~~ ~~"~~,74~~",~~ ~~"~~,75~~"~~], then associated Restricted Benefits Code value must ~~equal "~~be in [1,7~~"~~] and State Plan Option Type must equal "06" ~~6~~7. If associated CHIP Code value ~~is~~equals "2", then value must be in [~~"~~07~~",~~ ~~"~~,31~~",~~ ~~"~~,61~~"~~] ~~7~~8. If associated CHIP Code value ~~is~~equals "3", then value must be in [~~"~~61~~",~~ ~~"~~,62~~",~~ ~~"~~,63~~",~~ ~~"~~,64~~",~~ ~~"~~,65~~",~~ ~~"~~,66~~",~~ ~~"~~,67~~",~~ ~~"~~,68~~"~~] ~~8. Value must be 2 characters~~ ~~9.~~] 9. If value is "23", then Dual Eligible Code value must be in ~~[~~"[01~~",~~ ~~"~~,02~~"~~]~~]~~ 10. If value is "25", then Dual Eligible Code value must be in ~~[~~"[03~~",~~ ~~"~~,04~~"~~]~~]~~ 11. If value is "24", then Dual Eligible Code value must be "05"
ELG088	ELG.005.088	LEVEL-OF-CARE-STATUS	Level Of Care Status	~~Conditional~~ Mandatory	The level of care required to meet an individual's needs and to determine LTSS program eligibility.	LEVEL-OF-CARE-STATUS	ELG00005	ELIGIBILITY-DETERMINANTS	X(3)	~~10~~9	~~61~~59	~~63~~61	~~1.~~1. Value must be 3 characters 2. Value must be in Level of Care Status List (VVL) ~~2. Value must be 3 characters~~ ~~3. Conditional~~3. Mandatory
ELG089	ELG.005.089	SSDI-IND	SSDI Indicator	Conditional	A flag indicating if the individual is enrolled in Social Security Disability Insurance (SSDI) administered via the Social Security Administration (SSA).	SSDI-IND	ELG00005	ELIGIBILITY-DETERMINANTS	X(1)	~~11~~10	~~64~~62	~~64~~62	~~1.~~1. Value must be 1 character 2. Value must be in SSDI Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Conditional

ELG090	ELG.005.090	SSI-IND	SSI Indicator	Conditional	A flag indicating if the individual receives Supplemental Security Income (SSI) administered via the Social Security Administration (SSA).	SSI-IND	ELG00005	ELIGIBILITY-DETERMINANTS	X(1)	~~12~~11	~~65~~63	~~65~~63	~~1.~~1. Value must be 1 character 2. Value must be in SSI Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Conditional 4. Value must equal ~~'0'~~"0" when SSI status (ELG.005.092) equals ~~'003'~~"000" or "003" or is not populated 5. Value must equal "1" when SSI status (ELG.005.092) equals "001" or "002"
ELG091	ELG.005.091	SSI-STATE-SUPPLEMENT-STATUS-CODE	SSI State Supplement Status Code	Conditional	Indicates the individual's State Supplemental Income Status.	SSI-STATE-SUPPLEMENT-STATUS-CODE	ELG00005	ELIGIBILITY-DETERMINANTS	X(3)	~~13~~12	~~66~~64	~~68~~66	~~1.~~1. Value must be 3 characters 2. Value must be in SSI State Supplement Status Code List (VVL) ~~2~~3. (individual not receiving Federal SSI) If ~~SSI State Supplemental Status Code~~value is "001" or "002", then SSI Status ~~cannot~~(ELG.005.092) must be "00~~0~~1" or "~~003~~" ~~3. Value must be 3 characters~~ 002" 4. ~~Conditional~~(Individual not receiving Federal SSI)If value is "001" or "002", then SSI Indicator (ELG.005.090) must be "1" 5. Value must not be populated or must be "000" when SSI Status (ELG.005.092) is not populated or is "000" 6. Conditional
ELG092	ELG.005.092	SSI-STATUS	SSI Status	Conditional	Indicates the individual's SSI Status.	SSI-STATUS	ELG00005	ELIGIBILITY-DETERMINANTS	X(3)	~~14~~13	~~69~~67	~~71~~69	~~1.~~1. Value must be 3 characters 2. Value must be in SSI Status List (VVL) ~~2. Value must be 3 characters~~ 3. Conditional 4. ~~Value must be populated when~~When value is "001" or "002", then SSI Indicator ~~equals '1'~~must be "1" 5. When value is "000" or "003" or not populate, then SSI Indicator must be "0"

ELG093	ELG.005.093	STATE-SPEC-ELIG-GROUP	State Specific Eligibility Group	Mandatory	The composite of eligibility mapping factors used to create the corresponding Maintenance Assistance Status (MAS) and Basis of Eligibility (BOE) values (before January 1, 2014) and Eligibility -Group values (on or after January 1, 2014). 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 or Eligibility Group algorithm (e.g., age information computed from Date of Birth or County Code).	N/A	ELG00005	ELIGIBILITY-DETERMINANTS	X(6)	~~15~~14	~~72~~70	~~77~~75	~~1. If value is in the range [000000 .. 999999], then associated Date of Death value must not be before the start of the reporting period.~~ ~~2.~~1. Value must be 6 characters or less ~~3~~2. Mandatory
ELG094	ELG.005.094	CONCEPTION-TO-BIRTH-IND	Conception To Birth Indicator	Conditional	A flag to identify children eligible through the conception to birth option, which is available only through a separate State CHIP Program.	CONCEPTION-TO-BIRTH-IND	ELG00005	ELIGIBILITY-DETERMINANTS	X(1)	~~16~~15	~~78~~76	~~78~~76	~~1.~~1. Value must be 1 character 2. Value must be in Conception to Birth Indicator List (VVL) ~~2~~3. If the value is equal to "1", then the Eligibility Group (ELG.005.087) must equal "64" ~~3~~4. If the value is equal to "1", then any associated claims must indicate the Program Type ~~='14'~~equals "14" (State Plan CHIP) ~~4~~5. If the value is equal to "1", then CHIP Code (ELG.003.054) must equal "3" (Individual was not Medicaid Expansion CHIP eligible, but was included in a separate title XXI CHIP Program ~~5. Value must be 1 character)~~ 6. Conditional

ELG095	ELG.005.095	ELIGIBILITY-~~CHANGE~~TERMINATION-REASON	Eligibility ~~Change~~Termination Reason	Conditional	~~The reason for a change in an individual's eligibility status. Report this reason when there is a change in the individual's eligibility status.~~The reason for a complete loss/termination in an individual's eligibility for Medicaid and CHIP. The end date of the segment in which the value is reported must represent the date that the complete loss/termination of Medicaid and CHIP eligibility occurred. The reason for the termination represents the reason that the segment in which it was reported was closed. If for a single termination in eligibility for a single individual there are multiple distinct co-occurring values in the state's system explaining the reason for the termination, and if one of the multiple co-occurring values maps to T-MSIS ELIGIBILITY-CHANGE-REASON value '21'; (Other) '22'; (Unknown), then the state should not report the co-occurring value '21'; and/or '22'; to T-MSIS. If there are multiple co-occurring distinct values between '01'; and '19', then the state should choose whichever is first in the state's system. Of the values that could logically co-occur in the range of '01'; through '19', CMS does not currently have a preference for any one value over another. Do not populate if at the time someone loses Medicaid eligibility they become eligible for and enrolled in CHIP. Also do not populate if at the time someone loses CHIP eligibility they become eligible for and enrolled in Medicaid.	ELIGIBILITY-~~CHANGE~~TERMINATION-REASON	ELG00005	ELIGIBILITY-DETERMINANTS	X(2)	~~17~~16	~~79~~77	~~80~~78	~~1.~~1. Value must be 2 characters 2. Value must be in Eligibility Change Reason List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional
~~ELG096~~	~~ELG.005.096~~	~~MAINTENANCE-ASSISTANCE-STATUS~~	~~Maintenance Assistance Status~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~ELG00005~~	~~ELIGIBILITY-DETERMINANTS~~	~~X(1)~~	~~18~~	~~81~~	~~81~~	~~1. Not Applicable~~

ELG097	ELG.005.097	RESTRICTED-BENEFITS-CODE	Restricted Benefits Code	Mandatory	A flag that indicates the scope of Medicaid or CHIP benefits to which an individual is entitled to.	RESTRICTED-BENEFITS-CODE	ELG00005	ELIGIBILITY-DETERMINANTS	X(1)	~~19~~17	~~82~~79	~~82~~79	~~1.~~1. Value must be 1 character 2. Value must be in Restricted Benefits Code List (VVL) ~~2~~3. (Restricted Benefits) if value ~~is~~equals "3" and Dual Eligible Code (ELG.005.085) value ~~is~~equals "05", then Eligibility Group (ELG.005.087) must be "24" 4. (Restricted Benefits) if value equals "3" and Dual Eligible Code (ELG.005.085) value equals "06", then Eligibility Group (ELG.005.087) must be "26" ~~3~~5. (Restricted Benefits) if value ~~is~~equals "1" and Dual Eligible Code (ELG.005.085) value ~~is~~equals "02", then Eligibility Group (ELG.005.087) must be "23" ~~4~~6. (Restricted Benefits) if value ~~is~~equals "1" and Dual Eligible Code (ELG.005.085) value ~~is~~equals "04", then Eligibility Group (ELG.005.087) must be "25" ~~5~~7. (Restricted Benefits) if value ~~is~~equals "3", then Dual Eligible Code (ELG.005.085) cannot be "00" ~~6~~8. Mandatory ~~7. If value is populated, then Eligibility Group (ELG.005.087) must be populated.~~ ~~8.~~9. If value is "6" then Eligibility ~~-~~ Group(ELG.DE.087) must be in ~~("~~[35~~",",~~70~~")" 9.~~] 10. If value is in [1,7] then Eligibility Group (EGL.DE.087) must be in [72,73,74,75] and State Plan Option Type (ELG.DE.163) must equal "06" 11. (Restricted Pregnancy-Related) if value ~~is~~equals "4", then associated Sex (ELG.002.023) value must be ~~'F'~~ ~~10~~"F" 12. (Non-Citizen) if value ~~is~~equals "2", then

													associated Citizenship Indicator (ELG.003.040) value must not be equal to "1" ~~11~~13. If value is "D", there must be a corresponding MFP enrollment segment (ELG00010) with Effective and End dates that are within the timespan of this segment ~~12. Value must be 1 character~~ ~~13.~~14. (Restricted Benefits) if value ~~is~~equals "3" and Dual Eligible Code (ELG.005.085) value ~~is~~equals "01", then Eligibility Group (ELG.005.087) must be "23" ~~14~~15. (Restricted Benefits) if value ~~is~~equals "3" and Dual Eligible Code (ELG.005.085) value ~~is~~equals "03", then Eligibility Group (ELG.005.087) must be "25" ~~15~~16. (Restricted Benefits) if value is "~~3~~" and~~G~~", then Dual Eligible Code (ELG.005.085) ~~value is "05", then Eligibility Group (ELG.005.087)~~ must be "~~24~~"in [01,03,06]
ELG098	ELG.005.098	TANF-CASH-CODE	TANF Cash Code	Conditional	A flag that indicates whether the individual received Federal Temporary Assistance for Needy Families (TANF) benefits.	TANF-CASH-CODE	ELG00005	ELIGIBILITY-DETERMINANTS	X(1)	~~20~~18	~~83~~80	~~83~~80	~~1.~~1. Value must be 1 character 2. Value must be in TANF Cash Code List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Conditional

ELG099	ELG.005.099	ELIGIBILITY-DETERMINANT-EFF-DATE	Eligibility Determinant Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00005	ELIGIBILITY-DETERMINANTS	9(8)	~~21~~19	~~84~~81	~~91~~88	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~19,20,99]
ELG100	ELG.005.100	ELIGIBILITY-DETERMINANT-END-DATE	Eligibility Determinant End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00005	ELIGIBILITY-DETERMINANTS	9(8)	~~22~~20	~~92~~89	~~99~~96	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on~~ in the form "CCYYMMDD" 2. Value must be after or the ~~leap year, never April 31st or Sept 31st)~~ ~~3. Value must be greater than or equal to~~ same as the associated Segment Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~19,20,99]
ELG101	ELG.005.101	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	ELG00005	ELIGIBILITY-DETERMINANTS	X(500)	~~23~~29	~~100~~363	~~599~~862	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational

ELG103	ELG.006.103	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	ELG00006	HEALTH-HOME-SPA-PARTICIPATION-INFORMATION	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00006"
ELG104	ELG.006.104	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	ELG00006	HEALTH-HOME-SPA-PARTICIPATION-INFORMATION	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
ELG105	ELG.006.105	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	ELG00006	HEALTH-HOME-SPA-PARTICIPATION-INFORMATION	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory

ELG106	ELG.006.106	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual ~~(except on service tracking payments).~~ . Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47572~~reporting-shared-msis-identification-numbers-eligibility/	N/A	ELG00006	HEALTH-HOME-SPA-PARTICIPATION-INFORMATION	X(20)	4	22	41	~~1. Mandatory~~ ~~2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN~~ ~~3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN~~ ~~4.~~1. Value must be 20 characters or less 2. Mandatory
ELG107	ELG.006.107	HEALTH-HOME-SPA-NAME	Health Home SPA Name	Mandatory	A free-form text field for the name of the health home program approved by CMS. This name needs to be consistent across files to be used for linking.	N/A	ELG00006	HEALTH-HOME-SPA-PARTICIPATION-INFORMATION	X(100)	5	42	141	1. Value must be 100 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
ELG108	ELG.006.108	HEALTH-HOME-ENTITY-NAME	Health Home Entity Name	Mandatory	A field to identify the health home SPA in which an individual is enrolled. Because an identification numbering schema has not been established, the entities' names are being used instead.	N/A	ELG00006	HEALTH-HOME-SPA-PARTICIPATION-INFORMATION	X(100)	6	142	241	~~1.~~ 1. Value must not contain a pipe or asterisk symbols 2. Value must 100 characters or less ~~2. Value must not contain a pipe symbol~~ 3. Mandatory

ELG109	ELG.006.109	HEALTH-HOME-SPA-PARTICIPATION-EFF-DATE	Health Home SPA Participation Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00006	HEALTH-HOME-SPA-PARTICIPATION-INFORMATION	9(8)	7	242	249	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~19,20,99]
ELG110	ELG.006.110	HEALTH-HOME-SPA-PARTICIPATION-END-DATE	Health Home SPA Participation End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00006	HEALTH-HOME-SPA-PARTICIPATION-INFORMATION	9(8)	8	250	257	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on~~ in the form "CCYYMMDD" 2. Value must be after or the ~~leap year, never April 31st or Sept 31st)~~ ~~3. Value must be greater than or equal to~~ same as the associated Segment Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~19,20,99]
ELG111	ELG.006.111	HEALTH-HOME-ENTITY-EFF-DATE	Health Home Entity Effective Date	~~Not Applicable~~ Mandatory	The date on which the health home entity was approved by CMS to participate in the Health Home Program.	N/A	ELG00006	HEALTH-HOME-SPA-PARTICIPATION-INFORMATION	9(8)	9	258	265	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~in the form "CCYYMMDD" 2. Mandatory
ELG112	ELG.006.112	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	ELG00006	HEALTH-HOME-SPA-PARTICIPATION-INFORMATION	X(500)	10	266	765	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational

ELG114	ELG.007.114	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	ELG00007	HEALTH-HOME-SPA-PROVIDERS	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00007"
ELG115	ELG.007.115	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	ELG00007	HEALTH-HOME-SPA-PROVIDERS	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
ELG116	ELG.007.116	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	ELG00007	HEALTH-HOME-SPA-PROVIDERS	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory

ELG117	ELG.007.117	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual ~~(except on service tracking payments).~~ . Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47572~~reporting-shared-msis-identification-numbers-eligibility/	N/A	ELG00007	HEALTH-HOME-SPA-PROVIDERS	X(20)	4	22	41	~~1. Mandatory~~ ~~2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN~~ ~~3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN~~ ~~4.~~1. Value must be 20 characters or less 2. Mandatory
ELG118	ELG.007.118	HEALTH-HOME-SPA-NAME	Health Home SPA Name	Mandatory	A free-form text field for the name of the health home program approved by CMS. This name needs to be consistent across files to be used for linking.	N/A	ELG00007	HEALTH-HOME-SPA-PROVIDERS	X(100)	5	42	141	1. Value must be 100 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
ELG119	ELG.007.119	HEALTH-HOME-ENTITY-NAME	Health Home Entity Name	Mandatory	A field to identify the health home SPA in which an individual is enrolled. Because an identification numbering schema has not been established, the entities' names are being used instead.	N/A	ELG00007	HEALTH-HOME-SPA-PROVIDERS	X(100)	6	142	241	~~1.~~1. Value must not contain a pipe or asterisk symbols 2. Value must 100 characters or less ~~2. Value must not contain a pipe symbol~~ 3. Mandatory
ELG120	ELG.007.120	HEALTH-HOME-PROV-NUM	Health Home Provider Number	Mandatory	The State-specific Medicaid Provider Identifier is a state-assigned unique identifier that states should report with all individual providers, practice groups, facilities, and other entities. This should be the identifier that is used in the	N/A	ELG00007	HEALTH-HOME-SPA-PROVIDERS	X(30)	7	242	271	1. Value must be 30 characters or less 2. ~~Value must be reported in Provider Identifier (PRV.005.080) with an associated Provider Identifier Type (PRV.005.081) equal to '1'~~ ~~3.~~ Value must match Provider Identifier

					state's Medicaid Management Information System.								(PRV.005.081) ~~4~~3. Mandatory
ELG121	ELG.007.121	HEALTH-HOME-SPA-PROVIDER-EFF-DATE	Health Home SPA Provider Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00007	HEALTH-HOME-SPA-PROVIDERS	9(8)	8	272	279	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~19,20,99]
ELG122	ELG.007.122	HEALTH-HOME-SPA-PROVIDER-END-DATE	Health Home Spa Provider End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00007	HEALTH-HOME-SPA-PROVIDERS	9(8)	9	280	287	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on~~ in the form "CCYYMMDD" 2. Value must be after or the ~~leap year, never April 31st or Sept 31st)~~ ~~3. Value must be greater than or equal to~~ same as the associated Segment Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~19,20,99]
ELG123	ELG.007.123	HEALTH-HOME-ENTITY-EFF-DATE	Health Home Entity Effective Date	Mandatory	The date on which the health home entity was approved by CMS to participate in the Health Home Program.	N/A	ELG00007	HEALTH-HOME-SPA-PROVIDERS	9(8)	10	288	295	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Mandatory

ELG124	ELG.007.124	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	ELG00007	HEALTH-HOME-SPA-PROVIDERS	X(500)	11	296	795	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
ELG126	ELG.008.126	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	ELG00008	HEALTH-HOME-CHRONIC-CONDITIONS	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00008"
ELG127	ELG.008.127	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	ELG00008	HEALTH-HOME-CHRONIC-CONDITIONS	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
ELG128	ELG.008.128	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	ELG00008	HEALTH-HOME-CHRONIC-CONDITIONS	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory

ELG129	ELG.008.129	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual ~~(except on service tracking payments).~~ . Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47572~~reporting-shared-msis-identification-numbers-eligibility/	N/A	ELG00008	HEALTH-HOME-CHRONIC-CONDITIONS	X(20)	4	22	41	~~1. Mandatory~~ ~~2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN~~ ~~3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN~~ ~~4.~~1. Value must be 20 characters or less 2. Mandatory
ELG130	ELG.008.130	HEALTH-HOME-CHRONIC-CONDITION	Health Home Chronic Condition	Mandatory	The chronic condition used to determine the individual's eligibility for the health home provision.	HEALTH-HOME-CHRONIC-CONDITION	ELG00008	HEALTH-HOME-CHRONIC-CONDITIONS	X(1)	5	42	42	~~1.~~1. Value must be 1 character 2. Value must be in Health Home Chronic Condition List (VVL) ~~2~~3. If value equals "H~~,~~", associated Health Home Chronic Condition Other Explanation must be provided ~~3. Value must be 1 character~~ ~~4.~~4. Mandatory
ELG131	ELG.008.131	HEALTH-HOME-CHRONIC-CONDITION-OTHER-EXPLANATION	Health Home Chronic Condition Other Explanation	Conditional	A free-text field to capture the description of the other chronic condition (or conditions) when value "H" (Other) appears in the Health~~-HOME-CHRONIC-CONDITION.~~ Home Chronic Condition data element.	N/A	ELG00008	HEALTH-HOME-CHRONIC-CONDITIONS	X(50)	6	43	92	1. Value must be 50 characters or less 2. If associated Health Home Chronic Condition (ELG.008.130) value equals "H", the~~n~~ value ~~is mandatory and~~ must be ~~provided~~populated 3. Value must not contain a pipe or asterisk

													symbols 4. Conditional
ELG132	ELG.008.132	HEALTH-HOME-CHRONIC-CONDITION-EFF-DATE	Health Home Chronic Condition Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00008	HEALTH-HOME-CHRONIC-CONDITIONS	9(8)	7	93	100	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in ['~~18', '19', '20~~'19,20,99]
ELG133	ELG.008.133	HEALTH-HOME-CHRONIC-CONDITION-END-DATE	Health Home Chronic Condition End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00008	HEALTH-HOME-CHRONIC-CONDITIONS	9(8)	8	101	108	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on~~ in the form "CCYYMMDD" 2. Value must be after or the ~~leap year, never April 31st or Sept 31st)~~ ~~3. Value must be greater than or equal to~~ same as the associated Segment Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in ['~~18', '19', '20', '99~~'19,20,99]
ELG134	ELG.008.134	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	ELG00008	HEALTH-HOME-CHRONIC-CONDITIONS	X(500)	9	109	608	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational

ELG136	ELG.009.136	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	ELG00009	LOCK-IN-INFORMATION	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00009"
ELG137	ELG.009.137	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	ELG00009	LOCK-IN-INFORMATION	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
ELG138	ELG.009.138	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	ELG00009	LOCK-IN-INFORMATION	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory

ELG139	ELG.009.139	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual ~~(except on service tracking payments).~~ . Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47572~~reporting-shared-msis-identification-numbers-eligibility/	N/A	ELG00009	LOCK-IN-INFORMATION	X(20)	4	22	41	~~1. Mandatory~~ ~~2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN~~ ~~3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN~~ ~~4.~~1. Value must be 20 characters or less 2. Mandatory
ELG140	ELG.009.140	LOCKIN-PROV-NUM	Lockin Provider Num	Mandatory	The State-specific Medicaid Provider Identifier is a state-assigned unique identifier that states should report with all individual providers, practice groups, facilities, and other entities. This should be the identifier that is used in the state's Medicaid Management Information System.	N/A	ELG00009	LOCK-IN-INFORMATION	X(30)	5	42	71	1. Value must be 30 characters or less 2. ~~Value must be reported in Provider Identifier (PRV.005.080) with an associated Provider Identifier Type (PRV.005.081) equal to '1'~~ ~~3.~~ Mandatory ~~4. Value must match Provider Identifier (PRV.005.081)~~
ELG141	ELG.009.141	LOCKIN-PROV-TYPE	Lockin Provider Type	Mandatory	A code describing the provider type classification for which the provider/beneficiary lock-in relationship exists.	PROV-TYPE	ELG00009	LOCK-IN-INFORMATION	X(2)	6	72	73	1. Value must be 2 characters 2. Value must be in ~~Lockin~~ Provider Type Code List (VVL) ~~2. Value must be 2 characters~~ 3. Mandatory

ELG142	ELG.009.142	LOCKIN-EFF-DATE	Lockin Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00009	LOCK-IN-INFORMATION	9(8)	7	74	81	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~19,20,99]
ELG143	ELG.009.143	LOCKIN-END-DATE	Lockin End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00009	LOCK-IN-INFORMATION	9(8)	8	82	89	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on~~ in the form "CCYYMMDD" 2. Value must be after or the ~~leap year, never April 31st or Sept 31st)~~ ~~3. Value must be greater than or equal to~~ same as the associated Segment Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~19,20,99]
ELG144	ELG.009.144	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	ELG00009	LOCK-IN-INFORMATION	X(500)	~~9~~10	~~90~~93	5~~8~~92	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational

ELG146	ELG.010.146	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	ELG00010	MFP-INFORMATION	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00010"
ELG147	ELG.010.147	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	ELG00010	MFP-INFORMATION	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
ELG148	ELG.010.148	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	ELG00010	MFP-INFORMATION	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory

ELG149	ELG.010.149	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual ~~(except on service tracking payments).~~ . Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47572~~reporting-shared-msis-identification-numbers-eligibility/	N/A	ELG00010	MFP-INFORMATION	X(20)	4	22	41	~~1. Mandatory~~ ~~2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN~~ ~~3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN~~ ~~4.~~1. Value must be 20 characters or less 2. Mandatory
ELG150	ELG.010.150	MFP-LIVES-WITH-FAMILY	MFP Lives with Family	Mandatory	A code indicating if the individual lives with his/her family or is not a participant in the MFP program.	MFP-LIVES-WITH-FAMILY	ELG00010	MFP-INFORMATION	X(1)	5	42	42	~~1.~~1. Value must be 1 character 2. Value must be in MFP Lives with Family List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory
ELG151	ELG.010.151	MFP-QUALIFIED-INSTITUTION	MFP Qualified Institution	Mandatory	A code describing type of qualified institution at the time of transition to the community for an eligible MFP Demonstration participant.	MFP-QUALIFIED-INSTITUTION	ELG00010	MFP-INFORMATION	X(2)	6	43	44	~~1.~~1. Value must be 2 characters 2. Value must be in MFP Qualified Institution List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory
ELG152	ELG.010.152	MFP-QUALIFIED-RESIDENCE	MFP Qualified Residence	Mandatory	A code ~~describing~~ indicating the type of qualified ~~institution at the time of transition to the community for an eligible MFP Demonstration participant~~residence.	MFP-QUALIFIED-RESIDENCE	ELG00010	MFP-INFORMATION	X(2)	7	45	46	~~1.~~1. Value must be 2 characters 2. Value must be in MFP Qualified Residence List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory

ELG153	ELG.010.153	MFP-REASON-PARTICIPATION-ENDED	MFP Reason Participation Ended	Conditional	A code describing why an individual's participation in Money Follows the Person demonstration ended.	MFP-REASON-PARTICIPATION-ENDED	ELG00010	MFP-INFORMATION	X(2)	8	47	48	~~1.~~1. Value must be 2 characters 2. Value must be in MFP Reason Participation Ended List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional 4. Value must not be populated when Enrollment End Date equals ~~'~~"9999-12-~~31'~~31" 5. Value must be populated when Enrollment End Date does not equal "9999-12-31"
ELG154	ELG.010.154	MFP-REINSTITUTIONALIZED-REASON	MFP Reinstitutionalized Reason	Conditional	A code describing why the individual was reinstitutionalized after participation in the Money Follows the Person Demonstration.	MFP-REINSTITUTIONALIZED-REASON	ELG00010	MFP-INFORMATION	X(2)	9	49	50	~~1.~~1. Value must be 2 characters 2. Value must be in MFP Reinstitutionalized Reason List (VVL) ~~2. Value must be 2 characters~~ 3. Conditional
ELG155	ELG.010.155	MFP-ENROLLMENT-EFF-DATE	MFP Enrollment Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00010	MFP-INFORMATION	9(8)	10	51	58	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~19,20,99]
ELG156	ELG.010.156	MFP-ENROLLMENT-END-DATE	MFP Enrollment End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00010	MFP-INFORMATION	9(8)	11	59	66	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on~~ in the form "CCYYMMDD" 2. Value must be after or the ~~leap year, never April 31st or Sept 31st)~~ ~~3. Value must be greater than or equal to~~ same as the associated Segment Effective Date value ~~4~~3. Mandatory

													~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~19,20,99]
ELG157	ELG.010.157	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	ELG00010	MFP-INFORMATION	X(500)	12	67	566	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
ELG159	ELG.011.159	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	ELG00011	STATE-PLAN-OPTION-PARTICIPATION	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~ 3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00011"
ELG160	ELG.011.160	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	ELG00011	STATE-PLAN-OPTION-PARTICIPATION	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)

ELG161	ELG.011.161	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	ELG00011	STATE-PLAN-OPTION-PARTICIPATION	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory
ELG162	ELG.011.162	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual ~~(except on service tracking payments). .~~ Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47572~~reporting-shared-msis-identification-numbers-eligibility/	N/A	ELG00011	STATE-PLAN-OPTION-PARTICIPATION	X(20)	4	22	41	~~1. Mandatory~~ ~~2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN~~ ~~3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN~~ ~~4.~~1. Value must be 20 characters or less 2. Mandatory
ELG163	ELG.011.163	STATE-PLAN-OPTION-TYPE	State Plan Option Type	Mandatory	This field specifies the State Plan Options in which the individual is enrolled. Use on occurrence for each State Plan Option enrollment.	STATE-PLAN-OPTION-TYPE	ELG00011	STATE-PLAN-OPTION-PARTICIPATION	X(2)	5	42	43	~~1.~~1. Value must be 2 characters 2. Value must be in State Plan Option Type List (VVL) ~~2~~3. If associated Eligibility Group (ELG.005.087) value is in [~~"~~72~~",~~ ~~"~~73~~",~~ ~~"~~74~~",~~ ~~"~~75~~"~~], and Restricted Benefits Code (ELG.DE.097) is in [1,7], then value must be "06" ~~3. Value must be 2 characters~~

													4. Mandatory ~~5. Value must equal '02' when Program Type (CIP.002.129) equals '13'~~ ~~6. Value must equal '02' when Program Type (COT.002.065) equals '13'~~
ELG164	ELG.011.164	STATE-PLAN-OPTION-EFF-DATE	State Plan Option Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00011	STATE-PLAN-OPTION-PARTICIPATION	9(8)	6	44	51	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in ['~~18', '19', '20~~'19,20,99]
ELG165	ELG.011.165	STATE-PLAN-OPTION-END-DATE	State Plan Option End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00011	STATE-PLAN-OPTION-PARTICIPATION	9(8)	7	52	59	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be greater than or equal to associated Segment Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in ['~~18', '19', '20', '99~~'18,19,20,99]
ELG166	ELG.011.166	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	ELG00011	STATE-PLAN-OPTION-PARTICIPATION	X(500)	8	60	559	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational

ELG168	ELG.012.168	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	ELG00012	WAIVER-PARTICIPATION	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00012"
ELG169	ELG.012.169	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	ELG00012	WAIVER-PARTICIPATION	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
ELG170	ELG.012.170	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	ELG00012	WAIVER-PARTICIPATION	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory

ELG171	ELG.012.171	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual ~~(except on service tracking payments).~~ . Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47572~~reporting-shared-msis-identification-numbers-eligibility/	N/A	ELG00012	WAIVER-PARTICIPATION	X(20)	4	22	41	~~1. Mandatory~~ ~~2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN~~ ~~3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN~~ ~~4.~~1. Value must be 20 characters or less 2. Mandatory

ELG172	ELG.012.172	WAIVER-ID	Waiver ID	Mandatory	Field specifying the waiver or demonstration which authorized payment for a claim. These IDs must be the approved, full federal waiver ID number assigned during the state submission and CMS approval process. Waiver IDs should actually only be the "core" part of the waiver IDs, without including suffixes for renewals or amendments.	N/A	ELG00012	WAIVER-PARTICIPATION	X(20)	5	42	61	~~1.~~1. Value must be 20 characters or less 2. Value must be associated with a populated Waiver Type ~~2. Value must be 20 characters or less~~ ~~3.~~3. (1115 demonstration ~~waivers~~) If value begins with "11-W-" or "21-W-", the associated Claim Waiver Type value must be 01 or in [21-30] 4. (1115 demonstration) If value begins with"11-W-" or "21-W-", then the value must include slash "/" in the 11th position followed by the last digit of the CMS Region [0-9] in the 12th position 5. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation followed by a period (.), the associated ~~Claim~~ Waiver Type value must be in [02-20,32,33] ~~5~~6. Value must have a corresponding value in Waiver Type (ELG.012.173) ~~6~~7. Mandatory
ELG173	ELG.012.173	WAIVER-TYPE	Eligible Waiver Type	Mandatory	Code for specifying waiver types under which the eligible individual is covered during the month.	WAIVER-TYPE	ELG00012	WAIVER-PARTICIPATION	X(2)	6	62	63	~~1.~~1. Value must be 2 characters 2. Value must be in Waiver Type List (VVL) ~~2~~3. Value must have a corresponding value in Waiver ID (ELG.012.172) ~~3~~4. Mandatory ~~4. Value must be 2 characters~~
ELG174	ELG.012.174	WAIVER-ENROLLMENT-EFF-DATE	Waiver Enrollment Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00012	WAIVER-PARTICIPATION	9(8)	7	64	71	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory

													~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~19,20,99]
ELG175	ELG.012.175	WAIVER-ENROLLMENT-END-DATE	Waiver Enrollment End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00012	WAIVER-PARTICIPATION	9(8)	8	72	79	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be greater than or equal to associated Segment Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~18,19,20,99]
ELG176	ELG.012.176	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	ELG00012	WAIVER-PARTICIPATION	X(500)	9	80	579	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
ELG178	ELG.013.178	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP,	RECORD-ID	ELG00013	LTSS-PARTICIPATION	X(8)	1	1	8	1. Mandatory 2. Value must be 8 characters 3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00013"

					etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).								
ELG179	ELG.013.179	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	ELG00013	LTSS-PARTICIPATION	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
ELG180	ELG.013.180	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	ELG00013	LTSS-PARTICIPATION	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory

ELG181	ELG.013.181	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual ~~(except on service tracking payments).~~ . Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47572~~reporting-shared-msis-identification-numbers-eligibility/	N/A	ELG00013	LTSS-PARTICIPATION	X(20)	4	22	41	~~1. Mandatory~~ ~~2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN~~ ~~3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN~~ ~~4.~~1. Value must be 20 characters or less 2. Mandatory
ELG182	ELG.013.182	LTSS-LEVEL-CARE	LTSS Level of Care	Mandatory	The level of care provided to the individual by the long term care facility.	LTSS-LEVEL-CARE	ELG00013	LTSS-PARTICIPATION	X(1)	5	42	42	1. Value must be 1 character 2. Value must be in LTSS Level of Care List (VVL) ~~2. Value must be 1 character~~ 3. Mandatory
ELG183	ELG.013.183	LTSS-PROV-NUM	LTSS Provider Num	Mandatory	A unique identification number assigned by the state to the long term care facility furnishing healthcare services to the individual.	N/A	ELG00013	LTSS-PARTICIPATION	X(30)	6	43	72	1. Value must be 30 characters or less 2. ~~Value must be reported in Provider Identifier (PRV.005.080) with an associated Provider Identifier Type (PRV.005.081) equal to '1'~~ ~~3.~~ Mandatory ~~4. Value must match Provider Identifier (PRV.005.081)~~

ELG184	ELG.013.184	LTSS-ELIGIBILITY-EFF-DATE	LTSS Eligibility Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00013	LTSS-PARTICIPATION	9(8)	7	73	80	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~19,20,99]
ELG185	ELG.013.185	LTSS-ELIGIBILITY-END-DATE	LTSS Eligibility End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00013	LTSS-PARTICIPATION	9(8)	8	81	88	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on~~ in the form "CCYYMMDD" 2. Value must be after or the ~~leap year, never April 31st or Sept 31st)~~ ~~3. Value must be greater than or equal to~~ same as the associated Segment Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~19,20,99]
ELG186	ELG.013.186	STATE-NOTATION	State Notation	~~Op~~Situatio nal	A free text field for the submitting state to enter whatever information it chooses.	N/A	ELG00013	LTSS-PARTICIPATION	X(500)	9	89	588	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational

ELG188	ELG.014.188	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	ELG00014	MANAGED-CARE-PARTICIPATION	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00014"
ELG189	ELG.014.189	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	ELG00014	MANAGED-CARE-PARTICIPATION	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
ELG190	ELG.014.190	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	ELG00014	MANAGED-CARE-PARTICIPATION	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory

ELG191	ELG.014.191	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual ~~(except on service tracking payments).~~ . Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47572~~reporting-shared-msis-identification-numbers-eligibility/	N/A	ELG00014	MANAGED-CARE-PARTICIPATION	X(20)	4	22	41	~~1. Mandatory~~ ~~2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN~~ ~~3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN~~ ~~4.~~1. Value must be 20 characters or less 2. Mandatory
ELG192	ELG.014.192	MANAGED-CARE-PLAN-ID	Managed Care Plan ID	Mandatory	The managed care plan identification number under which the eligible individual is enrolled. See T-MSIS Guidance Document, "CMS Guidance: Best Practice for Reporting Managed-Care-Plan-ID in the Eligible File". https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47565~~reporting-managedcareplantype-in-the-eligible-file-managed-care/ See T-MSIS Guidance Document, "CMS Guidance: Preliminary guidance for Primary Care Case Management Reporting". https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-	N/A	ELG00014	MANAGED-CARE-PARTICIPATION	X(12)	5	42	53	~~1.~~1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbol ~~2. Value must be 12 characters or less~~ ~~3.~~3. Value reported must match the value reported on State Plan Identification Number (MCR.002.019) 4. Mandatory

					coding-blog/~~entry/52896~~cms-guidance-primary-care-case-management-reporting-updated/								
ELG193	ELG.014.193	MANAGED-CARE-PLAN-TYPE	Managed Care Plan Type	Mandatory	A model of health care delivery organized to provide a defined set of services. See T-MSIS Guidance Document, "CMS Guidance: Best Practice for Reporting Non-Emergency Medical Transportation (NEMT) Prepaid Ambulatory Health Plans (PAHPs) in the T-MSIS Managed Care File" https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/dataguide/t-msis-coding-blog/reporting-nonemergency-medical-transportation-nemt-prepaid-ambulatory-health-plans-pahps-in-the-tmsis-~~blog/entry/47540~~managed-care-filemanaged-care/ See T-MSIS Guidance Document, "CMS Guidance: Best Practice for Reporting Managed Care Plan Type in the T-MSIS Managed Care File" https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-	MANAGED-CARE-PLAN-TYPE	ELG00014	MANAGED-CARE-PARTICIPATION	X(2)	6	54	55	~~1.~~1. Value must be 2 characters 2. Value must be in Managed Care Plan Type List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. ~~Value must not be populated when Managed Care Plan ID (ELG.014.192) is not populated~~ ~~5.~~ Value must equal the Managed Care Plan Type (MCR.002.024) associated with the State Plan Identification Number (MCR.002.018)

					coding-blog/~~entry/47564~~reporting-managedcareplantype-in-the-t-msis-managed-care-file-managed-care/								
~~ELG194~~	~~ELG.014.194~~	~~NATIONAL-HEALTH-CARE-ENTITY-ID~~	~~National Health Care Entity ID~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~ELG00014~~	~~MANAGED-CARE-PARTICIPATION~~	~~X(10)~~	~~7~~	~~56~~	~~65~~	~~1. Not Applicable~~
~~ELG195~~	~~ELG.014.195~~	~~NATIONAL-HEALTH-CARE-ENTITY-ID-TYPE~~	~~National Health Care Entity ID Type~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~ELG00014~~	~~MANAGED-CARE-PARTICIPATION~~	~~X(1)~~	~~8~~	~~66~~	~~66~~	~~1. Not Applicable~~

ELG196	ELG.014.196	MANAGED-CARE-PLAN-ENROLLMENT-EFF-DATE	Managed Care Plan Enrollment Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00014	MANAGED-CARE-PARTICIPATION	9(8)	~~9~~7	~~67~~56	~~74~~63	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~19,20,99]
ELG197	ELG.014.197	MANAGED-CARE-PLAN-ENROLLMENT-END-DATE	Managed Care Plan Enrollment End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00014	MANAGED-CARE-PARTICIPATION	9(8)	~~10~~8	~~75~~64	~~82~~71	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on~~ in the form "CCYYMMDD" 2. Value must be after or the ~~leap year, never April 31st or Sept 31st)~~ ~~3. Value must be greater than or equal to~~ same as the associated Segment Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~19,20,99]
ELG198	ELG.014.198	STATE-NOTATION	State Notation	~~Op~~Situatio nal	A free text field for the submitting state to enter whatever information it chooses.	N/A	ELG00014	MANAGED-CARE-PARTICIPATION	X(500)	~~11~~9	~~83~~72	~~582~~571	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational

ELG200	ELG.015.200	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	ELG00015	ETHNICITY-INFORMATION	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00015"
ELG201	ELG.015.201	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	ELG00015	ETHNICITY-INFORMATION	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
ELG202	ELG.015.202	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	ELG00015	ETHNICITY-INFORMATION	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory

ELG203	ELG.015.203	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual ~~(except on service tracking payments).~~ . Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47572~~reporting-shared-msis-identification-numbers-eligibility/	N/A	ELG00015	ETHNICITY-INFORMATION	X(20)	4	22	41	~~1. Mandatory~~ ~~2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN~~ ~~3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN~~ ~~4.~~1. Value must be 20 characters or less 2. Mandatory

ELG204	ELG.015.204	ETHNICITY-CODE	Ethnicity Code	Mandatory	A code indicating that the individual's ethnicity is Hispanic, Latino/a, or Spanish ethnicity of a Medicaid/CHIP enrolled individual. Ethnicity Code clarifications: If state has beneficiaries coded in their database as "Hispanic" or "Latino," then code them in T-MSIS as "Hispanic or Latino Unknown" (valid value "5"). DO NOT USE "Another Hispanic, Latino, or Spanish Origin," "Ethnicity Unknown" or "Ethnicity Unspecified." NOTE 1: The "Ethnicity Unspecified" category in T-MSIS (valid value "6") should be used with an individual who explicitly did not provide information or refused to answer a question.	ETHNICITY-CODE	ELG00015	ETHNICITY-INFORMATION	X(1)	5	42	42	~~1.~~1. Value must be 1 character 2. Value must be in Ethnicity Code List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory
ELG205	ELG.015.205	ETHNICITY-DECLARATION-EFF-DATE	Ethnicity Declaration Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00015	ETHNICITY-INFORMATION	9(8)	6	43	50	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~19,20,99]
ELG206	ELG.015.206	ETHNICITY-DECLARATION-END-DATE	Ethnicity Declaration End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00015	ETHNICITY-INFORMATION	9(8)	7	51	58	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on~~ in the form "CCYYMMDD" 2. Value must be after or the ~~leap year, never April 31st or Sept 31st)~~ ~~3. Value must be greater than or equal to~~ same as the associated Segment Effective Date

													value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~19,20,99]
ELG207	ELG.015.207	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	ELG00015	ETHNICITY-INFORMATION	X(500)	~~8~~9	~~59~~84	5~~5~~83	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
ELG209	ELG.016.209	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	ELG00016	RACE-INFORMATION	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~ 3. Value must be in Record ID List (VVL) 4. Value must equal "ELG000016"
ELG210	ELG.016.210	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	ELG00016	RACE-INFORMATION	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)

ELG211	ELG.016.211	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	ELG00016	RACE-INFORMATION	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory
ELG212	ELG.016.212	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual ~~(except on service tracking payments).~~ . Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47572~~reporting-shared-msis-identification-numbers-eligibility/	N/A	ELG00016	RACE-INFORMATION	X(20)	4	22	41	~~1. Mandatory~~ ~~2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN~~ ~~3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN~~ ~~4.~~1. Value must be 20 characters or less 2. Mandatory

ELG213	ELG.016.213	RACE	Race	Mandatory	A code indicating the individual's race either in accordance with requirements of Section 4302 of the Affordable Care Act classifications. Race Code clarifications: If state has beneficiaries coded in their database as "Asian" with no additional detail, then code them in T-MSIS as "Asian Unknown" (valid value "011"). DO NOT USE "Other Asian," "Unspecified" or "Unknown." ". If state has beneficiaries coded in their database as "Native Hawaiian or Other Pacific Islander" with no additional detail, then code them in T-MSIS as "Native Hawaiian and Other Pacific Islander Unknown" (valid value "016"). DO NOT USE "Native Hawaiian," "Other Pacific Islander," "Unspecified" or "Unknown." DO NOT USE "Native Hawaiian," "Other Pacific Islander," "Unspecified" or "Unknown". If state has beneficiaries coded in their database as "Other" with no additional detail or in a category that is not available in the code set provided, then code them in T-MSIS as "Other" (valid value "018"), but only use "Other" if the use of "Other Asian" or "Other Pacific Islander" are not appropriate. DO NOT USE "Unspecified" or "Unknown". The "Other" valid value was added to T-MSIS to better align T-MSIS with the single-streamlined application and to accommodate some atypical states, despite the requirements of Section 4302 of the ACA. NOTE 1: The "Other Asian" category in T-MSIS (valid value "010") should be used in situations in which an individual's specific Asian subgroup	RACE	ELG00016	RACE-INFORMATION	X(3)	5	42	44	1.1. Value must be 3 characters 2. Value must be in Race List (VVL) 2. Value must be 3 characters 3. Mandatory

					is not available in the code set provided (e.g., Malaysian, Burmese). NOTE 2: The "Unspecified" category in T-MSIS (valid value "017") should be used with an individual who explicitly did not provide information or refused to answer a question.								
ELG214	ELG.016.214	RACE-OTHER	Race Other	Conditional	A freeform field to document the race of the beneficiary when the beneficiary identifies themselves as Other Asian, Other Pacific Islander (race codes 010 or 015).	N/A	ELG00016	RACE-INFORMATION	X(25)	6	45	69	~~1.~~1. Value must be 25 characters or less 2. If associated Race (ELG.016.213) value is in [~~"~~010~~",~~ ~~"~~015~~",~~018], then value must be populated~~.~~ ~~2~~ 3. Value must not contain a pipe or asterisk symbol

													~~3. Value must be 25 characters or less~~ ~~4.~~4. Conditional
ELG215	ELG.016.215	AMERICAN-INDIAN-ALASKA~~N~~-NATIVE-INDICATOR	American Indian Alaska~~n~~ Native Indicator	Conditional	"'American Indian or Alaska Native"' means any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, pursuant to 42 CFR 136.12. This means the individual: a. Is a member of a Federally-recognized Indian tribe; b. Resides in an urban center and meets one or more of the following four criteria: i. Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member; ii. Is an Eskimo or Aleut or other Alaska Native; iii. Is considered by the Secretary of the Interior to be an Indian for any purpose; or iv. Is determined to be an Indian under regulations promulgated by the `'Secretary of Health and Human Services; c. Is considered by the Secretary of the Interior to be an Indian for any purpose; or d. Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native. NOTE Applicants who complete Appendix B of the Marketplace/Medicaid application and respond affirmatively to the two questions shown below are considered to meet the definition of an American Indian/Alaskan Native. Are you a	AMERICAN-INDIAN-ALASKA-NATIVE-INDICATOR	ELG00016	RACE-INFORMATION	X(1)	7	70	70	~~1.~~1. Value must be 1 character 2. Value must be in American Indian Alaskan Native Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Conditional

					member of a federally recognized tribe? Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?								
ELG216	ELG.016.216	RACE-DECLARATION-EFF-DATE	Race Declaration Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00016	RACE-INFORMATION	9(8)	8	71	78	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory

													~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~19,20,99]
ELG217	ELG.016.217	RACE-DECLARATION-END-DATE	Race Declaration End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00016	RACE-INFORMATION	9(8)	9	79	86	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be greater than or equal to associated Segment Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~18,19,20,99]
ELG218	ELG.016.218	STATE-NOTATION	State Notation	~~Op~~Situatio nal	A free text field for the submitting state to enter whatever information it chooses.	N/A	ELG00016	RACE-INFORMATION	X(500)	10	87	586	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
ELG220	ELG.017.220	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier	RECORD-ID	ELG00017	DISABILITY-INFORMATION	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~ 3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00017"

					padded with leading zeros (e.g., 00001, 00002, 00003, etc.).								
ELG221	ELG.017.221	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	ELG00017	DISABILITY-INFORMATION	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
ELG222	ELG.017.222	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	ELG00017	DISABILITY-INFORMATION	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory

ELG223	ELG.017.223	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual ~~(except on service tracking payments).~~ . Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47572~~reporting-shared-msis-identification-numbers-eligibility/	N/A	ELG00017	DISABILITY-INFORMATION	X(20)	4	22	41	~~1. Mandatory~~ ~~2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN~~ ~~3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN~~ ~~4.~~1. Value must be 20 characters or less 2. Mandatory
ELG224	ELG.017.224	DISABILITY-TYPE-CODE	Disability Type Code	~~Conditional~~ Mandatory	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~A code to identify disability status in accordance with requirements of Section 4302 of the Affordable Care Act.	DISABILITY-TYPE-CODE	ELG00017	DISABILITY-INFORMATION	X(2)	5	42	43	1. ~~Not Applicable~~ ~~2.~~ Value must be 2 characters 2. Value must be in Disability Type Code List (VVL) 3. ~~Conditional~~Mandatory
ELG225	ELG.017.225	DISABILITY-TYPE-EFF-DATE	Disability Type Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00017	DISABILITY-INFORMATION	9(8)	6	44	51	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory

													~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~19,20,99]
ELG226	ELG.017.226	DISABILITY-TYPE-END-DATE	Disability Type End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00017	DISABILITY-INFORMATION	9(8)	7	52	59	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on~~ in the form "CCYYMMDD" 2. Value must be after or the ~~leap year, never April 31st or Sept 31st)~~ ~~3. Value must be greater than or equal to~~ same as the associated Segment Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~19,20,99]
ELG227	ELG.017.227	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	ELG00017	DISABILITY-INFORMATION	X(500)	8	60	559	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
ELG229	ELG.018.229	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP,	RECORD-ID	ELG00018	1115A-DEMONSTRATION-INFORMATION	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~ 3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00018"

					etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).								
ELG230	ELG.018.230	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	ELG00018	1115A-DEMONSTRATION-INFORMATION	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
ELG231	ELG.018.231	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	ELG00018	1115A-DEMONSTRATION-INFORMATION	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory

ELG232	ELG.018.232	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual ~~(except on service tracking payments).~~ . Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47572~~reporting-shared-msis-identification-numbers-eligibility/	N/A	ELG00018	1115A-DEMONSTRATION-INFORMATION	X(20)	4	22	41	~~1. Mandatory~~ ~~2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN~~ ~~3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN~~ ~~4.~~1. Value must be 20 characters or less 2. Mandatory
ELG233	ELG.018.233	1115A-DEMONSTRATION-IND	1115A Demonstration Indicator	Conditional	Indicates that the individual participates in an ~~1115(A)~~1115A demonstration. ~~1115(A)~~1115A is a Center for Medicare and Medicaid Innovation (CMMI) demonstration.	1115A-DEMONSTRATION-IND	ELG00018	1115A-DEMONSTRATION-INFORMATION	X(1)	5	42	42	~~1.~~1. Value must be 1 character 2. Value must be in 1115A Demonstration Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Conditional
ELG234	ELG.018.234	1115A-EFF-DATE	1115A Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00018	1115A-DEMONSTRATION-INFORMATION	9(8)	6	43	50	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory

													~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~19,20,99]
ELG235	ELG.018.235	1115A-END-DATE	1115A End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00018	1115A-DEMONSTRATION-INFORMATION	9(8)	7	51	58	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on~~ in the form "CCYYMMDD" 2. Value must be after or the ~~leap year, never April 31st or Sept 31st)~~ ~~3. Value must be greater than or equal to~~ same as the associated Segment Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~19,20,99]
ELG236	ELG.018.236	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	ELG00018	1115A-DEMONSTRATION-INFORMATION	X(500)	8	59	558	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
ELG238	ELG.020.238	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP,	RECORD-ID	ELG00020	HCBS-CHRONIC-CONDITIONS-NON-HEALTH-HOME	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~ 3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00020"

					etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).								
ELG239	ELG.020.239	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	ELG00020	HCBS-CHRONIC-CONDITIONS-NON-HEALTH-HOME	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
ELG240	ELG.020.240	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	ELG00020	HCBS-CHRONIC-CONDITIONS-NON-HEALTH-HOME	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory

ELG241	ELG.020.241	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual ~~(except on service tracking payments).~~ . Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47572~~reporting-shared-msis-identification-numbers-eligibility/	N/A	ELG00020	HCBS-CHRONIC-CONDITIONS-NON-HEALTH-HOME	X(20)	4	22	41	~~1. Mandatory~~ ~~2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN~~ ~~3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN~~ ~~4.~~1. Value must be 20 characters or less 2. Mandatory
ELG242	ELG.020.242	HCBS-CHRONIC-CONDITION-NON-HEALTH-HOME-CODE	HCBS Chronic Condition Non Health Home Code	Mandatory	The chronic condition for which the eligible person is receiving non-Health-Home home and community based care.	HCBS-CHRONIC-CONDITION-NON-HEALTH-HOME-CODE	ELG00020	HCBS-CHRONIC-CONDITIONS-NON-HEALTH-HOME	X(3)	5	42	44	~~1.~~1. Value must be 3 characters 2. Value must be in HCBS Chronic Condition Non Health Home Code List (VVL) ~~2. Value must be 3 characters~~ ~~3.~~3. Mandatory
ELG243	ELG.020.243	HCBS-CHRONIC-CONDITION-NON-HEALTH-HOME-EFF-DATE	HCBS Chronic Condition Non Health Home Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00020	HCBS-CHRONIC-CONDITIONS-NON-HEALTH-HOME	9(8)	6	45	52	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory

														~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~19,20,99]
ELG244	ELG.020.244	HCBS-CHRONIC-CONDITION-NON-HEALTH-HOME-END-DATE	HCBS Chronic Condition Non Health Home End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00020	HCBS-CHRONIC-CONDITIONS-NON-HEALTH-HOME	9(8)	7	53	60	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on~~ in the form "CCYYMMDD" 2. Value must be after or the ~~leap year, never April 31st or Sept 31st)~~ ~~3. Value must be greater than or equal to~~ same as the associated Segment Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~19,20,99]
ELG245	ELG.020.245	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	ELG00020	HCBS-CHRONIC-CONDITIONS-NON-HEALTH-HOME	X(500)	8	61	560	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
ELG247	ELG.001.247	SEQUENCE-NUMBER	Sequence Number	Mandatory	To enable states to sequentially number files, when related, follow-on files are necessary (i.e. update files, replace files). This should begin with 1 for the original Create submission type and be incremented by one for each Replacement or Update submission for the same reporting period and file type (subject area).	N/A	ELG00001	FILE-HEADER-RECORD-ELIGIBILITY	X(4)	~~14~~15	~~79~~81	~~82~~84	~~1.~~1. Value must be 4 characters or less 2. Value must between 1 and 9999 ~~2~~3. Value must be equal to the largest of any prior values for the same reporting period and file type, plus 1 (i.e. incremented by 1) ~~3~~4. Value must not contain a pipe symbol ~~4. Value must be 4 characters or less~~ 5. Mandatory

ELG248	ELG.021.248	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	ELG00021	ENROLLMENT-TIME-SPAN-SEGMENT	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00021"
ELG249	ELG.021.249	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	ELG00021	ENROLLMENT-TIME-SPAN-SEGMENT	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
ELG250	ELG.021.250	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	ELG00021	ENROLLMENT-TIME-SPAN-SEGMENT	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory

ELG251	ELG.021.251	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual ~~(except on service tracking payments).~~ . Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47572~~reporting-shared-msis-identification-numbers-eligibility/	N/A	ELG00021	ENROLLMENT-TIME-SPAN-SEGMENT	X(20)	4	22	41	~~1. Mandatory~~ ~~2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN~~ ~~3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN~~ ~~4.~~1. Value must be 20 characters or less 2. Mandatory
ELG252	ELG.021.252	ENROLLMENT-TYPE	Enrollment Type	Mandatory	Identify the type of enrollment that the eligible person has been enrolled into as either Medicaid/Medicaid Expansion CHIP or Separate CHIP.	ENROLLMENT-TYPE	ELG00021	ENROLLMENT-TIME-SPAN-SEGMENT	X(1)	5	42	42	1. Value must be in Enrollment Type List (VVL) 2. Value must be 1 character 3. If value equals "1," then associated CHIP Code (ELG.003.054) value must be in [1, 2] 4. If value equals "2," then associated CHIP Code (ELG.003.054) value must be "3" 5. A person enrolled in Medicaid/CHIP must have a primary eligibility group classification for any given day of enrollment. (There may or may not be a secondary eligibility group classification for that same day.) 6. Mandatory

ELG253	ELG.021.253	ENROLLMENT-EFF-DATE	Enrollment Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00021	ENROLLMENT-TIME-SPAN-SEGMENT	9(8)	6	43	50	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~19,20,99]
ELG254	ELG.021.254	ENROLLMENT-END-DATE	Enrollment End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00021	ENROLLMENT-TIME-SPAN-SEGMENT	9(8)	7	51	58	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on~~ in the form "CCYYMMDD" 2. Value must be the ~~leap year, never April 31st~~after or ~~Sept 31st)~~ ~~3. Value must be greater than or equal to~~the same as the associated Segment Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~19,20,99]
ELG255	ELG.021.255	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	ELG00021	ENROLLMENT-TIME-SPAN-SEGMENT	X(500)	8	59	558	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational

ELG257	ELG.022.257	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	ELG00022	~~ELIGIBLE-IDENTIFIER~~ELG-IDENTIFIERS	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00022"
ELG258	ELG.022.258	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	ELG00022	~~ELIGIBLE-IDENTIFIER~~ELG-IDENTIFIERS	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
ELG259	ELG.022.259	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	ELG00022	~~ELIGIBLE-IDENTIFIER~~ELG-IDENTIFIERS	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory

ELG260	ELG.022.260	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual ~~(except on service tracking payments).~~ . Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47572~~reporting-shared-msis-identification-numbers-eligibility/	N/A	ELG00022	~~ELIGIBLE-IDENTIFIER~~ELG-IDENTIFIERS	X(20)	4	22	41	~~1. Mandatory~~ ~~2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN~~ ~~3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN~~ ~~4.~~1. Value must be 20 characters or less 2. Mandatory
ELG261	ELG.022.261	ELG-IDENTIFIER-TYPE	Eligible Identifier Type	Mandatory	A code to identify the kind of eligible identifier that is captured in the Eligible Identifier data element.	ELG-IDENTIFIER-TYPE	ELG00022	~~ELIGIBLE-IDENTIFIER~~ELG-IDENTIFIERS	X(1)	5	42	42	~~1.~~1. Value must be 1 character 2. Value must be in Eligible Identifier Type List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory
ELG262	ELG.022.262	ELG-IDENTIFIER-ISSUING-ENTITY-ID	Eligible Identifier Issuing Entity Identifier	~~Op~~Situational	This data element is reserved for future use.	N/A	ELG00022	~~ELIGIBLE-IDENTIFIER~~ELG-IDENTIFIERS	X(18)	6	43	60	1. Value must be 18 characters or less 2. ~~Op~~Situational

ELG263	ELG.022.263	ELG-IDENTIFIER-EFF-DATE	Eligible Identifier Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00022	~~ELIGIBLE-IDENTIFIER~~ELG-IDENTIFIERS	9(8)	7	61	68	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in ['~~18', '19', '20'~~19,20,99]
ELG264	ELG.022.264	ELG-IDENTIFIER-END-DATE	Eligible Identifier End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00022	~~ELIGIBLE-IDENTIFIER~~ELG-IDENTIFIERS	9(8)	8	69	76	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on~~ in the form "CCYYMMDD" 2. Value must be the ~~leap year, never April 31st~~after or ~~Sept 31st)~~ ~~3. Value must be greater than or equal to~~the same as the associated Segment Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in ['~~18', '19', '20', '99'~~19,20,99]

ELG265	ELG.022.265	ELG-IDENTIFIER	Eligible Identifier	Mandatory	A data element to capture the various identifiers assigned to Medicaid and CHIP beneficiary by various entities. The specific type of identifier is shown in the corresponding value in the Eligible Identifier Type data element. States should provide all Old MSIS Identification Number with Eligible Identifier Type = 2 to T-MSIS in case the state changes the MSIS Identification Number of a beneficiary. The state should submit updates to T-MSIS whenever an identifier is retired or issued. States should provide Old MSIS Identification Number with Reason for Change = 'MERGE' to T-MSIS if the state was reporting multiple MSIS Identification Numbers for a single beneficiary and merges them under a single MSIS Identification Number. States should provide Old MSIS Identification Number with Reason for Change = 'UNMERGE' to T-MSIS if the state unmerges a beneficiary from another beneficiary. For example, if a newborn child is originally reported with the mother's MSIS Identification Number and is then assigned a different MSIS Identification Number. States should provide Old MSIS Identification Number with Reason for Change = 'LSE' to T-MSIS if the state assigns a new MSIS Identification Number to any beneficiaries during large system enhancement in state MMIS. States should provide Old MSIS Identification Number with Reason for Change = 'TCAM' to T-	N/A	ELG00022	~~ELIGIBLE-IDENTIFIER~~ELG-IDENTIFIERS	X(20)	9	77	96	1. Value must be 20 characters or less 2. Mandatory 3. Must not contain a pipe symbol

					MSIS if the Medicaid and Separate CHIP programs use different MSIS Identifier Number schemas and beneficiaries are transferred from CHIP to Medicaid or from Medicaid to CHIP and a new MSIS Identification Number is issued.								
ELG266	ELG.022.266	REASON-FOR-CHANGE	Reason for Change	Conditional	A code to identify the reason for changing the MSIS Identification Number of a beneficiary and only required for ~~ELG-IDENTIFIER-TYPE~~Eligible Identifier Type = '2-Old MSIS Identification Number'. For example, If MSIS Identification Number of a beneficiary is being changed due to 'Merge with other MSIS ID' or 'Unmerge'.	REASON-FOR-CHANGE	ELG00022	~~ELIGIBLE-IDENTIFIER~~ELG-IDENTIFIERS	X(10)	10	97	106	~~1.~~1. Value must be 10 characters or less 2. Value must be in Reason for Change List (VVL) ~~2. Value must be 10 characters or less~~ ~~3.~~3. Conditional 4. (Old MSIS Identification Number) value must be populated when Eligible Identifier Type (ELG.022.261) equals ~~'2'~~"2"

ELG267	ELG.022.267	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	ELG00022	~~ELIGIBLE-IDENTIFIER~~ELG-IDENTIFIERS	X(500)	11	107	606	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
ELG269	ELG.003.269	ELIGIBLE-FEDERAL-POVERTY-LEVEL-PERCENTAGE	Eligible Federal Poverty Level Percentage	Conditional	This data element provides the beneficiary's or their household's income as a percentage of the federal poverty level. Used to assign the beneficiary to the eligibility group that covered their Medicaid or CHIP benefits. If the beneficiary's income was assessed using multiple methodologies (MAGI and Non-MAGI), report the income that applies to their primary eligibility group. A beneficiary's income is applicable unless it is not required by the eligibility group for which they were determined eligible. For example, the eligibility groups for children with adoption assistance, foster care, or guardianship care under title IV-E and optional eligibility for individuals needing treatment for breast or cervical cancer do not have a Medicaid income test. Additionally, for individuals receiving SSI, states with section 1634 agreements with the Social Security Administration (SSA) and states that use SSI financial methodologies for Medicaid determinations do not conduct separate Medicaid financial eligibility for this group.	N/A	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	9(3)	25	167	169	1. Value must be between 000 and 400 inclusively 2. Conditional
ELG270	ELG.009.270	LOCKED-IN-SRVCS	Locked In Services	Conditional	The type(s) of services that are locked-in.	TYPE-OF-SERVICE	ELG00009	LOCK-IN-INFORMATION	X(3)	9	90	92	1. Value must be 3 characters 2. Conditional 3. Value must be in Type of Service List (VVL)

ELG271	ELG.015.271	ETHNICITY-OTHER	Ethnicity Other	Conditional	A freeform field to document the ethnicity of the beneficiary when the beneficiary identifies themselves as Another Hispanic, Latino, or Spanish origin (ethnicity code 4).	N/A	ELG00015	ETHNICITY-INFORMATION	X(25)	8	59	83	1. Value must be 25 characters or less 2. If Ethnicity Code (ELG.015.204) equals "4" (Other), then value must be populated 3. Conditional
ELG272	ELG.001.272	FILE-SUBMISSION-METHOD	File Submission Method	Mandatory	The file submission method (e.g., TFFR, RHFR, IT, or CSO) used by the state to build and submit the file. This should correspond with the state's declared file submission method for the same file type and time period.	FILE-SUBMISSION-METHOD	ELG00001	FILE-HEADER-RECORD-ELIGIBILITY	X(2)	14	79	80	1. Value must be 2 characters 2. Value must be in File Submission Method List (VVL) 3. Mandatory
ELG273	ELG.003.273	APPLICATION-SIGNATURE-DATE	Application Signature Date	Conditional	The date that a beneficiary signed their Medicaid or CHIP application. If the beneficiary was deemed eligible via an administrative determination then a signature may not be applicable/available.	N/A	ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY	9(8)	26	170	177	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Conditional 3. Value must be less than the Variable Demographic Element End Date
ELG274	ELG.005.274	ELIGIBILITY-REDETERMINATION-DATE	Eligibility Redetermination Date	Conditional	The date by which a person's Medicaid or CHIP eligibility must be redetermined, per 1915(i)(1)(I), 42 CFR 435.916, 435.926, any other applicable regulations, or waiver of these regulations. This is effectively the "expiration date" of the eligibility characteristics with which the date is being reported. Upon this date the state is required to perform a renewal or redetermination of the individual's eligibility.	N/A	ELG00005	ELIGIBILITY-DETERMINANTS	9(8)	21	97	104	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Conditional 3. Value must be greater than the Eligibility Determinant Effective Date
ELG275	ELG.005.275	ELIGIBILITY-EXTENSION-CODE	Eligibility Extension Code	Conditional	A code to identify the authority used to extend eligibility during the period of coverage. This code should correspond to the eligibility characteristics, including eligibility redetermination date, with which the code is being reported.	ELIGIBILITY-EXTENSION-CODE	ELG00005	ELIGIBILITY-DETERMINANTS	X(3)	22	105	107	1. Value must be 3 characters or less 2. Value must be in Eligibility Extension Code List (VVL) 3. Conditional
ELG276	ELG.005.276	ELIGIBILITY-EXTENSION-OTHER-TEXT	Eligibility Extension Other Text	Conditional	A free-form text field where a state can identify the “other” authority used to extend eligibility; required when 995 is used.	N/A	ELG00005	ELIGIBILITY-DETERMINANTS	X(50)	23	108	157	1. Value must be 50 characters or less 2. Conditional 3. If Eligibility Extension Code is "Other", then value must be populated

ELG277	ELG.005.277	CONTINUOUS-ELIGIBILITY-CODE	Continuous Eligibility Code	Conditional	A code to identify the authority used to provide continuous eligibility during the period of coverage	CONTINUOUS-ELIGIBILITY-CODE	ELG00005	ELIGIBILITY-DETERMINANTS	X(3)	24	158	160	1. Value must be 3 characters 2. Value must be in Continuous Eligibility Code List (VVL) 3. Conditional
ELG278	ELG.005.278	CONTINUOUS-ELIGIBILITY-OTHER-TEXT	Continuous Eligibility Other Text	Conditional	A free-form text field where a state can identify the "other" authority used to provide continuous eligibility.	N/A	ELG00005	ELIGIBILITY-DETERMINANTS	X(50)	25	161	210	1. Value must not be more than 50 characters long 2. Conditional 3. If Continuous Eligibility Code is "Other", then value must be populated
ELG279	ELG.005.279	INCOME-STANDARD-CODE	Income Standard Code	Conditional	An indicator that identifies the income standard used by the state to assign the corresponding primary eligibility group.	INCOME-STANDARD-CODE	ELG00005	ELIGIBILITY-DETERMINANTS	X(2)	26	211	212	1. Value must be 2 characters 2. Value must be in Income Standard Code List (VVL) 3. Conditional
ELG280	ELG.005.280	INCOME-STANDARD-OTHER-TEXT	Income Standard Other Text	Conditional	A free-form text field where a state can identify the "other" income standard used to assign the corresponding primary eligibility group. Required when "Other" is reported to Income Standard Code.	N/A	ELG00005	ELIGIBILITY-DETERMINANTS	X(50)	27	213	262	1. Value must be 50 characters or less 2. Conditional 3. If Income Standard Code equals "Other", then value must be populated
ELG281	ELG.005.281	ELIGIBILITY-TERMINATION-REASON-OTHER-TYPE-TEXT	Eligibility Termination Reason Other Type Text	Conditional	Value must be populated with a state-specific reason for termination when the ELIGIBILITY-TERMINATION-REASON value is 'Other'.	N/A	ELG00005	ELIGIBILITY-DETERMINANTS	X(100)	28	263	362	1. Value must be 100 characters or less 2. Value must be populated when Eligibility Termination Reason equals "22" (Other) 3. Value must not be populated when Eligibility Termination Reason does not equal "22" (Other) 4. Conditional

ELG282	ELG.023.282	RECORD-ID	Record ID	Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements, so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	ELG00023	SOGI	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "ELG00023"
ELG283	ELG.023.283	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	ELG00023	SOGI	X(2)	2	9	10	1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (ELG.001.007)
ELG284	ELG.023.284	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	ELG00023	SOGI	9(11)	3	11	21	1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory

ELG285	ELG.023.285	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/	N/A	ELG00023	SOGI	X(20)	4	22	41	1. Value must be 20 characters or less 2. Mandatory
ELG286	ELG.023.286	SEX-ASSIGNED-AT-BIRTH	Sex Assigned at Birth	Conditional	This is the response from the beneficiary to an optional question posed to them on their Medicaid or CHIP application regarding the individual's sex assigned at birth (e.g., according to an original birth certificate or similar document). T-MSIS does not define or maintain these questions or responses. They are defined and maintained via the CMS single streamlined application and state Medicaid and CHIP agencies. T-MSIS is intended to reflect those sources and may be updated periodically as necessary to align with national standards and common practices. For more information, see: https://www.medicaid.gov/sites/default/files/2023-11/cib11092023.pdf.	SEX-ASSIGNED-AT-BIRTH	ELG00023	SOGI	X(1)	5	42	42	1. Value must be 1 character 2. Value must be in Sex Assigned at Birth List (VVL) 3. Conditional

ELG287	ELG.023.287	SEX-ASSIGNED-AT-BIRTH-OTHER-TEXT	Sex Assigned at Birth Other Text	Conditional	This is the response from the beneficiary to an optional question posed to them on their Medicaid or CHIP application regarding the individual's sex assigned at birth (e.g., according to an original birth certificate or similar document), if their response is not reflected by the values available for Sex Assigned at Birth.	N/A	ELG00023	SOGI	X(100)	6	43	142	1. Value must be 100 characters or less 2. Conditional 3. If Sex Assigned at Birth equals "5" (Other), then value must be populated
ELG288	ELG.023.288	GENDER-IDENTITY	Gender Identity	Conditional	This is the response from the beneficiary to an optional question posed to them on their Medicaid or CHIP application regarding the individual's gender identify-MSIS does not define or maintain these questions or responses. They are defined and maintained via the CMS single streamlined application and state Medicaid and CHIP agencies. T-MSIS is intended to reflect those sources and may be updated periodically as necessary to align with national standards and common practices. For more information, see https://www.medicaid.gov/sites/default/files/2023-11/cib11092023.pdf.	GENDER-IDENTITY	ELG00023	SOGI	X(1)	7	143	143	1. Value must be 1 character 2. Value must be in Gender Identity List (VVL) 3. Conditional
ELG289	ELG.023.289	GENDER-IDENTITY-OTHER-TEXT	Gender Identity Other Text	Conditional	This is the response from the beneficiary to an optional question posed to them on their Medicaid or CHIP application regarding the individual's gender identify if their response is not reflected by the values available for Gender Identity.	N/A	ELG00023	SOGI	X(100)	8	144	243	1. Value must be 100 characters or less 2. Conditional 3. If Gender Identity equals "7" (Other), then value must be populated

ELG290	ELG.023.290	SEXUAL-ORIENTATION	Sexual Orientation	Conditional	This is the response from the beneficiary to an optional question posed to them on their Medicaid or CHIP application regarding the individual's sexual orientation-MSIS does not define or maintain these questions or responses. They are defined and maintained via the CMS single streamlined application and state Medicaid and CHIP agencies. T-MSIS is intended to reflect those sources and may be updated periodically as necessary to align with national standards and common practices. For more information, see https://www.medicaid.gov/sites/default/files/2023-11/cib11092023.pdf.	SEXUAL-ORIENTATION	ELG00023	SOGI	X(1)	9	244	244	1. Value must be 1 character 2. Value must be in Sexual Orientation List (VVL) 3. Conditional
ELG291	ELG.023.291	SEXUAL-ORIENTATION-OTHER-TEXT	Sexual Orientation Other Text	Conditional	This is the response from the beneficiary to an optional question posed to them on their Medicaid or CHIP application regarding the individual's sexual orientation if their response is not reflected by the values available for Sexual Orientation.	N/A	ELG00023	SOGI	X(100)	10	245	344	1. Value must be 100 characters or less 2. Conditional 3. If Sex Orientation equals "6" (Other), then value must be populated
ELG292	ELG.023.292	SOGI-EFF-DATE	SOGI Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	ELG00023	SOGI	9(8)	11	345	352	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be "20"
ELG293	ELG.023.293	SOGI-END-DATE	SOGI End Date	Mandatory	The last calendar day on which all the other data elements in the same segment were effective.	N/A	ELG00023	SOGI	9(8)	12	353	360	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be greater than or equal to associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [20,99]

ELG294	ELG.023.294	STATE-NOTATION	State Notation	Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	ELG00023	SOGI	X(500)	13	361	860	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational

T-MSIS Data Dictionary – MCR File Changes Between Versions 2.4.0 and 4.0.0

MCR001	MCR.001.001	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	MCR00001	FILE-HEADER-RECORD-MANAGED-CARE	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "MCR00001"
MCR002	MCR.001.002	DATA-DICTIONARY-VERSION	Data Dictionary Version	Mandatory	A data element to capture the version of the T-MSIS data dictionary that was used to build the file. ~~Use the version number specified on the Cover Sheet of the data dictionary" to V2.4.~~	DATA-DICTIONARY-VERSION	MCR00001	FILE-HEADER-RECORD-MANAGED-CARE	X(10)	2	9	18	1. Value must be 10 characters or less 2. Value must be in Data Dictionary Version List (VVL) 3. Value must not include the pipe ("|") symbol ~~3~~4. Mandatory
MCR003	MCR.001.003	SUBMISSION-TRANSACTION-TYPE	Submission Transaction Type	Mandatory	A data element to identify the whether the transactions in the file are original submissions of the data, a resubmission of a previously submitted file, or corrections of edit rejects.	SUBMISSION-TRANSACTION-TYPE	MCR00001	FILE-HEADER-RECORD-MANAGED-CARE	X(1)	3	19	19	1. Value must be 1 character 2. Value must be in Submission Transaction Type List (VVL) ~~2. Value must be 1 character~~ 3. Mandatory
MCR004	MCR.001.004	FILE-ENCODING-SPECIFICATION	File Encoding Specification	Mandatory	Denotes which supported file encoding standard was used to create the file.	FILE-ENCODING-SPECIFICATION	MCR00001	FILE-HEADER-RECORD-MANAGED-CARE	X(3)	4	20	22	~~1.~~1. Value must be 3 characters 2. Value must be in File Encoding Specification List (VVL) ~~2. Value must be 3 characters~~ ~~3.~~3. Mandatory
MCR005	MCR.001.005	DATA-MAPPING-DOCUMENT-VERSION	Data Mapping Document Version	Mandatory	Identifies the version of the T-MSIS data mapping document used to build a state	N/A	MCR00001	FILE-HEADER-RECORD-	X(9)	5	23	31	1. Value must be 9 characters or less 2. Mandatory

					submission file. ~~Use the version number specified on the title page of the data mapping document~~			MANAGED-CARE					
MCR006	MCR.001.006	FILE-NAME	File Name	~~Not Applicable~~ Mandatory	A code to identify the subject area to which the records in its file relate. Each T-MSIS submission file should only contain records for one subject area (i.e., Eligible, Third-party liability, Provider, Managed Care Plan Information, Inpatient, Long-Term Care, Other, ~~and~~ Pharmacy Claim, and Financial Transactions).	N/A	MCR00001	FILE-HEADER-RECORD-MANAGED-CARE	X(8)	6	32	39	1. Value must equal ~~'MNGDCARE'~~"MNGDCARE" 2. Mandatory
MCR007	MCR.001.007	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	MCR00001	FILE-HEADER-RECORD-MANAGED-CARE	X(2)	7	40	41	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same for all records
MCR008	MCR.001.008	DATE-FILE-CREATED	Date File Created	Mandatory	The date on which the file was created.	N/A	MCR00001	FILE-HEADER-RECORD-MANAGED-CARE	9(8)	8	42	49	~~1.~~1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" ~~2~~3. Value must be ~~8 characters in the form "CCYYMMDD"~~ ~~3. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~4.~~less than current date 4. Value must be equal to or after the value of associated End of Time Period 5. Mandatory
MCR009	MCR.001.009	START-OF-TIME-PERIOD	Start of Time Period	Mandatory	This value must be the first day of the reporting month, regardless of the actual date span of the data in the file.	N/A	MCR00001	FILE-HEADER-RECORD-MANAGED-CARE	9(8)	9	50	57	~~1. Value of the CC component must be "20"~~ ~~2. Value must be 8 characters in the form "CCYYMMDD"~~ ~~3.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~4. Value must be less than current date~~ ~~5.~~in the form "CCYYMMDD"

													2. Value must be equal to or earlier than associated Date File Created ~~6~~3. Value must be before associated End of Time Period ~~7~~4. Mandatory 5. Value of the CC component must be "20"
MCR010	MCR.001.010	END-OF-TIME-PERIOD	End of Time Period	Mandatory	This value must be the last day of the reporting month, regardless of the actual date span.	N/A	MCR00001	FILE-HEADER-RECORD-MANAGED-CARE	9(8)	10	58	65	1. ~~Value~~The date must be ~~8 characters~~a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" 3. ~~The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~4.~~ Value must be equal to or earlier than associated Date File Created ~~5~~4. Value must be equal to or after associated Start of Time Period ~~6~~5. Mandatory
MCR011	MCR.001.011	FILE-STATUS-INDICATOR	File Status Indicator	Mandatory	A code to indicate whether the records in the file are test or production records.	FILE-STATUS-INDICATOR	MCR00001	FILE-HEADER-RECORD-MANAGED-CARE	X(1)	11	66	66	~~1.~~1. Value must be 1 character 2. For production files, value must be equal to ~~'P'~~ ~~2. Value must be 1 character~~ "P" 3. Value must be in File Status Indicator List (VVL) 4. Mandatory
MCR013	MCR.001.013	TOT-REC-CNT	Total Record Count	Mandatory	A count of all records in the file except for the file header record. This count will be used as a control total to help assure that the file did not become corrupted during transmission.	N/A	MCR00001	FILE-HEADER-RECORD-MANAGED-CARE	9(11)	12	67	77	~~1.~~1. Value must be 11 digits or less 2. Value must be a positive integer ~~2~~3. Value must be between 0:99999999999 (inclusive) ~~3. Value must be 11 digits or less~~ ~~4.~~4. Value must equal the number of records included in the file submission except for the

													file header record. 5. Mandatory
MCR014	MCR.001.014	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	MCR00001	FILE-HEADER-RECORD-MANAGED-CARE	X(500)	~~14~~15	~~82~~84	58~~13~~	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
MCR016	MCR.002.016	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	MCR00002	MANAGED-CARE-MAIN	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~ 3. Value must be in Record ID List (VVL) 4. Value must equal "MCR00002"
MCR017	MCR.002.017	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	MCR00002	MANAGED-CARE-MAIN	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (MCR.001.007)

MCR018	MCR.002.018	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	MCR00002	MANAGED-CARE-MAIN	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory
MCR019	MCR.002.019	STATE-PLAN-ID-NUM	State Plan ID Number	Mandatory	The ID number a state issues to a managed care entity	N/A	MCR00002	MANAGED-CARE-MAIN	X(12)	4	22	33	1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
MCR020	MCR.002.020	MANAGED-CARE-CONTRACT-EFF-DATE	Managed Care Contract Effective Date	Mandatory	The ~~first calendar day on which all~~start date of the ~~other data elements in~~managed care contract period with the ~~same segment were effective~~state.	N/A	MCR00002	MANAGED-CARE-MAIN	9(8)	5	34	41	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3. Value must be before or the same as the associated Segment End Date value~~ ~~4.~~in the form "CCYYMMDD" 2. Mandatory ~~5. Value of the CC component must be in ['18', '19', '20']~~ ~~6. Mandatory~~ ~~7.~~3. Value must occur before Managed Care Contract End Date (MCR.002.021)
MCR021	MCR.002.021	MANAGED-CARE-CONTRACT-END-DATE	Managed Care Contract End Date	Mandatory	The expiration date of the managed care contract period with the state.	N/A	MCR00002	MANAGED-CARE-MAIN	9(8)	6	42	49	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~in the form "CCYYMMDD" 2. Mandatory
MCR022	MCR.002.022	MANAGED-CARE-NAME	Managed Care Name	Mandatory	The name of the managed care entity under contract with the State Medicaid Agency. The name should be as it appears on the contract.	N/A	MCR00002	MANAGED-CARE-MAIN	X(55)	7	50	104	~~1.~~1. Value must be 55 characters or less 2. Value must not contain a pipe or asterisk symbol

													~~2. Value must be 55 characters or less~~ ~~3.~~3. Mandatory
MCR023	MCR.002.023	MANAGED-CARE-PROGRAM	Managed Care Program	Mandatory	The state program through which a managed care plan is approved to operate.	MANAGED-CARE-PROGRAM	MCR00002	MANAGED-CARE-MAIN	X(1)	8	105	105	~~1.~~1. Value must be 1 character 2. Value must be in Managed Care Program List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory
MCR024	MCR.002.024	MANAGED-CARE-PLAN-TYPE	Managed Care Plan Type	Mandatory	The type of managed care plan that corresponds to the State Plan Identification Number. The value reported in this data element should match the Managed Care Plan Type value reported on the Eligible file for the corresponding managed care plan number. Assign plan type value "15" for plans that primarily cover non-emergency medical transportation (NEMT). See T-MSIS Guidance Document, "CMS Guidance: Best Practice for Reporting Non-Emergency Medical Transportation (NEMT) Prepaid Ambulatory Health Plans (PAHPs) in the T-MSIS Managed Care File" https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/dataguide/t-msis-coding-blog/reporting-nonemergency-medical-transportation-nemt-prepaid-ambulatory-health-plans-pahps-in-the-tmsis-~~blog/entry/47540~~managed-care-filemanaged-care/ See T-MSIS Guidance Document, "CMS Guidance: Best Practice for Reporting Managed-~~CARE-PLAN-~~ Care Plan Type in the T-MSIS Managed Care File" https://www.medicaid.gov/~~medicaid/data-and-~~	MANAGED-CARE-PLAN-TYPE	MCR00002	MANAGED-CARE-MAIN	X(2)	9	106	107	~~1.~~1. Value must be 2 characters 2. Value must be in Managed Care Plan Type List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory

					~~systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47564~~reporting-managedcareplantype-in-the-t-msis-managed-care-file-managed-care/								
MCR025	MCR.002.025	REIMBURSEMENT-ARRANGEMENT	Reimbursement Arrangement	Mandatory	A code indicating the how the managed care entity is reimbursed.	REIMBURSEMENT-ARRANGEMENT	MCR00002	MANAGED-CARE-MAIN	X(2)	10	108	109	~~1.~~1. Value must be 2 characters 2. Value must be in Reimbursement Arrangement List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory
MCR026	MCR.002.026	MANAGED-CARE-PROFIT-STATUS	Managed Care Profit Status	Mandatory	A code denoting the profit status of managed care entity.	MANAGED-CARE-PROFIT-STATUS	MCR00002	MANAGED-CARE-MAIN	X(2)	11	110	111	~~1.~~1. Value must be 2 characters 2. Value must be in Managed Care Profit Status List (VVL)

													~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory
MCR027	MCR.002.027	CORE-BASED-STATISTICAL-AREA-CODE	Core Based Statistical Area Code	Mandatory	A code signifying whether the Managed Care Organization's (MCO) service area falls into one or more metropolitan or micropolitan statistical areas. Whenever a service area straddles two types of areas (e.g., metropolitan ~~&~~and micropolitan, metropolitan ~~&~~and non-CBSA area) classify the service area based on the denser classification. Metropolitan and micropolitan statistical areas (metro and micro areas) are geographic entities defined by the U.S. Office of Management and Budget (OMB). The term "Core Based Statistical Area" (CBSA) is a collective term for both metro and micro areas. A metro area contains a core urban area of 50,000 or more population, and a micro area contains an urban core of at least 10,000 (but less than 50,000) population. Each metro or micro area consists of one or more counties and includes the counties containing the core urban area, as well as any adjacent counties that have a high degree of social and economic integration (as measured by commuting to work) with the urban core. The U.S. Office of Management and Budget (OMB) defines metropolitan or micropolitan statistical areas based on published standards. The standards for defining the areas are reviewed and revised once every ten years, prior to each decennial census. Between censuses, the definitions are updated annually to reflect the most recent Census Bureau population estimates. The current definitions are as of December 2009. See the hyperlink below for further information.	CORE-BASED-STATISTICAL-AREA-CODE	MCR00002	MANAGED-CARE-MAIN	X(1)	12	112	112	~~1.~~1. Value must be 1 character 2. Value must be in Core Based Statistical Area Code List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory

					http://www.whitehouse.gov/sites/default/files/omb/assets/bulletins/b10-02.pdf								
MCR028	MCR.002.028	PERCENT-BUSINESS	Percent Business	Mandatory	The percentage of the managed care entity's total revenue that is derived from contracts with Medicare (Part C and D) in the state and State Medicaid agency contract(s) prior calendar year. Include Medicaid and Medicare in calculation of percentage of business in public programs for IRS health insurer tax exemption as required in ACA.	N/A	MCR00002	MANAGED-CARE-MAIN	9(3)	13	113	115	1. Value must be between ~~0~~000 and 100 inclusively 2. Mandatory

MCR029	MCR.002.029	MANAGED-CARE-SERVICE-AREA	Managed Care Service Area	Mandatory	Identifies the geographic unit under which the managed care entity is under contract to provide services. The value reported in Managed Care Service Area should represent the geographical unit of the values reported in the Managed Care Service Area Name. See T-MSIS Guidance Document, "CMS Guidance: Best Practice for Reporting Managed Care Service Area in the Managed Care File" ". https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47542~~reporting-managedcareservicearea-in-the-managed-care-file-managed-care/	MANAGED-CARE-SERVICE-AREA	MCR00002	MANAGED-CARE-MAIN	X(1)	14	116	116	~~1.~~1. Value must be 1 character 2. Value must be in Managed Care Service Area List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory 4. When value equals '"2"', the associated Managed Care Service Area Name (MCR.004.058) value must be a valid US County Code
MCR030	MCR.002.030	MANAGED-CARE-MAIN-REC-EFF-DATE	Managed Care Main Record Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	MCR00002	MANAGED-CARE-MAIN	9(8)	15	117	124	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in ['~~18', '19', '20~~19,20,99]
MCR031	MCR.002.031	MANAGED-CARE-MAIN-REC-END-DATE	Managed Care Main Record End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	MCR00002	MANAGED-CARE-MAIN	9(8)	16	125	132	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on~~ in the form "CCYYMMDD" 2. Value must be the ~~leap year, never April 31st~~after or ~~Sept 31st)~~ ~~3. Value must be greater than or equal to~~the same as the associated Segment Effective Date value ~~4~~3. Mandatory

													~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~19,20,99]
MCR032	MCR.002.032	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	MCR00002	MANAGED-CARE-MAIN	X(500)	17	133	632	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
MCR034	MCR.003.034	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~ 3. Value must be in Record ID List (VVL) 4. Value must equal "MCR00003"
MCR035	MCR.003.035	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (MCR.001.007)

MCR036	MCR.003.036	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory
MCR037	MCR.003.037	STATE-PLAN-ID-NUM	State Plan ID Number	Mandatory	The ID number a state issues to a managed care entity~~.~~	N/A	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	X(12)	4	22	33	1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
MCR038	MCR.003.038	MANAGED-CARE-LOCATION-ID	Managed Care Location ID	Mandatory	A field to differentiate a managed care entity's service locations through adding a sequential number in this data element identifier field. Use sequential numbers to indicate additional services locations.	N/A	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	X(15)	5	34	48	~~1.~~1. Value must be 15 characters or less 2. Value must not contain a pipe symbol ~~2~~3. Each managed care entity's locations must have a unique identifier ~~3. (Managed care entity's service location address)~~4. Value must be populated if associated Managed Care Address Type (MCR.003.041) equals 3 ~~4. Value must be 15 characters or less~~ (Managed care entity's service location address) 5. Mandatory
MCR039	MCR.003.039	MANAGED-CARE-LOCATION-AND-CONTACT-INFO-EFF-DATE	Managed Care Location and Contract Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	9(8)	6	49	56	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~19,20,99]

MCR040	MCR.003.040	MANAGED-CARE-LOCATION-AND-CONTACT-INFO-END-DATE	Managed Care Location and Contract End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	9(8)	7	57	64	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on~~ in the form "CCYYMMDD" 2. Value must be the ~~leap year, never April 31st~~after or ~~Sept 31st)~~ ~~3. Value must be greater than or equal to~~the same as the associated Segment Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~19,20,99]
MCR041	MCR.003.041	MANAGED-CARE-ADDR-TYPE	Managed Care Address Type	Mandatory	The type of address for the managed care organization submitted in the ~~record~~Managed Care Main segment.	MANAGED-CARE-ADDR-TYPE	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	X(1)	8	65	65	~~1.~~1. Value must be 1 character 2. Value must be in Managed Care Address Type List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory
MCR042	MCR.003.042	MANAGED-CARE-ADDR-LN1	Managed Care Address Line 1	Mandatory	The managed care entity's address listed on the contract with the state.	N/A	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	X(60)	9	66	125	1. Value must be 60 characters or less 2. Value must not be equal to associated Address Line 2 or Address Line 3 value(s) 3. Value must not contain a pipe or asterisk symbols 4. ~~When populated, the associated Address Type is required~~ ~~5. Mandatory~~Mandatory
MCR043	MCR.003.043	MANAGED-CARE-ADDR-LN2	Managed Care Address Line 2	Conditional	The managed care entity's address listed on the contract with the state.	N/A	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	X(60)	10	126	185	1. Value must be 60 characters or less 2. Value must not be equal to associated Address Line 1 or Address Line 3 value(s) 3. There must be an Address Line 1 in order to have an Address Line 2 4. Value must not contain a pipe or asterisk symbols 5. Conditional

MCR044	MCR.003.044	MANAGED-CARE-ADDR-LN3	Managed Care Address Line 3	Conditional	The managed care entity's address listed on the contract with the state.	N/A	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	X(60)	11	186	245	1. Value must be 60 characters or less 2. Value must not be equal to associated Address Line 1 or Address Line 2 value(s) 3. If Address Line 2 is not populated, then value should not be populated 4. Value must not contain a pipe or asterisk symbols 5. Conditional
MCR045	MCR.003.045	MANAGED-CARE-CITY	Managed Care City	Mandatory	The city component of an address associated with a given entity (e.g. person, organization, agency, etc.).	N/A	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	X(28)	12	246	273	1. Value must be 28 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
MCR046	MCR.003.046	MANAGED-CARE-STATE	Managed Care State	Mandatory	The ANSI state numeric code for the U.S. state, Territory, or the District of Columbia code of the of the managed care entity's address as listed on the contract with the state.	STATE	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	X(2)	13	274	275	~~1.~~1. Value must not be more than 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ 3. Mandatory
MCR047	MCR.003.047	MANAGED-CARE-ZIP-CODE	Managed Care ZIP Code	Mandatory	U.S. ZIP Code component of an address associated with a given entity (e.g. person, organization, agency, etc.)	ZIP-CODE	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	X(9)	14	276	284	1. Value may only be 5 digits (0-9) (Example: 91320) or 9 digits (0-9) (Example: 913200011) 2. Value must be in ZIP Code List (VVL) 3. Mandatory
MCR048	MCR.003.048	MANAGED-CARE-COUNTY	Managed Care County	Mandatory	The ANSI County numeric code for the county or county equivalent. One county code should be captured for each of a managed care entity's locations identified.	COUNTY	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	X(3)	15	285	287	~~1.~~1. Value must be 3 characters 2. Value must be in US County Code List (VVL) ~~2. Value must be 3 characters or less~~ ~~3.~~3. Mandatory
MCR049	MCR.003.049	MANAGED-CARE-TELEPHONE	Managed Care Phone Number	~~Op~~Situatio nal	Phone number for a given entity (e.g. person, organization, agency).	N/A	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	X(10)	16	288	297	1. Value must be 10 ~~characters, digits (0-9) only~~ digit number 2. ~~Op~~Situational

MCR050	MCR.003.050	MANAGED-CARE-EMAIL	Managed Care Email	~~Op~~Situational	The email address of the managed care entity listed on the contract with the state.	N/A	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	X(60)	17	298	357	1. Must contain the ~~'~~@~~'~~"@" symbol 2. May contain uppercase and lowercase Latin letters A to Z and a to z 3. May contain digits 0-9 4. Must contain a dot ~~'~~."~~'~~." that is not the first or last character and provided that it does not appear consecutively 5. Value must be 60 characters or less 6. ~~Op~~Situational
MCR051	MCR.003.051	MANAGED-CARE-FAX-NUMBER	Managed Care Fax Number	~~Op~~Conditional	A fax number, including area code, as listed on the contract with the state.	N/A	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	X(10)	18	358	367	~~1. Optional~~1. Value must be 10-digit number 2. Conditional
MCR052	MCR.003.052	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO	X(500)	19	368	867	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
MCR054	MCR.004.054	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier	RECORD-ID	MCR00004	MANAGED-CARE-SERVICE-AREA	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~ 3. Value must be in Record ID List (VVL) 4. Value must equal "MCR00004"

					padded with leading zeros (e.g., 00001, 00002, 00003, etc.).								
MCR055	MCR.004.055	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	MCR00004	MANAGED-CARE-SERVICE-AREA	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (MCR.001.007)
MCR056	MCR.004.056	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	MCR00004	MANAGED-CARE-SERVICE-AREA	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory
MCR057	MCR.004.057	STATE-PLAN-ID-NUM	State Plan ID Number	Mandatory	The ID number a state issues to a managed care entity	N/A	MCR00004	MANAGED-CARE-SERVICE-AREA	X(12)	4	22	33	1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory

MCR058	MCR.004.058	MANAGED-CARE-SERVICE-AREA-NAME	Managed Care Service Area Name	Conditional	The specific identifiers for the counties, cities, regions, ZIP Codes and/or other geographic areas that the managed care entity serves. Put each zip code, city, county, region, or other area descriptor on a separate record. Use 5 digit zip codes when service area definition is zip code based. Use ANSI codes when service area is defined by counties or cities. The value reported in Managed Care Service Area should represent the geographical unit of the values reported in the Managed Care Service Area Name. See T-MSIS Guidance Document, "CMS Guidance: Best Practice for Reporting Managed Care Service Area in the Managed Care File". https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47542~~reporting-managedcareservicearea-in-the-managed-care-file-managed-care/	MANAGED-CARE-SERVICE-AREA-NAME	MCR00004	MANAGED-CARE-SERVICE-AREA	X(30)	5	34	63	~~1.~~1. Value must be 30 characters or less 2. Value must be in Managed Care Service Area Name List (VVL) ~~2~~3. If associated Managed Care Service Area (MCR.002.029) is in [2,3,4,5,6], then value is mandatory and must be provided ~~3~~4. Value must not contain a pipe or asterisk symbol ~~4. Value must be 30 characters or less~~ ~~5.~~5. Conditional 6. If associated Managed Care Service Area (MCR.002.029) equals ~~'5'~~"5" (zip code), then value must be a 5-digit zip code 7. If associated Managed Care Service Area (MCR.002.029) equals ~~'2'~~"2" (county code), then value must be a 3-digit number
MCR059	MCR.004.059	MANAGED-CARE-SERVICE-AREA-EFF-DATE	Managed Care Service Area Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	MCR00004	MANAGED-CARE-SERVICE-AREA	9(8)	6	64	71	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~19,20,99]

MCR060	MCR.004.060	MANAGED-CARE-SERVICE-AREA-END-DATE	Managed Care Service Area End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	MCR00004	MANAGED-CARE-SERVICE-AREA	9(8)	7	72	79	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on~~ in the form "CCYYMMDD" 2. Value must be the ~~leap year, never April 31st~~after or ~~Sept 31st)~~ ~~3. Value must be greater than or equal to~~the same as the associated Segment Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~19,20,99]
MCR061	MCR.004.061	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	MCR00004	MANAGED-CARE-SERVICE-AREA	X(500)	8	80	579	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
MCR063	MCR.005.063	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	MCR00005	MANAGED-CARE-OPERATING-AUTHORITY	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~ 3. Value must be in Record ID List (VVL) 4. Value must equal "MCR00005"

MCR064	MCR.005.064	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	MCR00005	MANAGED-CARE-OPERATING-AUTHORITY	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (MCR.001.007)
MCR065	MCR.005.065	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	MCR00005	MANAGED-CARE-OPERATING-AUTHORITY	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory
MCR066	MCR.005.066	STATE-PLAN-ID-NUM	State Plan ID Number	Mandatory	The ID number a state issues to a managed care entity	N/A	MCR00005	MANAGED-CARE-OPERATING-AUTHORITY	X(12)	4	22	33	1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
MCR067	MCR.005.067	OPERATING-AUTHORITY	Operating Authority	Mandatory	The type of operating authority through which the managed care entity receives its contract authority. The Managed Care Plan Type assigned to the manage care plan in the Managed Care Main segment should be consistent with the Operating Authority value reported. See T-MSIS Guidance Document, "CMS Guidance: Best Practice for Reporting Managed Care Plan Type in the T-MSIS Managed Care File"". https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47566~~reporting-managedcareplantype-in-the-t-msis-managed-care-file-managed-care/	OPERATING-AUTHORITY	MCR00005	MANAGED-CARE-OPERATING-AUTHORITY	X(2)	5	34	35	~~1.~~1. Value must be 2 characters 2. Value must be in Operating Authority List (VVL) ~~2. Value must be 2 characters or less~~ ~~3.~~3. Mandatory

MCR068	MCR.005.068	WAIVER-ID	Waiver ID	Mandatory	Field specifying the ID of the waiver, demonstration or other authority which authorizes the state to operate the managed care program. These IDs must be the approved, full federal ID number assigned during the state submission and CMS approval process.	N/A	MCR00005	MANAGED-CARE-OPERATING-AUTHORITY	X(20)	6	36	55	1. Value must be 20 characters or less 2. Mandatory
MCR069	MCR.005.069	MANAGED-CARE-OP-AUTHORITY-EFF-DATE	Managed Care Op Authority Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	MCR00005	MANAGED-CARE-OPERATING-AUTHORITY	9(8)	7	56	63	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~19,20,99]
MCR070	MCR.005.070	MANAGED-CARE-OP-AUTHORITY-END-DATE	Managed Care Op Authority End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	MCR00005	MANAGED-CARE-OPERATING-AUTHORITY	9(8)	8	64	71	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on~~ in the form "CCYYMMDD" 2. Value must be the ~~leap year, never April 31st~~after or ~~Sept 31st)~~ ~~3. Value must be greater than or equal to~~the same as the associated Segment Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~19,20,99]
MCR071	MCR.005.071	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	MCR00005	MANAGED-CARE-OPERATING-AUTHORITY	X(500)	9	72	571	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational

MCR073	MCR.006.073	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	MCR00006	MANAGED-CARE-PLAN-POPULATION-ENROLLED	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "MCR00006"
MCR074	MCR.006.074	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	MCR00006	MANAGED-CARE-PLAN-POPULATION-ENROLLED	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (MCR.001.007)
MCR075	MCR.006.075	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	MCR00006	MANAGED-CARE-PLAN-POPULATION-ENROLLED	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory
MCR076	MCR.006.076	STATE-PLAN-ID-NUM	State Plan ID Number	Mandatory	The ID number a state issues to a managed care entity	N/A	MCR00006	MANAGED-CARE-PLAN-POPULATION-ENROLLED	X(12)	4	22	33	1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory

MCR077	MCR.006.077	MANAGED-CARE-PLAN-POP	Managed Care Plan Population	Mandatory	The eligibility group(s) the state is authorized to enroll in managed care plans by its operating authority. Submit a separate record segment for each eligibility group that can be enrolled in the managed care program in which the managed care plan is participating.	ELIGIBILITY-GROUP	MCR00006	MANAGED-CARE-PLAN-POPULATION-ENROLLED	9(2)	5	34	35	~~1.~~1. Value must be 2 characters 2. Value must be in Managed Care Plan Pop List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory
MCR078	MCR.006.078	MANAGED-CARE-PLAN-POP-EFF-DATE	Managed Care Plan Population Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	MCR00006	MANAGED-CARE-PLAN-POPULATION-ENROLLED	9(8)	6	36	43	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~19,20,99]
MCR079	MCR.006.079	MANAGED-CARE-PLAN-POP-END-DATE	Managed Care Plan Population End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	MCR00006	MANAGED-CARE-PLAN-POPULATION-ENROLLED	9(8)	7	44	51	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on~~ in the form "CCYYMMDD" 2. Value must be the ~~leap year, never April 31st~~after or ~~Sept 31st)~~ ~~3. Value must be greater than or equal to~~the same as the associated ~~Segment~~ Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~19,20,99]
MCR080	MCR.006.080	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	MCR00006	MANAGED-CARE-PLAN-POPULATION-ENROLLED	X(500)	8	52	551	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational

MCR082	MCR.007.082	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	MCR00007	MANAGED-CARE-ACCREDITATION-ORGANIZATION	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "MCR00007"
MCR083	MCR.007.083	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	MCR00007	MANAGED-CARE-ACCREDITATION-ORGANIZATION	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (MCR.001.007)
MCR084	MCR.007.084	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	MCR00007	MANAGED-CARE-ACCREDITATION-ORGANIZATION	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory
MCR085	MCR.007.085	STATE-PLAN-ID-NUM	State Plan ID Number	Mandatory	The ID number a state issues to a managed care entity	N/A	MCR00007	MANAGED-CARE-ACCREDITATION-ORGANIZATION	X(12)	4	22	33	1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory

MCR086	MCR.007.086	ACCREDITATION-ORGANIZATION	Accreditation Organization	Mandatory	Identify the accreditation awarded to the managed care entity.	ACCREDITATION-ORGANIZATION	MCR00007	MANAGED-CARE-ACCREDITATION-ORGANIZATION	X(2)	5	34	35	~~1.~~1. Value must be 2 characters 2. Value must be in Accreditation Organization List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory
MCR087	MCR.007.087	DATE-ACCREDITATION-ACHIEVED	Date Accreditation Achieved	Mandatory	The date the organization achieved accreditation.	N/A	MCR00007	MANAGED-CARE-ACCREDITATION-ORGANIZATION	9(8)	6	36	43	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~19,20,99]
MCR088	MCR.007.088	DATE-ACCREDITATION-END	Date Accreditation End	Mandatory	The date when organization's accreditation ends.	N/A	MCR00007	MANAGED-CARE-ACCREDITATION-ORGANIZATION	9(8)	7	44	51	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on~~ in the form "CCYYMMDD" 2. Value must be after or the ~~leap year, never April 31st or Sept 31st)~~ ~~3. Value must be greater than or equal to~~ same as the associated Segment Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~19,20,99]
MCR089	MCR.007.089	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	MCR00007	MANAGED-CARE-ACCREDITATION-ORGANIZATION	X(500)	8	52	551	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational

MCR091	MCR.008.091	RECORD-ID	Not Applicable	Not Applicable	[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]	N/A	MCR00008	NATIONAL-HEALTH-CARE-ENTITY-ID-INFO	X(8)	1	1	8	1. Not Applicable
MCR092	MCR.008.092	SUBMITTING-STATE	Not Applicable	Not Applicable	[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]	N/A	MCR00008	NATIONAL-HEALTH-CARE-ENTITY-ID-INFO	X(2)	2	9	10	1. Not Applicable
MCR093	MCR.008.093	RECORD-NUMBER	Not Applicable	Not Applicable	[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]	N/A	MCR00008	NATIONAL-HEALTH-CARE-ENTITY-ID-INFO	9(11)	3	11	21	1. Not Applicable
MCR094	MCR.008.094	STATE-PLAN-ID-NUM	Not Applicable	Not Applicable	[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]	N/A	MCR00008	NATIONAL-HEALTH-CARE-ENTITY-ID-INFO	X(12)	4	22	33	1. Not Applicable
MCR095	MCR.008.095	NATIONAL-HEALTH-CARE-ENTITY-ID	Not Applicable	Not Applicable	[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]	N/A	MCR00008	NATIONAL-HEALTH-CARE-ENTITY-ID-INFO	X(10)	5	34	43	1. Not Applicable
MCR096	MCR.008.096	NATIONAL-HEALTH-CARE-ENTITY-ID-TYPE	Not Applicable	Not Applicable	[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]	N/A	MCR00008	NATIONAL-HEALTH-CARE-ENTITY-ID-INFO	X(1)	6	44	44	1. Not Applicable
MCR097	MCR.008.097	NATIONAL-HEALTH-CARE-ENTITY-NAME	Not Applicable	Not Applicable	[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]	N/A	MCR00008	NATIONAL-HEALTH-CARE-ENTITY-ID-INFO	X(50)	7	45	94	1. Not Applicable

MCR098	MCR.008.098	NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-EFF-DATE	Not Applicable	Not Applicable	[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]	N/A	MCR00008	NATIONAL-HEALTH-CARE-ENTITY-ID-INFO	9(8)	8	95	102	1. Not Applicable
MCR099	MCR.008.099	NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-END-DATE	Not Applicable	Not Applicable	[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]	N/A	MCR00008	NATIONAL-HEALTH-CARE-ENTITY-ID-INFO	9(8)	9	103	110	1. Not Applicable
MCR100	MCR.008.100	STATE-NOTATION	Not Applicable	Not Applicable	[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]	N/A	MCR00008	NATIONAL-HEALTH-CARE-ENTITY-ID-INFO	X(500)	10	111	610	1. Not Applicable
MCR102	MCR.009.102	RECORD-ID	Not Applicable	Not Applicable	[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]	N/A	MCR00009	CHPID-SHPID-RELATIONSHIPS	X(8)	1	1	8	1. Not Applicable
MCR103	MCR.009.103	SUBMITTING-STATE	Not Applicable	Not Applicable	[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]	N/A	MCR00009	CHPID-SHPID-RELATIONSHIPS	X(2)	2	9	10	1. Not Applicable
MCR104	MCR.009.104	RECORD-NUMBER	Not Applicable	Not Applicable	[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]	N/A	MCR00009	CHPID-SHPID-RELATIONSHIPS	9(11)	3	11	21	1. Not Applicable
MCR105	MCR.009.105	STATE-PLAN-ID-NUM	Not Applicable	Not Applicable	[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]	N/A	MCR00009	CHPID-SHPID-RELATIONSHIPS	X(12)	4	22	33	1. Not Applicable

~~MCR106~~	~~MCR.009.106~~	~~CHPID~~	~~Not Applicable~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~MCR00009~~	~~CHPID-SHPID-RELATIONSHIPS~~	~~X(10)~~	~~5~~	~~34~~	~~43~~	~~1. Not Applicable~~
~~MCR107~~	~~MCR.009.107~~	~~SHPID~~	~~Not Applicable~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~SEX-ASSIGNED-AT-BIRTH~~	~~MCR00009~~	~~CHPID-SHPID-RELATIONSHIPS~~	~~X(10)~~	~~6~~	~~44~~	~~53~~	~~1. Not Applicable~~
~~MCR108~~	~~MCR.009.108~~	~~CHPID-SHPID-RELATIONSHIP-EFF-DATE~~	~~Not Applicable~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~MCR00009~~	~~CHPID-SHPID-RELATIONSHIPS~~	~~9(8)~~	~~7~~	~~54~~	~~61~~	~~1. Not Applicable~~
~~MCR109~~	~~MCR.009.109~~	~~CHPID-SHPID-RELATIONSHIP-END-DATE~~	~~Not Applicable~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~MCR00009~~	~~CHPID-SHPID-RELATIONSHIPS~~	~~9(8)~~	~~8~~	~~62~~	~~69~~	~~1. Not Applicable~~
~~MCR110~~	~~MCR.009.110~~	~~STATE-NOTATION~~	~~Not Applicable~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~MCR00009~~	~~CHPID-SHPID-RELATIONSHIPS~~	~~X(500)~~	~~9~~	~~70~~	~~569~~	~~1. Not Applicable~~
MCR112	MCR.001.112	SEQUENCE-NUMBER	Sequence Number	Mandatory	To enable states to sequentially number files, when related, follow-on files are necessary (i.e., update files, replacement files). This should begin with 1 for the original Create submission type and be incremented by one for each Replacement or Update submission for the same reporting period and file type (subject area).	N/A	MCR00001	FILE-HEADER-RECORD-MANAGED-CARE	X(4)	~~13~~14	~~78~~80	~~81~~83	~~1.~~1. Value must be 4 characters or less 2. Value must between 1 and 9999 ~~2~~3. Value must be equal to the largest of any prior values for the same reporting period and file type, plus 1 (i.e. incremented by 1) ~~3~~4. Value must not contain a pipe symbol ~~4. Value must be 4 characters or less~~ 5. Mandatory

MCR113	MCR.001.113	FILE-SUBMISSION-METHOD	File Submission Method	Mandatory	The file submission method (e.g., TFFR, RHFR, IT, or CSO) used by the state to build and submit the file. This should correspond with the state's declared file submission method for the same file type and time period.	FILE-SUBMISSION-METHOD	MCR00001	FILE-HEADER-RECORD-MANAGED-CARE	X(2)	13	78	79	1. Value must be 2 characters 2. Value must be in File Submission Method List (VVL) 3. Mandatory
MCR114	MCR.010.114	RECORD-ID	Record ID	Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	MCR00010	MANAGED-CARE-ID	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "MCR00010"
MCR115	MCR.010.115	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	MCR00010	MANAGED-CARE-ID	X(2)	2	9	10	1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory 4. Value must be the same as Submitting State (MCR.001.007)
MCR116	MCR.010.116	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	MCR00010	MANAGED-CARE-ID	9(11)	3	11	21	1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
MCR117	MCR.010.117	STATE-PLAN-ID-NUM	State Plan ID Number	Mandatory	The ID number a state issues to a managed care entity	N/A	MCR00010	MANAGED-CARE-ID	X(12)	4	22	33	1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory

MCR118	MCR.010.118	MANAGED-CARE-PLAN-OTHER-ID-TYPE	Managed Care Plan Other ID Type	Mandatory	A code to identify the kind of managed care identifier that is captured in the Managed Care Identifier data element. The state should submit updates to T-MSIS whenever an identifier is retired or issued.	MANAGED-CARE-PLAN-OTHER-ID-TYPE	MCR00010	MANAGED-CARE-ID	X(2)	5	34	35	1. Value must be 2 characters 2. Value must be in Managed Care Plan Other ID Type List (VVL) 3. Mandatory
MCR119	MCR.010.119	MANAGED-CARE-PLAN-OTHER-ID	Managed Care Plan Other ID	Mandatory	A data element to capture the various IDs used to identify a managed care plan. The specific type of identifier is defined in the corresponding value in the Managed Care Plan Identifier Type data element.	N/A	MCR00010	MANAGED-CARE-ID	X(30)	6	36	65	1. Value must be 30 characters 2. Value must not contain a pipe or asterisk symbol 3. Mandatory
MCR120	MCR.010.120	MANAGED-CARE-ID-EFF-DATE	Managed Care ID Effective Date	Mandatory	The date the organization achieved accreditation.	N/A	MCR00010	MANAGED-CARE-ID	9(8)	7	66	73	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
MCR121	MCR.010.121	MANAGED-CARE-ID-END-DATE	Managed Care ID End Date	Mandatory	The date when organization's accreditation ends.	N/A	MCR00010	MANAGED-CARE-ID	9(8)	8	74	81	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be the after or the same as the associated Segment Effective Date value 3. Mandatory 4. Value of the CC component must be in [19,20,99]
MCR122	MCR.010.122	STATE-NOTATION	State Notation	Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	MCR00010	MANAGED-CARE-ID	X(500)	9	82	581	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational

T-MSIS Data Dictionary – PRV File Changes Between Versions 2.4.0 and 4.0.0

PRV001	PRV.001.001	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	PRV00001	FILE-HEADER-RECORD-PROVIDER	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "PRV00001"
PRV002	PRV.001.002	DATA-DICTIONARY-VERSION	Data Dictionary Version	Mandatory	A data element to capture the version of the T-MSIS data dictionary that was used to build the file. ~~Use the version number specified on the Cover Sheet of the data dictionary" to V2.4.~~	DATA-DICTIONARY-VERSION	PRV00001	FILE-HEADER-RECORD-PROVIDER	X(10)	2	9	18	1. Value must be 10 characters or less 2. Value must be in Data Dictionary Version List (VVL) 3. Value must not include the pipe ("|") symbol ~~3~~4. Mandatory
PRV003	PRV.001.003	SUBMISSION-TRANSACTION-TYPE	Submission Transaction Type	Mandatory	A data element to identify the whether the transactions in the file are original submissions of the data, a resubmission of a previously submitted file, or corrections of edit rejects.	SUBMISSION-TRANSACTION-TYPE	PRV00001	FILE-HEADER-RECORD-PROVIDER	X(1)	3	19	19	1. Value must be 1 character 2. Value must be in Submission Transaction Type List (VVL) ~~2. Value must be 1 character~~ 3. Mandatory
PRV004	PRV.001.004	FILE-ENCODING-SPECIFICATION	File Encoding Specification	Mandatory	Denotes which supported file encoding standard was used to create the file.	FILE-ENCODING-SPECIFICATION	PRV00001	FILE-HEADER-RECORD-PROVIDER	X(3)	4	20	22	~~1.~~1. Value must be 3 characters 2. Value must be in File Encoding Specification List (VVL) ~~2. Value must be 3 characters~~ ~~3.~~3. Mandatory
PRV005	PRV.001.005	DATA-MAPPING-DOCUMENT-VERSION	Data Mapping Document Version	Mandatory	Identifies the version of the T-MSIS data mapping document used to build a state	N/A	PRV00001	FILE-HEADER-RECORD-PROVIDER	X(9)	5	23	31	1. Value must be 9 characters or less 2. Mandatory

					submission file. ~~Use the version number specified on the title page of the data mapping document~~								
PRV006	PRV.001.006	FILE-NAME	File Name	~~Not Applicable~~ Mandatory	A code to identify the subject area to which the records in its file relate. Each T-MSIS submission file should only contain records for one subject area (i.e., Eligible, Third-party liability, Provider, Managed Care Plan Information, Inpatient, Long-Term Care, Other, ~~and~~ Pharmacy Claim, and Financial Transactions).	N/A	PRV00001	FILE-HEADER-RECORD-PROVIDER	X(8)	6	32	39	1. Value must equal ~~'PROVIDER'~~"PROVIDER" 2. Mandatory
PRV007	PRV.001.007	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	PRV00001	FILE-HEADER-RECORD-PROVIDER	X(2)	7	40	41	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same for all records
PRV008	PRV.001.008	DATE-FILE-CREATED	Date File Created	Mandatory	The date on which the file was created.	N/A	PRV00001	FILE-HEADER-RECORD-PROVIDER	9(8)	8	42	49	~~1.~~1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" ~~2~~3. Value must be ~~8 characters in the form "CCYYMMDD"~~ ~~3. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~4.~~less than current date 4. Value must be equal to or after the value of associated End of Time Period 5. Mandatory
PRV009	PRV.001.009	START-OF-TIME-PERIOD	Start of Time Period	Mandatory	This value must be the first day of the reporting month, regardless of the actual date span of the data in the file.	N/A	PRV00001	FILE-HEADER-RECORD-PROVIDER	9(8)	9	50	57	~~1. Value of the CC component must be "20"~~ ~~2. Value must be 8 characters in the form "CCYYMMDD"~~ ~~3.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~4. Value must be less than current date~~ ~~5.~~in the form "CCYYMMDD"

													2. Value must be equal to or earlier than associated Date File Created ~~6~~3. Value must be before associated End of Time Period ~~7~~4. Mandatory 5. Value of the CC component must be "20"
PRV010	PRV.001.010	END-OF-TIME-PERIOD	End of Time Period	Mandatory	This value must be the last day of the reporting month, regardless of the actual date span.	N/A	PRV00001	FILE-HEADER-RECORD-PROVIDER	9(8)	10	58	65	1. ~~Value~~The date must be ~~8 characters~~a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" 3. ~~The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~4.~~ Value must be equal to or earlier than associated Date File Created ~~5~~4. Value must be equal to or after associated Start of Time Period ~~6~~5. Mandatory
PRV011	PRV.001.011	FILE-STATUS-INDICATOR	File Status Indicator	Mandatory	A code to indicate whether the records in the file are test or production records.	FILE-STATUS-INDICATOR	PRV00001	FILE-HEADER-RECORD-PROVIDER	X(1)	11	66	66	~~1.~~1. Value must be 1 character 2. For production files, value must be equal to ~~'P'~~ ~~2. Value must be 1 character "P"~~ 3. Value must be in File Status Indicator List (VVL) 4. Mandatory
PRV013	PRV.001.013	TOT-REC-CNT	Total Record Count	Mandatory	A count of all records in the file except for the file header record. This count will be used as a control total to help assure that the file did not become corrupted during transmission.	N/A	PRV00001	FILE-HEADER-RECORD-PROVIDER	9(11)	12	67	77	~~1.~~1. Value must be 11 digits or less 2. Value must be a positive integer ~~2~~3. Value must be between 0:99999999999 (inclusive) ~~3. Value must be 11 digits or less~~ ~~4.~~4. Value must equal the number of records included in the file submission except for the

													file header record. 5. Mandatory
PRV014	PRV.001.014	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	PRV00001	FILE-HEADER-RECORD-PROVIDER	X(500)	~~14~~15	~~82~~84	58~~13~~	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
PRV016	PRV.002.016	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	PRV00002	PROV-ATTRIBUTES-MAIN	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~ 3. Value must be in Record ID List (VVL) 4. Value must equal "PRV00002"
PRV017	PRV.002.017	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	PRV00002	PROV-ATTRIBUTES-MAIN	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (PRV.001.007)

PRV018	PRV.002.018	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	PRV00002	PROV-ATTRIBUTES-MAIN	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory
PRV019	PRV.002.019	SUBMITTING-STATE-PROV-ID	Submitting State Provider ID	Mandatory	The State-specific Medicaid Provider Identifier is a state-assigned unique identifier that states should report with all individual providers, practice groups, facilities, and other entities. This should be the identifier that is used in the state's Medicaid Management Information System.	N/A	PRV00002	PROV-ATTRIBUTES-MAIN	X(30)	4	22	51	1. Value must be 30 characters or less 2. Mandatory ~~3. Value must be 8 characters in the form "CCYYMMDD"~~
PRV020	PRV.002.020	PROV-ATTRIBUTES-EFF-DATE	Provider Attributes Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	PRV00002	PROV-ATTRIBUTES-MAIN	9(8)	5	52	59	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~19,20,99]
PRV021	PRV.002.021	PROV-ATTRIBUTES-END-DATE	Provider Attributes End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	PRV00002	PROV-ATTRIBUTES-MAIN	9(8)	6	60	67	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be greater than or equal to associated Segment Effective Date value ~~4~~3. Mandatory

													~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~18,19,20,99]
PRV022	PRV.002.022	PROV-DOING-BUSINESS-AS-NAME	Provider DBA Name	Conditional	The provider's name that is commonly used by the public when the "doing-business-as" name is different than the legal name. DBA is an abbreviation for "doing business as." Registering a DBA is required to operate a business under a name that differs from the company's legal name. If DBA name is the same as the legal name, do not populate DBA name.	N/A	PRV00002	PROV-ATTRIBUTES-MAIN	X(100)	7	68	167	~~1.~~1. Value must be 100 characters or less 2. Value must not contain a pipe or asterisk symbol ~~2. Value must be 100 characters or less~~ ~~3.~~3. Conditional
PRV023	PRV.002.023	PROV-LEGAL-NAME	Provider Legal Name	Mandatory	The name as it appears on the provider agreement between the state and the entity. Both persons and other entities can have a legal name.	N/A	PRV00002	PROV-ATTRIBUTES-MAIN	X(100)	8	168	267	~~1.~~1. Value must be 100 characters or less 2. Value must not contain a pipe or asterisk symbol ~~2. Value must be 100 characters or less~~ ~~3.~~3. Mandatory
PRV024	PRV.002.024	PROV-ORGANIZATION-NAME	Provider Organization Name	Conditional	The name of the provider when the provider is an organization. If the provider organization name exceeds 60 characters submit only the first 60 characters of the name. Provider Organization Name should be same as provider last name when provider is an individual.	N/A	PRV00002	PROV-ATTRIBUTES-MAIN	X(60)	9	268	327	~~1.~~1. Value must be 60 characters or less 2. Value must not contain a pipe or asterisk symbol ~~2. Value must be 60 characters or less~~ ~~3.~~3. Conditional
PRV025	PRV.002.025	PROV-TAX-NAME	Provider Tax Name	Mandatory	The name that the provider entity uses on IRS filings.	N/A	PRV00002	PROV-ATTRIBUTES-MAIN	X(100)	10	328	427	~~1.~~1. Value must be 100 characters or less 2. Value must not contain a pipe or asterisk symbol ~~2. Value must be 100 characters or less~~ ~~3.~~3. Mandatory

PRV026	PRV.002.026	FACILITY-GROUP-INDIVIDUAL-CODE	Facility Group Individual Code	Mandatory	A code to identify whether the Submitting State Provider Identifier is assigned to an individual, group, or a facility.	FACILITY-GROUP-INDIVIDUAL-CODE	PRV00002	PROV-ATTRIBUTES-MAIN	X(2)	11	428	429	1. Value must be in Facility Group Individual Code List (VVL) 2. Value must be 2 characters 3. Mandatory 4. (Individual) If value equals '03', then Provider First Name (PRV.002.028) must be populated 5. (~~organization) if value does not~~ Individual) NPPES Entity Type Code associate with this NPI must equal ~~'03', then Provider Middle Initial (PRV.002.029) must not be populated~~"1" (Individual) 6. (Individual) If value equals '03', then Provider Last Name (PRV.002.030) must be populated 7. (Individual) If value equals '03', then Provider Sex (PRV.002.031) must be populated 8. (Individual) If value equals '03', then Provider Date of Birth (PRV.002.034) must be populated 9. (Organization) If value equals '01' or '02', then Provider Date of Death (PRV.002.035) must not be populated 10. (Organization) If value does not equal "03", then Provider Middle Initial (PRV.002.029) must not be populated 11. (Organization) NPPES Entity Type Code associate with this NPI must equal "2" (Organization)
PRV027	PRV.002.027	TEACHING-IND	Teaching Indicator	Conditional	A code indicating if the provider's organization is a teaching facility.	TEACHING-IND	PRV00002	PROV-ATTRIBUTES-MAIN	X(1)	12	430	430	~~1.~~1. Value must be 1 character 2. Value must be in Teaching Indicator List (VVL) ~~2~~3. Value must be ~~1 character~~ ~~3.~~"0" when Facility Group Individual Code

													(PRV.002.026) equals '02' or '03' 4. Conditional
PRV028	PRV.002.028	PROV-FIRST-NAME	Provider First Name	Conditional	Individual's first name; first name component of full name (e.g. First Name, Middle Initial, Last Name).	N/A	PRV00002	PROV-ATTRIBUTES-MAIN	X(30)	13	431	460	1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional
PRV029	PRV.002.029	PROV-MIDDLE-INITIAL	Provider Middle Initial	Conditional	Individual's middle initial; middle initial component of full name (e.g. First Name, Middle Initial, Last Name).	N/A	PRV00002	PROV-ATTRIBUTES-MAIN	X(1)	14	461	461	1. ~~Value may include any alphanumeric characters, digits or symbols~~ ~~2.~~Value must be 1 character ~~3~~2. Value must not contain a pipe or asterisk symbols ~~4~~3. Conditional
PRV030	PRV.002.030	PROV-LAST-NAME	Provider Last Name	Conditional	Individual's last name; last name component of full name (e.g. First Name, Middle Initial, Last Name).	N/A	PRV00002	PROV-ATTRIBUTES-MAIN	X(30)	15	462	491	1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional
PRV031	PRV.002.031	SEX	Sex	Conditional	Either individual's biological sex or their self-identified sex.	SEX	PRV00002	PROV-ATTRIBUTES-MAIN	X(1)	16	492	492	~~1.~~1. Value must be 1 character 2. Value must be in Sex List (VVL) ~~2. Value must be 1 character~~ 3. Conditional
PRV032	PRV.002.032	OWNERSHIP-CODE	Ownership Code	Conditional	A code denoting the ownership interest and/or managing control information. The valid values list is a Medicare standard list.	OWNERSHIP-CODE	PRV00002	PROV-ATTRIBUTES-MAIN	X(2)	17	493	494	~~1.~~1. Value must be 2 characters 2. Value must be in Ownership Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional 4. Value is mandatory when associated Facility Group Individual Code (PRV.002.026) is in [~~'01, '02'~~01,02] (organization)

PRV033	PRV.002.033	PROV-PROFIT-STATUS	Provider Profit Status	Mandatory	A code denoting the profit status of the provider.	PROV-PROFIT-STATUS	PRV00002	PROV-ATTRIBUTES-MAIN	X(2)	18	495	496	~~1.~~1. Value must be 2 characters 2. Value must be in Provider Profit Status List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory
PRV034	PRV.002.034	DATE-OF-BIRTH	Date of Birth	Conditional	An individual's date of birth.	N/A	PRV00002	PROV-ATTRIBUTES-MAIN	9(8)	19	497	504	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be less than or equal to associated End of Time Period (PRV.001.010) ~~4. Value must be less than or equal to associated Date File Created (PRV.001.008)~~ ~~5.~~3. Conditional ~~6~~4. The difference between current value and Start of Time Period (PRV.001.009) must be between 18 and 85 years
PRV035	PRV.002.035	DATE-OF-DEATH	Date of Death	Conditional	The date an individual died on.	N/A	PRV00002	PROV-ATTRIBUTES-MAIN	9(8)	20	505	512	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Conditional ~~4~~3. If populated, value must be on or after individual's Date of Birth ~~5~~4. Value must be less than or equal to associated End of Time Period (PRV.001.010) ~~6~~5. There can only be one value on all records when the value is populated ~~7~~6. When populated, the difference between value and Date of Birth (PRV.002.034) must be 18 years or greater

PRV036	PRV.002.036	ACCEPTING-NEW-PATIENTS-IND	Accepting New Patients Indicator	Mandatory	An indicator to identify providers who are accepting new patients.	ACCEPTING-NEW-PATIENTS-IND	PRV00002	PROV-ATTRIBUTES-MAIN	X(1)	21	513	513	~~1.~~1. Value must be 1 character 2. Value must be in Accepting New Patients Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory
PRV037	PRV.002.037	STATE-NOTATION	State Notation	~~Op~~Situatio nal	A free text field for the submitting state to enter whatever information it chooses.	N/A	PRV00002	PROV-ATTRIBUTES-MAIN	X(500)	~~22~~23	514~~5~~	101~~34~~	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
PRV039	PRV.003.039	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "PRV00003"
PRV040	PRV.003.040	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (PRV.001.007)

PRV041	PRV.003.041	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory
PRV042	PRV.003.042	SUBMITTING-STATE-PROV-ID	Submitting State Provider ID	Mandatory	The State-specific Medicaid Provider Identifier is a state-assigned unique identifier that states should report with all individual providers, practice groups, facilities, and other entities. This should be the identifier that is used in the state's Medicaid Management Information System.	N/A	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(30)	4	22	51	1. Value must be 30 characters or less 2. Mandatory ~~3. Value must not contain a pipe symbol~~
PRV043	PRV.003.043	PROV-LOCATION-ID	Provider Location ID	~~Not Applicable~~ Mandatory	A code to uniquely identify the geographic location where the provider's services were performed. The Provider Location Identifier values reported on Inpatient, Long-Term Care, Other, and Pharmacy Claim Header Segments must correspond to an active Provider Location Identifier value on a Provider Location ~~&~~and Contact Info (~~PRV00003~~PRV.003) segment. If a particular license (e.g., a physician's medical license) or provider identifier (e.g., an individual provider's NPI or SSN) is applicable to all of their servicing locations, value "000" (a string of exactly three zeros) can be used in the ~~PRV00004~~PRV.004 or ~~PRV00005~~PRV.005, respectively, to represent all locations, however that location identifier must not be attributed to claims or provider bed type info.	N/A	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(5)	5	52	56	~~1. Value must not contain a pipe symbol~~ ~~2.~~1. Value must be 5 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory

PRV044	PRV.003.044	PROV-LOCATION-AND-CONTACT-INFO-EFF-DATE	Provider Location ~~&~~and Contact Info Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	9(8)	6	57	64	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~19,19,99]
PRV045	PRV.003.045	PROV-LOCATION-AND-CONTACT-INFO-END-DATE	Provider Location ~~&~~and Contact Info End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	9(8)	7	65	72	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be greater than or equal to associated Segment Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~19,20,99]
PRV046	PRV.003.046	PROV-ADDR-TYPE	Provider Address Type	Mandatory	The type of address and contact information for the provider submitted in the record segment.	PROV-ADDR-TYPE	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(1)	8	73	73	~~1.~~1. Value must be 1 character 2. Value must be in Provider Address Type List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory
PRV047	PRV.003.047	ADDR-LN1	Provider Address Line 1	Mandatory	The first line of a potentially multi-line physical street or mailing address for a given entity (e.g. person, organization, agency, etc.).	N/A	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(60)	9	74	133	1. Value must be 60 characters or less 2. Value must not be equal to associated Address Line 2 or Address Line 3 value(s) 3. Value must not contain a pipe or asterisk symbols 4. ~~When populated, the associated Address Type is required~~ ~~5. Mandatory~~Mandatory

PRV048	PRV.003.048	ADDR-LN2	Provider Address Line 2	Conditional	The second line of a multi-line physical street or mailing address for a given entity (e.g. person, organization, agency, etc.).	N/A	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(60)	10	134	193	1. Value must be 60 characters or less 2. Value must not be equal to associated Address Line 1 or Address Line 3 value(s) 3. There must be an Address Line 1 in order to have an Address Line 2 4. Value must not contain a pipe or asterisk symbols 5. Conditional
PRV049	PRV.003.049	ADDR-LN3	Provider Address Line 3	Conditional	The third line of a multi-line physical street or mailing address for a given entity (e.g. person, organization, agency, etc.).	N/A	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(60)	11	194	253	1. Value must be 60 characters or less 2. Value must not be equal to associated Address Line 1 or Address Line 2 value(s) 3. If Address Line 2 is not populated, then value should not be populated 4. Value must not contain a pipe or asterisk symbols 5. Conditional
PRV050	PRV.003.050	ADDR-CITY	Provider City	Mandatory	The city component of an address associated with a given entity (e.g. person, organization, agency, etc.).	N/A	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(28)	12	254	281	1. Value must be 28 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
PRV051	PRV.003.051	ADDR-STATE	Provider State	Mandatory	The ANSI numeric state code component of an address associated with a given entity (e.g. person, organization, agency, etc.)	STATE	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(2)	13	282	283	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ 3. Mandatory
PRV052	PRV.003.052	ADDR-ZIP-CODE	Provider ZIP Code	Mandatory	U.S. ZIP Code component of an address associated with a given entity (e.g. person, organization, agency, etc.)	ZIP-CODE	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(9)	14	284	292	1. Value may only be 5 digits (0-9) (Example: 91320) or 9 digits (0-9) (Example: 913200011) 2. Value must be in ZIP Code List (VVL) 3. Mandatory
PRV053	PRV.003.053	ADDR-TELEPHONE	Provider Phone Number	~~Op~~Situational	Phone number for a given entity (e.g. person, organization, agency).	N/A	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(10)	15	293	302	1. Value must be 10 ~~characters, digits (0-9) only~~ digit number 2. ~~Op~~Situational

PRV054	PRV.003.054	ADDR-EMAIL	Provider Address Email	~~Op~~Situational	The email address of the provider for the location being captured on this record	N/A	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(60)	16	303	362	1. Must contain the ~~'~~@~~'~~"@" symbol 2. May contain uppercase and lowercase Latin letters A to Z and a to z 3. May contain digits 0-9 4. Must contain a dot ~~'~~."~~'~~." that is not the first or last character and provided that it does not appear consecutively 5. Value must be 60 characters or less 6. ~~Op~~Situational
PRV055	PRV.003.055	ADDR-FAX-NUM	Provider Address Fax	~~Op~~Situational	The fax number of the provider for the location being captured on this record.	N/A	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(10)	17	363	372	1. Value must be 10 ~~characters, digits (0-9) only~~ digit number 2. ~~Op~~Situational
PRV056	PRV.003.056	ADDR-BORDER-STATE-IND	Address Border State Indicator	Mandatory	A code identify an out of state provider enrolled with the state (The provider location is out of state, but for payment purposes the provider is treated as an in-state provider.)	ADDR-BORDER-STATE-IND	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(1)	18	373	373	~~1.~~1. Value must be 1 character 2. Value must be in Address Border State Indicator List (VVL) ~~2~~3. Mandatory
PRV057	PRV.003.057	ADDR-COUNTY	Provider County Code	Mandatory	Standard ANSI code used to identify a specific U.S. County.	COUNTY	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(3)	19	374	376	~~1.~~1. Value must be 3 characters 2. Value must be in US County Code List (VVL) ~~2. Value must be 3 characters~~ ~~3.~~3. Mandatory
PRV058	PRV.003.058	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	PRV00003	PROV-LOCATION-AND-CONTACT-INFO	X(500)	20	377	876	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational

PRV060	PRV.004.060	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	PRV00004	PROV-LICENSING-INFO	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "PRV00004"
PRV061	PRV.004.061	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	PRV00004	PROV-LICENSING-INFO	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (PRV.001.007)
PRV062	PRV.004.062	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	PRV00004	PROV-LICENSING-INFO	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory
PRV063	PRV.004.063	SUBMITTING-STATE-PROV-ID	Submitting State Provider ID	Mandatory	The State-specific Medicaid Provider Identifier is a state-assigned unique identifier that states should report with all individual providers, practice groups, facilities, and other entities. This should be the identifier that is used in the	N/A	PRV00004	PROV-LICENSING-INFO	X(30)	4	22	51	1. Value must be 30 characters or less 2. Mandatory ~~3. Value must not contain a pipe symbol~~

					state's Medicaid Management Information System.								
PRV064	PRV.004.064	PROV-LOCATION-ID	Provider Location ID	~~Not Applicable~~ Mandatory	A code to uniquely identify the geographic location where the provider's services were performed. The Provider Location Identifier values reported on Inpatient, Long-Term Care, Other, and Pharmacy Claim Header Segments must correspond to an active Provider Location Identifier value on a Provider Location ~~&~~and Contact Info (~~PRV00003~~PRV.003) segment. If a particular license (e.g., a physician's medical license) or provider identifier (e.g., an individual provider's NPI or SSN) is applicable to all of their servicing locations, value "000" (a string of exactly three zeros) can be used in the ~~PRV00004~~PRV.004 or ~~PRV00005~~PRV.005, respectively, to represent all locations, however that location identifier must not be attributed to claims or provider bed type info.	N/A	PRV00004	PROV-LICENSING-INFO	X(5)	5	52	56	~~1. Value must not contain a pipe symbol~~ ~~2.~~ 1. Value must be 5 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
PRV065	PRV.004.065	PROV-LICENSE-EFF-DATE	Provider License Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	PRV00004	PROV-LICENSING-INFO	9(8)	6	57	64	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~19,20,99]

PRV066	PRV.004.066	PROV-LICENSE-END-DATE	Provider License End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	PRV00004	PROV-LICENSING-INFO	9(8)	7	65	72	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be greater than or equal to associated Segment Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~18,19,20,99]
PRV067	PRV.004.067	LICENSE-TYPE	License Type	Mandatory	A code to identify the kind of license or accreditation number that is captured in the License ~~OR ACCREDITATION~~ or Accreditation Number data element.	LICENSE-TYPE	PRV00004	PROV-LICENSING-INFO	X(1)	8	73	73	~~1.~~1. Value must be 1 character 2. Value must be in License Type List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory

PRV068	PRV.004.068	LICENSE-ISSUING-ENTITY-ID	License Issuing Entity ID	Mandatory	A free text field to capture the identity of the entity issuing the license or accreditation. Enter the applicable state code, county code, municipality name, "DEA", professional society's name, or the CLIA accreditation body's name. ~~(county) -~~If associated License Type is equal to 1 and issuing authority is a State, then value must be ANSI State abbreviation code.- If associated License Type is equal to 1 and issuing authority is a county, then value must be a 5-digit, concatenated code consisting of the ANSI ~~2-digit~~ state code plus the ANSI county ~~3-digit code of the applicable.~~ ~~If associated License Type is equal to 1 and the issuing authority is the State, then value must be a 5-digit, concatenated~~ code ~~consisting of the ANSI 2 digit state code plus the ANSI 3-digit county code.~~ ~~For example, Orange County, CA would be 06059 Orange County, NC 37135.~~ . A list of codes can be found here: https://www.nrcs.usda.gov/wps/portal/nrcs/detail/national/home/?cid=nrcs143_013697 ~~(CLIA)~~ If associated License Type is equal to 1 and issuing authority is a municipality, then enter a text string with the name of the municipality. If associated License Type is equal to 3, then enter the text string identifying the professional society issuing the accreditation. If associated License Type is equal to 4, then value must be the text string identifying the CLIA accreditation body's name. ~~(Professional society accreditation) if associated~~	N/A	PRV00004	PROV-LICENSING-INFO	X(60)	9	74	133	~~1.~~1. Value must be 60 characters or less 2. Value must not contain a pipe or asterisk symbol ~~2. Value must be 60 characters or less~~ ~~3. (required)~~ 3. Mandatory 4. If associated License ~~or Accreditation Number (PRV.005.069) value is populated,~~Type equals "2", then value ~~is mandatory and must be provided~~ ~~4. Mandatory~~ ~~5. Value~~ must equal ~~'DEA' when associated License Type equals '2'~~"DEA"

					~~License Type is equal to three, then enter the text string identifying the professional society issuing the accreditation.~~ ~~(DEA) if associated License Type is equal to 2 , then value must be the text string "DEA"~~ ~~(state) if associated License Type is equal to 1 and issuing authority is a State, then value must be a 2 digit ANSI State abbreviation code.~~								
PRV069	PRV.004.069	LICENSE-OR-ACCREDITATION-NUMBER	License or Accreditation Number	Mandatory	A data element to capture the license or accreditation number issued to the provider by the licensing entity or accreditation body identified in the License ~~ISSUING-ENTITY-~~ Issuing Entity ID data element.	N/A	PRV00004	PROV-LICENSING-INFO	X(20)	10	134	153	~~1.~~1. Value must be 20 characters or less 2. Value must not contain a pipe and asterisk symbol ~~2. Value must be 20 characters or less~~ ~~3.~~3. Mandatory
PRV070	PRV.004.070	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	PRV00004	PROV-LICENSING-INFO	X(500)	11	154	653	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational

PRV072	PRV.005.072	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	PRV00005	PROV-IDENTIFIERS	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "PRV00005"
PRV073	PRV.005.073	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	PRV00005	PROV-IDENTIFIERS	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (PRV.001.007)
PRV074	PRV.005.074	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	PRV00005	PROV-IDENTIFIERS	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory
PRV075	PRV.005.075	SUBMITTING-STATE-PROV-ID	Submitting State Provider ID	Mandatory	The State-specific Medicaid Provider Identifier is a state-assigned unique identifier that states should report with all individual providers, practice groups, facilities, and other entities. This should be the identifier that is used in the	N/A	PRV00005	PROV-IDENTIFIERS	X(30)	4	22	51	1. Value must be 30 characters or less 2. Mandatory ~~3. Value must not contain a pipe symbol~~

					state's Medicaid Management Information System.								
PRV076	PRV.005.076	PROV-LOCATION-ID	Provider Location ID	~~Not Applicable~~ Mandatory	A code to uniquely identify the geographic location where the provider's services were performed. The Provider Location Identifier values reported on Inpatient, Long-Term Care, Other, and Pharmacy Claim Header Segments must correspond to an active Provider Location Identifier value on a Provider Location ~~&~~and Contact Info (~~PRV00003~~PRV.003) segment. If a particular license (e.g., a physician's medical license) or provider identifier (e.g., an individual provider's NPI or SSN) is applicable to all of their servicing locations, value "000" (a string of exactly three zeros) can be used in the ~~PRV00004~~PRV.004 or ~~PRV00005~~PRV.005, respectively, to represent all locations, however that location identifier must not be attributed to claims or provider bed type info.	N/A	PRV00005	PROV-IDENTIFIERS	X(5)	5	52	56	~~1. Value must not contain a pipe symbol~~ ~~2.~~ 1. Value must be 5 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
PRV077	PRV.005.077	PROV-IDENTIFIER-TYPE	Provider Identifier Type	Mandatory	A code to identify the kind of provider identifier that is captured in the Provider Identifier data element. The state should submit updates to T-MSIS whenever an identifier is retired or issued. see Provider Identifier Type List (VVL.146)	PROV-IDENTIFIER-TYPE	PRV00005	PROV-IDENTIFIERS	X(1)	6	57	57	~~1.~~1. Value must be 1 character 2. Value must be in Provider Identifier Type List (VVL) ~~2~~3. Mandatory ~~3. Value must be 1 character~~ 4. When value equals ~~'~~"2~~'~~", the associated Provider Identifier (PRV.005.081) must be a valid NPI

PRV078	PRV.005.078	PROV-IDENTIFIER-ISSUING-ENTITY-ID	Provider Identifier Issuing Entity ID	Mandatory	A free text field to capture the identity of the entity that issued the provider identifier in the ~~PROV-IDENTIFIER~~Provider Identifier (PRV.005.081) data element. For (State Tax ID), if associated Provider Identifier Type (~~DE~~PRV.005.077) value is equal to 6, then value must be the name of the state's taxation division. For (Other), if associated Provider Identifier Type (~~DE~~PRV.005.077) value is equal to 8, then value must be the name of the entity that issued the identifier.	N/A	PRV00005	PROV-IDENTIFIERS	X(18)	7	58	75	~~1.~~1. Value must be 18 characters or less 2. Value must not contain a pipe or asterisk symbol ~~2~~3. (State-specific Medicaid Provider) if associated Provider Identifier Type (PRV.005.077) value ~~is equal to~~ equals "1~~,~~", then value must equal (PRV.005.073) Submitting State ~~3~~4. (NPI) if associated Provider Identifier Type (PRV.005.077) value ~~is equal to~~ equals "2~~,~~", then value must equal ~~'NPI'~~ ~~4~~"NPI" 5. (Medicare) if associated Provider Identifier Type (PRV.005.077) value ~~is equal to~~ equals "3~~,~~", then value must equal ~~'CMS'~~ ~~5~~"CMS" 6. (NCPDP) if associated Provider Identifier Type (PRV.005.077) value ~~is equal to~~ equals "4~~,~~", then value must equal ~~'NCPDP'~~ ~~6~~"NCPDP" 7. (Federal Tax ID) if associated Provider Identifier Type (PRV.005.077) value ~~is equal to~~ equals "5~~,~~", then value must equal ~~'IRS'~~ ~~7~~"IRS" 8. (SSN) if associated Provider Identifier Type (PRV.005.077) value ~~is equal to~~ equals "7~~,~~", then value must be equal to ~~'SSA'~~ ~~8. Value must be 18 characters or less~~ "SSA" 9. Mandatory

PRV079	PRV.005.079	PROV-IDENTIFIER-EFF-DATE	Provider Identifier Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	PRV00005	PROV-IDENTIFIERS	9(8)	8	76	83	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~19,20,99]
PRV080	PRV.005.080	PROV-IDENTIFIER-END-DATE	Provider Identifier End Date	Mandatory	The ~~first~~last calendar day on which all of the other data elements in the same segment were effective.	N/A	PRV00005	PROV-IDENTIFIERS	9(8)	9	84	91	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be greater than or equal to associated Segment Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~18,19,20,99]
PRV081	PRV.005.081	PROV-IDENTIFIER	Provider Identifier	Mandatory	A data element to capture the various ways used to distinguish providers from one another on claims and other interactions between providers and other entities. The specific type of identifier is defined in the corresponding value in the ~~PROVIDER-IDENTIFIER.~~ Provider Identifier Type data element.	N/A	PRV00005	PROV-IDENTIFIERS	X(~~12~~30)	10	92	~~103~~121	1. Value must be 30 characters or less 2. Mandatory ~~2~~3. Value must not contain a pipe or asterisk symbol ~~3~~4. Value must have an associated Provider Identifier Type (PRV.005.077) ~~4~~5. One record must have a Provider Identifier Type (PRV.005.077) equal to "1" ~~5. Value must be 12 characters or less~~
PRV082	PRV.005.082	STATE-NOTATION	State Notation	~~Op~~Situati o nal	A free text field for the submitting state to enter whatever information it chooses.	N/A	PRV00005	PROV-IDENTIFIERS	X(500)	11	~~104~~122	~~603~~621	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational

PRV084	PRV.006.084	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	PRV00006	PROV-TAXONOMY-CLASSIFICATION	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "PRV00006"
PRV085	PRV.006.085	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	PRV00006	PROV-TAXONOMY-CLASSIFICATION	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (PRV.001.007)
PRV086	PRV.006.086	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	PRV00006	PROV-TAXONOMY-CLASSIFICATION	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory
PRV087	PRV.006.087	SUBMITTING-STATE-PROV-ID	Submitting State Provider ID	Mandatory	The State-specific Medicaid Provider Identifier is a state-assigned unique identifier that states should report with all individual providers, practice groups, facilities, and other entities. This should be the identifier that is used in the	~~PROV-CLASSIFICATION-TYPE~~N/A	PRV00006	PROV-TAXONOMY-CLASSIFICATION	X(30)	4	22	51	1. Value must be 30 characters or less 2. Mandatory ~~3. Value must be in Provider Classification Type List (VVL)~~

					state's Medicaid Management Information System.								
PRV088	PRV.006.088	PROV-CLASSIFICATION-TYPE	Provider Classification Type	Mandatory	A code to identify the schema used in the Provider Classification Code field to categorize providers. See T-MSIS Guidance Document, "CMS Guidance: Best Practice for Reporting Provider Classification Type and Provider Classification Code in the T-MSIS Provider File" ". https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47562~~cms-technical-instructions-provider-classification-requirements-in-tmsis/ A provider may be reported with multiple active record segments with the same Provider Classification Type if different Provider Classification Code values apply.	PROV-CLASSIFICATION-TYPE	PRV00006	PROV-TAXONOMY-CLASSIFICATION	X(1)	5	52	52	~~1.~~1. Value must be 1 character 2. Value must be in Provider Classification Type List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory

PRV089	PRV.006.089	PROV-CLASSIFICATION-CODE	Provider Classification Code	Mandatory	The code values from the categorization schema identified in the Provider Classification Type data element. Note: States should apply these classification schemas consistently across all providers.	PROV-CLASSIFICATION-CODE-TYPE-4, PROV-TAXONOMY, PROV-TYPE, PROV-SPECIALTY	PRV00006	PROV-TAXONOMY-CLASSIFICATION	X(20)	6	53	72	~~1.~~1. Value must be 20 characters or less 2. If associated Provider Classification Type equals "1~~,~~", value must be in Provider Taxonomy List (VVL) ~~2~~3. If associated Provider Classification Type equals "2~~,~~", value must be in Provider Specialty ~~Code~~ List (VVL) ~~3~~4. If associated Provider Classification Type equals "3~~,~~", value must be in Provider Type Code List (VVL) ~~4~~5. If associated Provider Classification Type equals "4~~,~~", value must be in Provider Authorized Category of Service Code List (VVL) ~~5. Value must be 20 characters or less~~ ~~6.~~6. Mandatory
PRV090	PRV.006.090	PROV-TAXONOMY-CLASSIFICATION-EFF-DATE	Provider Taxonomy Classification Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	PRV00006	PROV-TAXONOMY-CLASSIFICATION	9(8)	7	73	80	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~19,20,99]
PRV091	PRV.006.091	PROV-TAXONOMY-CLASSIFICATION-END-DATE	Provider Taxonomy Classification End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	PRV00006	PROV-TAXONOMY-CLASSIFICATION	9(8)	8	81	88	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be greater than or equal to associated Segment Effective Date value ~~4~~3. Mandatory

													~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~18,19,20,99]
PRV092	PRV.006.092	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	PRV00006	PROV-TAXONOMY-CLASSIFICATION	X(500)	9	89	588	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
PRV094	PRV.007.094	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	PRV00007	PROV-MEDICAID-ENROLLMENT	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~ 3. Value must be in Record ID List (VVL) 4. Value must equal "PRV00007"
PRV095	PRV.007.095	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	PRV00007	PROV-MEDICAID-ENROLLMENT	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (PRV.001.007)

PRV096	PRV.007.096	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	PRV00007	PROV-MEDICAID-ENROLLMENT	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory
PRV097	PRV.007.097	SUBMITTING-STATE-PROV-ID	Submitting State Provider ID	Mandatory	The State-specific Medicaid Provider Identifier is a state-assigned unique identifier that states should report with all individual providers, practice groups, facilities, and other entities. This should be the identifier that is used in the state's Medicaid Management Information System.	N/A	PRV00007	PROV-MEDICAID-ENROLLMENT	X(30)	4	22	51	1. Value must be 30 characters or less 2. Mandatory ~~3. Value must be 8 characters in the form "CCYYMMDD"~~
PRV098	PRV.007.098	PROV-MEDICAID-EFF-DATE	Provider Medicaid Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	PRV00007	PROV-MEDICAID-ENROLLMENT	9(8)	5	52	59	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~19,20,99]
PRV099	PRV.007.099	PROV-MEDICAID-END-DATE	Provider Medicaid End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	PRV00007	PROV-MEDICAID-ENROLLMENT	9(8)	6	60	67	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be greater than or equal to associated Segment Effective Date value ~~4~~3. Mandatory

													~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~18,19,20,99]
PRV100	PRV.007.100	PROV-MEDICAID-ENROLLMENT-STATUS-CODE	Provider Medicaid Enrollment Status Code	Mandatory	A code representing the provider's Medicaid and/or CHIP enrollment status for the time span specified by the ~~PROV-MEDICAID-EFF-~~Provider Medicaid Effective Date and ~~PROV-MEDICAID-END-~~Provider Medicaid End Date data elements. Note: The State~~-PLAN-~~ Plan Enrollment data element identifies whether the provider is enrolled in Medicaid, CHIP, or both.	PROV-MEDICAID-ENROLLMENT-STATUS-CODE	PRV00007	PROV-MEDICAID-ENROLLMENT	X(2)	7	68	69	~~1.~~1. Value must be 2 characters 2. Value must be in Provider Medicaid Enrollment Status Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory
PRV101	PRV.007.101	STATE-PLAN-ENROLLMENT	State Plan Enrollment	Mandatory	The state plan with which a provider has an affiliation and is able to provide services to the state's fee for service enrollees.	STATE-PLAN-ENROLLMENT	PRV00007	PROV-MEDICAID-ENROLLMENT	X(1)	8	70	70	~~1.~~1. Value must be 1 character 2. Value must be in State Plan Enrollment List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory
PRV102	PRV.007.102	PROV-ENROLLMENT-METHOD	Provider Enrollment Method	Mandatory	Process by which a provider was enrolled in Medicaid or CHIP.	PROV-ENROLLMENT-METHOD	PRV00007	PROV-MEDICAID-ENROLLMENT	X(1)	9	71	71	~~1.~~1. Value must be 1 character 2. Value must be in Provider Enrollment Method List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory
PRV103	PRV.007.103	APPL-DATE	Application Date	Mandatory	The date on which the provider applied for enrollment into the State's Medicaid and/or CHIP program.	N/A	PRV00007	PROV-MEDICAID-ENROLLMENT	9(8)	10	72	79	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must not be earlier than associated Provider Medicaid Effective Date (PRV.007.098) value ~~4~~3. Mandatory

PRV104	PRV.007.104	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	PRV00007	PROV-MEDICAID-ENROLLMENT	X(500)	11	80	579	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
PRV106	PRV.008.106	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	PRV00008	PROV-AFFILIATED-GROUPS	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "PRV00008"
PRV107	PRV.008.107	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	PRV00008	PROV-AFFILIATED-GROUPS	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (PRV.001.007)
PRV108	PRV.008.108	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	PRV00008	PROV-AFFILIATED-GROUPS	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory

PRV109	PRV.008.109	SUBMITTING-STATE-PROV-ID	Submitting State Provider ID	Mandatory	The State-specific Medicaid Provider Identifier is a state-assigned unique identifier that states should report with all individual providers, practice groups, facilities, and other entities. This should be the identifier that is used in the state's Medicaid Management Information System.	N/A	PRV00008	PROV-AFFILIATED-GROUPS	X(30)	4	22	51	1. Value must be 30 characters or less 2. Mandatory ~~3. Value must not contain a pipe symbol~~
PRV110	PRV.008.110	SUBMITTING-STATE-PROV-ID-OF-AFFILIATED-ENTITY	Submitting State Provider ID of Affiliated Entity	Mandatory	The unique, state-assigned identification number for the group or subpart with which the individual or subpart is associated. (The submitting state's unique identifier for the group. (Note: The group will also be in the provider data set as a provider (i.e., the group-as-a-provider).	N/A	PRV00008	PROV-AFFILIATED-GROUPS	X(~~12~~30)	5	52	~~63~~81	~~1.~~1. Value must be 30 characters or less 2. Value must not contain a pipe symbol ~~2. Value must be 12 characters or less~~ 3. Mandatory
PRV111	PRV.008.111	PROV-AFFILIATED-GROUP-EFF-DATE	Provider Affiliated Group Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	PRV00008	PROV-AFFILIATED-GROUPS	9(8)	6	~~64~~82	~~71~~89	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in ['~~18', '19', '20~~19,20,99]
PRV112	PRV.008.112	PROV-AFFILIATED-GROUP-END-DATE	Provider Affiliated Group End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	PRV00008	PROV-AFFILIATED-GROUPS	9(8)	7	~~72~~90	~~79~~97	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be greater than or equal to associated Segment Effective Date value ~~4~~3. Mandatory

													~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~18,19,20,99]
PRV113	PRV.008.113	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	PRV00008	PROV-AFFILIATED-GROUPS	X(500)	8	~~80~~98	5~~7~~97	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
PRV115	PRV.009.115	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	PRV00009	PROV-AFFILIATED-PROGRAMS	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~ 3. Value must be in Record ID List (VVL) 4. Value must equal "PRV00009"
PRV116	PRV.009.116	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	PRV00009	PROV-AFFILIATED-PROGRAMS	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (PRV.001.007)

PRV117	PRV.009.117	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	PRV00009	PROV-AFFILIATED-PROGRAMS	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory
PRV118	PRV.009.118	SUBMITTING-STATE-PROV-ID	Submitting State Provider ID	Mandatory	The State-specific Medicaid Provider Identifier is a state-assigned unique identifier that states should report with all individual providers, practice groups, facilities, and other entities. This should be the identifier that is used in the state's Medicaid Management Information System.	~~AFFILIATED-PROGRAM-TYPE~~N/A	PRV00009	PROV-AFFILIATED-PROGRAMS	X(30)	4	22	51	1. Value must be 30 characters or less 2. Mandatory ~~3. Value must be in Affiliated Program Type List (VVL)~~
PRV119	PRV.009.119	AFFILIATED-PROGRAM-TYPE	Affiliated Program Type	Mandatory	~~A code to identify the category of program that the provider is affiliated.~~ ~~see Affiliated Program Type List (VVL.004)~~ ~~(health plan federal assigned) if associated Affiliated Program Type (DE) value is 1, then value must be the federal-assigned plan ID of the health plan in which a provider is enrolled to provide services.~~ ~~(health plan state assigned) if associated Affiliated Program Type (DE) value is 2, then value must be the state-assigned plan ID of the health plan in which a provider is enrolled to provide services.~~ ~~(waiver) if associated Affiliated Program Type (DE) value is 3, then value must be the core Federal Waiver ID in which a provider is allowed to deliver services to eligible beneficiaries.~~ ~~(health home entity) if associated Affiliated Program Type (DE) value is 4, then value must be the name of a health home in which a provider is participating.~~	AFFILIATED-PROGRAM-TYPE	PRV00009	PROV-AFFILIATED-PROGRAMS	X(1)	5	52	52	~~1.~~1. Value must be 1 character 2. Value must be in Affiliated Program Type List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory

					~~(other) if associated Affiliated Program Type (DE) value is 5, then value must be an identifier for something other than a health plan, waiver, or health home entity.~~A code to identify the category of program that the provider is affiliated.								
PRV120	PRV.009.120	AFFILIATED-PROGRAM-ID	Affiliated Program ID	Mandatory	~~A data element to identify the Medicaid/CHIP programs, waivers and demonstrations in which the provider participates.~~ ~~(health plan federal assigned) if associated Affiliated Program Type (DE) value is 1, then value must be the federal-assigned plan ID of the health plan in which a provider is enrolled to provide services.~~ ~~(health plan state assigned) if associated Affiliated Program Type (DE) value is 2, then value must be the state-assigned plan ID of the health plan in which a provider is enrolled to provide services.~~ ~~(waiver) if associated Affiliated Program Type (DE) value is 3, then value must be the core Federal Waiver ID in which a provider is allowed to deliver services to eligible beneficiaries.~~ ~~(health home entity) if associated Affiliated Program Type (DE) value is 4, then value must be the name of a health home in which a provider is participating.~~ ~~(other) if associated Affiliated Program Type (DE) value is 5, then value must be an identifier for something other than a health plan, waiver, or health home entity.~~A data element to identify the Medicaid/CHIP programs, waivers and demonstrations in which the provider participates.	N/A	PRV00009	PROV-AFFILIATED-PROGRAMS	X(50)	6	53	102	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory

PRV121	PRV.009.121	PROV-AFFILIATED-PROGRAM-EFF-DATE	Provider Affiliated Program Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	PRV00009	PROV-AFFILIATED-PROGRAMS	9(8)	7	103	110	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~19,20,99]
PRV122	PRV.009.122	PROV-AFFILIATED-PROGRAM-END-DATE	Provider Affiliated Program End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	PRV00009	PROV-AFFILIATED-PROGRAMS	9(8)	8	111	118	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be greater than or equal to associated Segment Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~18,19,20,99]
PRV123	PRV.009.123	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	PRV00009	PROV-AFFILIATED-PROGRAMS	X(500)	9	119	618	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational

PRV125	PRV.010.125	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	PRV00010	PROV-BED-TYPE-INFO	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "PRV00010"
PRV126	PRV.010.126	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	PRV00010	PROV-BED-TYPE-INFO	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (PRV.001.007)
PRV127	PRV.010.127	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	PRV00010	PROV-BED-TYPE-INFO	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory
PRV128	PRV.010.128	SUBMITTING-STATE-PROV-ID	Submitting State Provider ID	Mandatory	The State-specific Medicaid Provider Identifier is a state-assigned unique identifier that states should report with all individual providers, practice groups, facilities, and other entities. This should be the identifier that is used in the	N/A	PRV00010	PROV-BED-TYPE-INFO	X(30)	4	22	51	1. Value must be 30 characters or less 2. Mandatory ~~3. Value must not contain a pipe symbol~~

					state's Medicaid Management Information System.								
PRV129	PRV.010.129	PROV-LOCATION-ID	Provider Location ID	~~Not Applicable~~ Mandatory	A code to uniquely identify the geographic location where the provider's services were performed. The Provider Location Identifier values reported on Inpatient, Long-Term Care, Other, and Pharmacy Claim Header Segments must correspond to an active Provider Location Identifier value on a Provider Location ~~&~~and Contact Info (~~PRV00003~~PRV.003) segment. If a particular license (e.g., a physician's medical license) or provider identifier (e.g., an individual provider's NPI or SSN) is applicable to all of their servicing locations, value "000" (a string of exactly three zeros) can be used in the ~~PRV00004~~PRV.004 or ~~PRV00005~~PRV.005, respectively, to represent all locations, however that location identifier must not be attributed to claims or provider bed type info.	N/A	PRV00010	PROV-BED-TYPE-INFO	X(5)	5	52	56	~~1. Value must not contain a pipe symbol~~ ~~2.~~ 1. Value must be 5 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
PRV130	PRV.010.130	BED-TYPE-EFF-DATE	Bed Type Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	PRV00010	PROV-BED-TYPE-INFO	9(8)	6	57	64	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~19,20,99]

PRV131	PRV.010.131	BED-TYPE-END-DATE	Bed Type End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	PRV00010	PROV-BED-TYPE-INFO	9(8)	7	65	72	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on~~ in the form "CCYYMMDD" 2. Value must be the ~~leap year, never April 31st~~after or ~~Sept 31st)~~ ~~3. Value must be greater than or equal to~~the same as the associated Segment Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~19,20,99]
PRV134	PRV.010.134	BED-TYPE-CODE	Bed Type Code	Mandatory	A code to classify beds available at a facility.	BED-TYPE-CODE	PRV00010	PROV-BED-TYPE-INFO	X(1)	8	73	73	~~1.~~1. Value must be 1 character 2. Value must be in Bed Type Code List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory
PRV135	PRV.010.135	BED-COUNT	Bed Count	Mandatory	A count of the number of beds available at the facility for the category of bed identified in the Bed Type Code data element. Beds should not be counted twice under different bed types. See T-MSIS Guidance Document, "CMS Guidance: Best Practice for Reporting Provider Bed Information in the T-MSIS Provider File" ". https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/dataguide/t-msis-coding-blog/reporting-provider-bed-information-in-the-tmsis-~~blog/entry/47561~~provider-file-provider/	N/A	PRV00010	PROV-BED-TYPE-INFO	9(5)	9	74	78	1. Value must be 5 digits or less 2. Mandatory
PRV136	PRV.010.136	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	PRV00010	PROV-BED-TYPE-INFO	X(500)	10	79	578	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational

PRV138	PRV.001.138	SEQUENCE-NUMBER	Sequence Number	Mandatory	To enable states to sequentially number files, when related, follow-on files are necessary (i.e., update files, replacement files). This should begin with 1 for the original Create submission type and be incremented by one for each Replacement or Update submission for the same reporting period and file type (subject area).	N/A	PRV00001	FILE-HEADER-RECORD-PROVIDER	X(4)	~~13~~14	~~78~~80	~~81~~83	~~1.~~1. Value must be 4 characters or less 2. Value must between 1 and 9999 ~~2~~3. Value must be equal to the largest of any prior values for the same reporting period and file type, plus 1 (i.e. incremented by 1) ~~3~~4. Value must not contain a pipe symbol ~~4. Value must be 4 characters or less~~ 5. Mandatory
PRV139	PRV.001.139	FILE-SUBMISSION-METHOD	File Submission Method	Mandatory	The file submission method (e.g., TFFR, RHFR, IT, or CSO) used by the state to build and submit the file. This should correspond with the state's declared file submission method for the same file type and time period.	FILE-SUBMISSION-METHOD	PRV00001	FILE-HEADER-RECORD-PROVIDER	X(2)	13	78	79	1. Value must be 2 characters 2. Value must be in File Submission Method List (VVL) 3. Mandatory
PRV140	PRV.002.140	ATYPICAL-PROV-IND	Atypical Provider Indicator	Mandatory	An indicator to identify whether the provider is an atypical provider and therefore not eligible for an NPI.	ATYPICAL-PROV-IND	PRV00002	PROV-ATTRIBUTES-MAIN	X(1)	22	514	514	1. Value must be 1 character 2. Value must be in Atypical Provider Indicator code list (VVL) 3. Mandatory

T-MSIS Data Dictionary – TPL File Changes Between Versions 2.4.0 and 4.0.0

TPL001	TPL.001.001	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	TPL00001	FILE-HEADER-RECORD-TPL	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "TPL00001"
TPL002	TPL.001.002	DATA-DICTIONARY-VERSION	Data Dictionary Version	Mandatory	A data element to capture the version of the T-MSIS data dictionary that was used to build the file. ~~Use the version number specified on the Cover Sheet of the data dictionary" to V2.4.~~	DATA-DICTIONARY-VERSION	TPL00001	FILE-HEADER-RECORD-TPL	X(10)	2	9	18	1. Value must be 10 characters or less 2. Value must be in Data Dictionary Version List (VVL) 3. Value must not include the pipe ("|") symbol ~~3~~4. Mandatory
TPL003	TPL.001.003	SUBMISSION-TRANSACTION-TYPE	Submission Transaction Type	Mandatory	A data element to identify the whether the transactions in the file are original submissions of the data, a resubmission of a previously submitted file, or corrections of edit rejects.	SUBMISSION-TRANSACTION-TYPE	TPL00001	FILE-HEADER-RECORD-TPL	X(1)	3	19	19	1. Value must be 1 character 2. Value must be in Submission Transaction Type List (VVL) ~~2. Value must be 1 character~~ 3. Mandatory
TPL004	TPL.001.004	FILE-ENCODING-SPECIFICATION	File Encoding Specification	Mandatory	Denotes which supported file encoding standard was used to create the file.	FILE-ENCODING-SPECIFICATION	TPL00001	FILE-HEADER-RECORD-TPL	X(3)	4	20	22	~~1.~~1. Value must be 3 characters 2. Value must be in File Encoding Specification List (VVL) ~~2. Value must be 3 characters~~ ~~3.~~3. Mandatory
TPL005	TPL.001.005	DATA-MAPPING-DOCUMENT-VERSION	Data Mapping Document Version	Mandatory	Identifies the version of the T-MSIS data mapping document used to build a state	N/A	TPL00001	FILE-HEADER-RECORD-TPL	X(9)	5	23	31	1. Value must be 9 characters or less 2. Mandatory

					submission file. ~~Use the version number specified on the title page of the data mapping document~~								
TPL006	TPL.001.006	FILE-NAME	File Name	~~Not Applicable~~ Mandatory	A code to identify the subject area to which the records in its file relate. Each T-MSIS submission file should only contain records for one subject area (i.e., Eligible, Third-party liability, Provider, Managed Care Plan Information, Inpatient, Long-Term Care, Other, ~~and~~ Pharmacy Claim, and Financial Transactions).	N/A	TPL00001	FILE-HEADER-RECORD-TPL	X(8)	6	32	39	1. Value must equal ~~'TPL-FILE'~~"TPL-FILE" 2. Mandatory
TPL007	TPL.001.007	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	TPL00001	FILE-HEADER-RECORD-TPL	X(2)	7	40	41	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same for all records
TPL008	TPL.001.008	DATE-FILE-CREATED	Date File Created	Mandatory	The date on which the file was created.	N/A	TPL00001	FILE-HEADER-RECORD-TPL	9(8)	8	42	49	~~1.~~1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" ~~2~~3. Value must be ~~8 characters in the form "CCYYMMDD"~~ ~~3. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~4.~~less than current date 4. Value must be equal to or after the value of associated End of Time Period 5. Mandatory
TPL009	TPL.001.009	START-OF-TIME-PERIOD	Start of Time Period	Mandatory	This value must be the first day of the reporting month, regardless of the actual date span of the data in the file.	N/A	TPL00001	FILE-HEADER-RECORD-TPL	9(8)	9	50	57	~~1. Value of the CC component must be "20"~~ ~~2. Value must be 8 characters in the form "CCYYMMDD"~~ ~~3.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~4. Value must be less than current date~~ ~~5.~~in the form "CCYYMMDD"

													2. Value must be equal to or earlier than associated Date File Created ~~6~~3. Value must be before associated End of Time Period ~~7~~4. Mandatory 5. Value of the CC component must be "20"
TPL010	TPL.001.010	END-OF-TIME-PERIOD	End of Time Period	Mandatory	This value must be the last day of the reporting month, regardless of the actual date span.	N/A	TPL00001	FILE-HEADER-RECORD-TPL	9(8)	10	58	65	1. ~~Value~~The date must be ~~8 characters~~a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" 3. ~~The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~4.~~ Value must be equal to or earlier than associated Date File Created ~~5~~4. Value must be equal to or after associated Start of Time Period ~~6~~5. Mandatory
TPL011	TPL.001.011	FILE-STATUS-INDICATOR	File Status Indicator	Mandatory	A code to indicate whether the records in the file are test or production records.	FILE-STATUS-INDICATOR	TPL00001	FILE-HEADER-RECORD-TPL	X(1)	11	66	66	~~1.~~1. Value must be 1 character 2. For production files, value must be equal to ~~'P'~~ ~~2. Value must be 1 character~~ "P" 3. Value must be in File Status Indicator List (VVL) 4. Mandatory
TPL012	TPL.001.012	SSN-INDICATOR	SSN Indicator	Mandatory	Indicates whether the state uses the eligible person's social security number instead of an MSIS Identification Number as the unique, unchanging eligible person identifier. A state's SSN/Non-SSN designation on the eligibility file should match on the claims and third party liability files.	SSN-INDICATOR	TPL00001	FILE-HEADER-RECORD-TPL	X(1)	12	67	67	~~1.~~1. Value must be 1 character 2. Value must be in SSN Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory

TPL013	TPL.001.013	TOT-REC-CNT	Total Record Count	Mandatory	A count of all records in the file except for the file header record. This count will be used as a control total to help assure that the file did not become corrupted during transmission.	N/A	TPL00001	FILE-HEADER-RECORD-TPL	9(11)	13	68	78	~~1.~~1. Value must be 11 digits or less 2. Value must be a positive integer ~~2~~3. Value must be between 0:99999999999 (inclusive) ~~3. Value must be 11 digits or less~~ ~~4.~~4. Value must equal the number of records included in the file submission except for the file header record. 5. Mandatory
TPL014	TPL.001.014	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	TPL00001	FILE-HEADER-RECORD-TPL	X(500)	~~15~~16	~~83~~85	58~~24~~	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
TPL016	TPL.002.016	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	TPL00002	TPL-MEDICAID-ELIGIBLE-PERSON-MAIN	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "TPL00002"
TPL017	TPL.002.017	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	TPL00002	TPL-MEDICAID-ELIGIBLE-PERSON-MAIN	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (TPL.001.007)

TPL018	TPL.002.018	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	TPL00002	TPL-MEDICAID-ELIGIBLE-PERSON-MAIN	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory
TPL019	TPL.002.019	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual ~~(except on service tracking payments). .~~ Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47572~~reporting-shared-msis-identification-numbers-eligibility/	N/A	TPL00002	TPL-MEDICAID-ELIGIBLE-PERSON-MAIN	X(20)	4	22	41	~~1. Mandatory~~ ~~2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN~~ ~~3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN~~ ~~4.~~1. Value must be 20 characters or less 2. Mandatory

TPL020	TPL.002.020	TPL-HEALTH-INSURANCE-COVERAGE-IND	TPL Health Insurance Coverage Indicator	Mandatory	A flag to indicate that the Medicaid/CHIP eligible person has some form of third party insurance coverage.	TPL-HEALTH-INSURANCE-COVERAGE-IND	TPL00002	TPL-MEDICAID-ELIGIBLE-PERSON-MAIN	X(1)	5	42	42	~~1.~~1. Value must be 1 character 2. Value must be in [0, 1] or not populated 3. Value must be in TPL Health Insurance Coverage Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~4. Mandatory ~~4~~5. When value equals ~~'~~"1~~'~~", there must be one corresponding TPL Medicaid Eligible Person Health Insurance Coverage Information (TPL.003) segment with the same MSIS ID~~.~~
TPL021	TPL.002.021	TPL-OTHER-COVERAGE-IND	TPL Other Coverage Indicator	Mandatory	A flag to indicate that the Medicaid/CHIP eligible person has some other form of third party funding besides insurance coverage.	TPL-OTHER-COVERAGE-IND	TPL00002	TPL-MEDICAID-ELIGIBLE-PERSON-MAIN	X(1)	6	43	43	~~1.~~1. Value must be 1 character 2. Value must be in TPL Other Coverage Indicator List (VVL) ~~2. Value must be 1 character~~ ~~3.~~3. Mandatory
TPL022	TPL.002.022	ELIGIBLE-FIRST-NAME	Eligible First Name	Mandatory	The first name of the individual to whom the services were provided.	N/A	TPL00002	TPL-MEDICAID-ELIGIBLE-PERSON-MAIN	X(30)	7	44	73	1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
TPL023	TPL.002.023	ELIGIBLE-MIDDLE-INIT	Eligible Middle Initial	Conditional	Individual's middle initial; middle initial component of full name (e.g. First Name, Middle Initial, Last Name).	N/A	TPL00002	TPL-MEDICAID-ELIGIBLE-PERSON-MAIN	X(1)	8	74	74	1. ~~Value may include any alphanumeric characters, digits or symbols~~ ~~2.~~ Value must be 1 character ~~3~~2. Value must not contain a pipe or asterisk symbols ~~4~~3. Conditional
TPL024	TPL.002.024	ELIGIBLE-LAST-NAME	Eligible Last Name	Mandatory	The last name of the individual to whom the services were provided.	N/A	TPL00002	TPL-MEDICAID-ELIGIBLE-PERSON-MAIN	X(30)	9	75	104	1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory

TPL025	TPL.002.025	ELIG-PRSN-MAIN-EFF-DATE	Eligible Person Main Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	TPL00002	TPL-MEDICAID-ELIGIBLE-PERSON-MAIN	9(8)	10	105	112	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~] ~~6. Value must be equal to or less than the individual's Date of Death (ELG.002.025)~~19,20,99]
TPL026	TPL.002.026	ELIG-PRSN-MAIN-END-DATE	Eligible Person Main End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	TPL00002	TPL-MEDICAID-ELIGIBLE-PERSON-MAIN	9(8)	11	113	120	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on~~ in the form "CCYYMMDD" 2. Value must be the ~~leap year, never April 31st~~after or ~~Sept 31st)~~ ~~3. Value must be greater than or equal to~~the same as the associated Segment Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~19,20,99]
TPL027	TPL.002.027	STATE-NOTATION	State Notation	~~Op~~Situatio nal	A free text field for the submitting state to enter whatever information it chooses.	N/A	TPL00002	TPL-MEDICAID-ELIGIBLE-PERSON-MAIN	X(500)	12	121	620	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational

TPL029	TPL.003.029	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "TPL00003"
TPL030	TPL.003.030	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (TPL.001.007)
TPL031	TPL.003.031	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory

TPL032	TPL.003.032	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual ~~(except on service tracking payments).~~ . Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47572~~reporting-shared-msis-identification-numbers-eligibility/	N/A	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	X(20)	4	22	41	~~1. Mandatory~~ ~~2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN~~ ~~3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN~~ ~~4.~~1. Value must be 20 characters or less 2. Mandatory
TPL033	TPL.003.033	INSURANCE-CARRIER-ID-NUM	Insurance Carrier ID Number	Conditional	The ~~state's internal~~state-assigned identification number of the Third Party Liability ~~Insurance carrier~~(TPL) Entity.	N/A	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	X(12)	5	42	53	1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional
TPL034	TPL.003.034	INSURANCE-PLAN-ID	Insurance Plan ID	Conditional	The ID number issued by the Insurance carrier providing third party liability insurance coverage to beneficiaries. Typically the Plan ID/Plan Number is on the beneficiaries' insurance card.	N/A	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	X(20)	6	54	73	1. Value must be 20 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional

TPL035	TPL.003.035	GROUP-NUM	Group Number	Conditional	The group number of the TPL health insurance policy.	N/A	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	X(16)	7	74	89	~~1.~~1. Value must be 16 characters or less 2. Value must not contain a pipe ~~or asterisk~~ symbol ~~2. Value must be 16 characters or less~~ 3. Conditional
TPL036	TPL.003.036	MEMBER-ID	Member ID	Conditional	Member identification number as it appears on the card issued by the TPL insurance carrier.	N/A	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	X(20)	8	90	109	~~1.~~1. Value must be 20 characters or less 2. Value must not contain a pipe ~~or asterisk~~ symbol ~~2. Value must be 20 characters or less~~ 3. Conditional
TPL037	TPL.003.037	INSURANCE-PLAN-TYPE	Insurance Plan Type	Conditional	Code to classify the type of insurance plan providing TPL coverage.	INSURANCE-PLAN-TYPE	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	X(2)	9	110	111	~~1.~~1. Value must be 2 characters or less 2. Value must be in Insurance Plan Type List (VVL) ~~2~~3. Conditional ~~3. Value must be 2 characters or less~~ ~~4.~~4. Value must have an associated Insurance Plan ID
TPL038	TPL.003.038	ANNUAL-DEDUCTIBLE-AMT	Annual Deductible Amount	Conditional	Annual amount paid each year by the enrollee in the plan before a health plan benefit begins.	N/A	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	S9(11) V99	~~11~~10	11~~4~~2	12~~6~~4	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Conditional
TPL044	TPL.003.044	POLICY-OWNER-FIRST-NAME	Policy Owner First Name	~~Not Applicable~~ Mandatory	Individual's first name; first name component of full name (e.g. First Name, Middle Initial, Last Name).	N/A	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-	X(30)	~~12~~11	12~~7~~5	15~~6~~4	1. Value must be 30 characters or less 2. Value must not contain a pipe ~~or asterisk symbols~~symbol 3. ~~If TPL Health Insurance Coverage Indicator (TPL.002.020) equals "1", then value is~~ Mandatory

								COVERAGE-INFO					
TPL045	TPL.003.045	POLICY-OWNER-LAST-NAME	Policy Owner Last Name	~~Not Applicable~~ Mandatory	Individual's last name; last name component of full name (e.g. First Name, Middle Initial, Last Name).	N/A	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	X(30)	~~13~~12	15~~7~~5	18~~6~~4	1. Value must be 30 characters or less 2. Value must not contain a pipe ~~or asterisk symbols~~symbol 3. ~~If TPL Health Insurance Coverage Indicator (TPL.002.020) equals "1", then value is~~ Mandatory
TPL046	TPL.003.046	POLICY-OWNER-SSN	Policy Owner SSN	Conditional	Unique identifier issued to an individual by the SSA for the purpose of identification.	N/A	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	X(9)	~~14~~13	18~~7~~5	19~~5~~3	1. Value must be 9-digit number 2. For any individual, the value must be the same over all segment effective and end dates 3. Conditional
TPL047	TPL.003.047	POLICY-OWNER-CODE	Policy Owner Code	Conditional	This code identifies the relationship of the policy holder to the Medicaid/CHIP beneficiary.	POLICY-OWNER-CODE	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	X(2)	~~15~~14	19~~6~~4	19~~7~~5	~~1.~~1. Value must be 2 characters 2. Value must be in Policy Owner Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Conditional
TPL048	TPL.003.048	INSURANCE-COVERAGE-EFF-DATE	Insurance Coverage Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	9(8)	~~16~~15	19~~8~~6	20~~5~~3	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value

													~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~19,20,99]
TPL049	TPL.003.049	INSURANCE-COVERAGE-END-DATE	Insurance Coverage End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	9(8)	~~17~~16	20~~6~~4	21~~3~~1	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on~~ in the form "CCYYMMDD" 2. Value must be after or the ~~leap year, never April 31st or Sept 31st)~~ ~~3. Value must be greater than or equal to~~ same as the associated ~~Segment~~ Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~] ~~6. When associated Date of Death (ELG.002.025) is populated, data element value must be less than or equal to Date of Death~~19,20,99]
TPL050	TPL.003.050	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	X(500)	18	214	713	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational

TPL052	TPL.004.052	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	TPL00004	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-CATEGORIES	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "TPL00004"
TPL053	TPL.004.053	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	TPL00004	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-CATEGORIES	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (TPL.001.007)
TPL054	TPL.004.054	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	TPL00004	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-CATEGORIES	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory

TPL055	TPL.004.055	INSURANCE-CARRIER-ID-NUM	Insurance Carrier ID Number	Mandatory	The ~~state's internal~~state-assigned identification number of the Third Party Liability ~~Insurance carrier~~(TPL) Entity.	N/A	TPL00004	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-CATEGORIES	X(12)	4	22	33	1. Mandatory 2. Value must be 12 characters or less 3. Value must not contain a pipe or asterisk symbols
TPL056	TPL.004.056	INSURANCE-PLAN-ID	Insurance Plan ID	Mandatory	The ID number issued by the Insurance carrier providing third party liability insurance coverage to beneficiaries. Typically the Plan ID/Plan Number is on the beneficiar~~y~~'ies' insurance card.	N/A	TPL00004	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-CATEGORIES	X(20)	5	34	53	~~1.~~1. Value must be 20 characters or less 2. Value must not contain a pipe or asterisk ~~symbol~~ ~~2. Value must be 20 characters or less~~ symbols 3. Mandatory
TPL057	TPL.004.057	INSURANCE-PLAN-TYPE	Insurance Plan Type	Mandatory	Code to classify the entity providing TPL coverage.	INSURANCE-PLAN-TYPE	TPL00004	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-CATEGORIES	X(2)	6	54	55	~~1.~~1. Value must be 2 characters or less 2. Value must be in Insurance Plan Type List (VVL) ~~2~~3. Mandatory ~~3. Value must be 2 characters or less~~ ~~4.~~4. Value must have an associated Insurance Plan ID
TPL058	TPL.004.058	COVERAGE-TYPE	Coverage Type	Mandatory	~~This code identifies~~Code indicating the ~~relationship~~level of ~~the~~ coverage being provided under this policy ~~holder to~~for the insured by the ~~Medicaid/CHIP beneficiary.~~ ~~see Policy Owner Code List (VVL.099)~~TPL carrier.	COVERAGE-TYPE	TPL00004	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-CATEGORIES	X(2)	7	56	57	~~1.~~1. Value must be 2 characters 2. Value must be in Coverage Type List (VVL~~).~~ ~~2. Value must be 2 characters~~) 3. Mandatory

TPL059	TPL.004.059	INSURANCE-CATEGORIES-EFF-DATE	Insurance Categories Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	TPL00004	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-CATEGORIES	9(8)	8	58	65	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20'~~19,20,99]
TPL060	TPL.004.060	INSURANCE-CATEGORIES-END-DATE	Insurance Categories End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	TPL00004	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-CATEGORIES	9(8)	9	66	73	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on~~ in the form "CCYYMMDD" 2. Value must be the ~~leap year, never April 31st~~after or ~~Sept 31st)~~ ~~3. Value must be greater than or equal to~~the same as the associated ~~Segment~~ Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~19,20,99]
TPL061	TPL.004.061	STATE-NOTATION	State Notation	~~Op~~Situation al	A free text field for the submitting state to enter whatever information it chooses.	N/A	TPL00004	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-CATEGORIES	X(500)	10	74	573	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational

TPL063	TPL.005.063	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	TPL00005	TPL-MEDICAID-ELIGIBLE-OTHER-THIRD-PARTY-COVERAGE-INFORMATION	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "TPL00005"
TPL064	TPL.005.064	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	TPL00005	TPL-MEDICAID-ELIGIBLE-OTHER-THIRD-PARTY-COVERAGE-INFORMATION	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (TPL.001.007)
TPL065	TPL.005.065	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	TPL00005	TPL-MEDICAID-ELIGIBLE-OTHER-THIRD-PARTY-COVERAGE-INFORMATION	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory

TPL066	TPL.005.066	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual ~~(except on service tracking payments). .~~ Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/~~medicaid/data-and-systems/macbis/~~tmsis/~~tmsis~~dataguide/t-msis-coding-blog/~~entry/47572~~reporting-shared-msis-identification-numbers-eligibility/	N/A	TPL00005	TPL-MEDICAID-ELIGIBLE-OTHER-THIRD-PARTY-COVERAGE-INFORMATION	X(20)	4	22	41	~~1. Mandatory~~ ~~2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN~~ ~~3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN~~ ~~4.~~1. Value must be 20 characters or less 2. Mandatory
TPL067	TPL.005.067	TYPE-OF-OTHER-THIRD-PARTY-LIABILITY	Type of Other ~~Third Party Liability~~ TPL	Mandatory	This code identifies the other types of liabilities an individual may have which are not necessarily defined as a health insurance plan listed Insurance ~~TYPE~~ Type Plan.	TYPE-OF-OTHER-THIRD-PARTY-LIABILITY	TPL00005	TPL-MEDICAID-ELIGIBLE-OTHER-THIRD-PARTY-COVERAGE-INFORMATION	X(1)	5	42	42	1. ~~If value equals "Other", then Policy Owner (TPL.003.044-047) information is not required~~ ~~2.~~ Value must be 1 character ~~3~~2. Value must be in Type of Other Third-Party Liability List (VVL) ~~4~~3. Mandatory
TPL068	TPL.005.068	OTHER-TPL-EFF-DATE	Other TPL Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	TPL00005	TPL-MEDICAID-ELIGIBLE-OTHER-THIRD-PARTY-COVERAGE-INFORMATION	9(8)	6	43	50	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be before or the same as the associated Segment End Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in

													[~~'18', '19', '20']~~ ~~6.~~19,20,99] 5. Value must occur on or before individual's Date of Death (ELG.002.025) when populated
TPL069	TPL.005.069	OTHER-TPL-END-DATE	Other TPL End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	TPL00005	TPL-MEDICAID-ELIGIBLE-OTHER-THIRD-PARTY-COVERAGE-INFORMATION	9(8)	7	51	58	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be greater than or equal to associated Segment Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~18,19,20,99]
TPL070	TPL.005.070	STATE-NOTATION	State Notation	~~Op~~Situatio nal	A free text field for the submitting state to enter whatever information it chooses.	N/A	TPL00005	TPL-MEDICAID-ELIGIBLE-OTHER-THIRD-PARTY-COVERAGE-INFORMATION	X(500)	8	59	558	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational

TPL072	TPL.006.072	RECORD-ID	Record ID	Mandatory	~~The Record Identifier element uniquely identifies each segment in a multi-segment entity record and is primarily used as a "key" to maintain referential integrity between data distributed over many segments for a particular entity.~~The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory ~~2.~~3. Value must be in Record ID List (VVL) 4. Value must equal "TPL00006"
TPL073	TPL.006.073	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	X(2)	2	9	10	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ ~~3.~~3. Mandatory 4. Value must be the same as Submitting State (TPL.001.007)
TPL074	TPL.006.074	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	9(11)	3	11	21	~~1.~~1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID ~~2. Value must be greater than or equal to 1~~ ~~3. Value must be 11 digits or less~~ ~~4.~~3. Mandatory
TPL075	TPL.006.075	INSURANCE-CARRIER-ID-NUM	Insurance Carrier ID Number	Mandatory	The ~~state's internal~~state-assigned identification number of the Third Party Liability ~~Insurance carrier~~(TPL) Entity.	N/A	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	X(12)	4	22	33	1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory

TPL076	TPL.006.076	TPL-ENTITY-ADDR-TYPE	TPL Entity Address Type	~~Conditional~~ Mandatory	The type of address for a TPL Entity submitted in the record segment.	TPL-ENTITY-ADDR-TYPE	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	X(2)	5	34	35	~~1.~~1. Value must be 2 characters 2. Value must be in TPL Entity Address Type List (VVL) ~~2. Value must be 2 characters~~ ~~3. Conditional~~3. Mandatory
TPL077	TPL.006.077	INSURANCE-CARRIER-ADDR-LN1	Insurance Carrier Address Line 1	~~Op~~Situati o nal	The first line of a potentially multi-line physical street or mailing address for a given entity (e.g. person, organization, agency, etc.).	N/A	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	X(60)	6	36	95	1. Value must be 60 characters or less 2. Value must not be equal to associated Address Line 2 or Address Line 3 value(s) 3. Value must not contain a pipe or asterisk symbols 4. Situational 5. When populated, the associated Address Type is required ~~5. Optional~~
TPL078	TPL.006.078	INSURANCE-CARRIER-ADDR-LN2	Insurance Carrier Address Line 2	Conditional	The second line of a multi-line physical street or mailing address for a given entity (e.g. person, organization, agency, etc.).	N/A	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	X(60)	7	96	155	1. Value must be 60 characters or less 2. Value must not be equal to associated Address Line 1 or Address Line 3 value(s) 3. There must be an Address Line 1 in order to have an Address Line 2 4. Value must not contain a pipe or asterisk symbols 5. Conditional
TPL079	TPL.006.079	INSURANCE-CARRIER-ADDR-LN3	Insurance Carrier Address Line 3	Conditional	The third line of a multi-line physical street or mailing address for a given entity (e.g. person, organization, agency, etc.).	N/A	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	X(60)	8	156	215	1. Value ~~of the CC component~~ must be ~~"20"~~ ~~2. Value must be 8~~60 characters ~~in the form "CCYYMMDD"~~ ~~3. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April 31st~~ or ~~Sept 31st)~~ 4less 2. Value must not be equal to ~~or after the value of~~ associated ~~End of Time Period~~ Address Line 1 or Address Line 2 value(s) 3. If Address Line 2 is not populated, then value should not be populated 4. Value must not contain a pipe or asterisk

													symbols 5. ~~Mandatory~~Conditional
TPL080	TPL.006.080	INSURANCE-CARRIER-CITY	Insurance Carrier City	~~Op~~Situational	The city component of an address associated with a given entity (e.g. person, organization, agency, etc.).	N/A	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	X(28)	9	216	243	1. Value must be 28 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
TPL081	TPL.006.081	INSURANCE-CARRIER-STATE	Insurance Carrier State	~~Op~~Situational	The ANSI state numeric code for the U.S. state, Territory, or the District of Columbia code of the TPL Insurance carrier.	STATE	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	X(2)	10	244	245	~~1.~~1. Value must be 2 characters 2. Value must be in State Code List (VVL) ~~2. Value must be 2 characters~~ 3. ~~Op~~Situational
TPL082	TPL.006.082	INSURANCE-CARRIER-ZIP-CODE	Insurance Carrier ZIP Code	~~Op~~Situational	The ZIP Code for the location being captured on the TPL Entity Contact Information record.	~~N/A~~ZIP-CODE	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	X(9)	11	246	254	1. Value may only be 5 digits (0-9) (Example: 91320) or 9 digits (0-9) (Example: 913200011) 2. ~~Optional~~Value must be in ZIP Code List (VVL) 3. Situational
TPL083	TPL.006.083	INSURANCE-CARRIER-PHONE-NUM	Insurance Carrier Phone Number	~~Op~~Situational	Phone number for a given entity (e.g. person, organization, agency).	N/A	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	X(10)	12	255	264	1. Value must be 10 ~~characters, digits (0-9) only~~ digit number 2. ~~Op~~Situational
TPL084	TPL.006.084	TPL-ENTITY-CONTACT-INFO-EFF-DATE	TPL Entity Contact Info Effective Date	Mandatory	The first calendar day on which all of the other data elements in the same segment were effective.	N/A	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	9(8)	13	265	272	~~1. Value of the CC component must be "20"~~ ~~2. Value must be 8 characters in the form "CCYYMMDD"~~ ~~3.~~1. The date must be a valid calendar date ~~(i.e. Feb 29th only on~~in the form "CCYYMMDD" 2. Value must be before or the same as the ~~leap year, never April 31st or Sept 31st)~~ ~~4. Value must be equal to or after the value of~~ associated Segment End ~~of Time Period~~ ~~5~~Date value 3. Mandatory

													4. Value of the CC component must be in [19,20,99]
TPL085	TPL.006.085	TPL-ENTITY-CONTACT-INFO-END-DATE	TPL Entity Contact Info End Date	Mandatory	The last calendar day on which all of the other data elements in the same segment were effective.	N/A	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	9(8)	14	273	280	~~1. Value must be 8 characters in the form "CCYYMMDD"~~ ~~2.~~ 1. The date must be a valid calendar date ~~(i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)~~ ~~3.~~ in the form "CCYYMMDD" 2. Value must be greater than or equal to associated Segment Effective Date value ~~4~~3. Mandatory ~~5~~4. Value of the CC component must be in [~~'18', '19', '20', '99'~~18,19,20,99]
TPL086	TPL.006.086	STATE-NOTATION	State Notation	~~Op~~Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	X(500)	~~15~~17	32~~8~~1	~~7~~820	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. ~~Op~~Situational
TPL088	TPL.001.088	SEQUENCE-NUMBER	Sequence Number	Mandatory	To enable states to sequentially number files, when related, follow-on files are necessary (i.e., update files, replacement files). This should begin with 1 for the original Create submission type and be incremented by one for each Replacement or Update submission for the same reporting period and file type (subject area).	N/A	TPL00001	FILE-HEADER-RECORD-TPL	X(4)	~~14~~15	~~79~~81	~~82~~84	~~1.~~1. Value must be 4 characters or less 2. Value must between 1 and 9999 ~~2~~3. Value must be equal to the largest of any prior values for the same reporting period and file type, plus 1 (i.e. incremented by 1) ~~3~~4. Value must not contain a pipe symbol ~~4. Value must be 4 characters or less~~ 5. Mandatory

TPL089	TPL.003.089	COVERAGE-TYPE	Coverage Type	Mandatory	A code to indicate the level of coverage being provided under this policy for the insured by the TPL carrier.	COVERAGE-TYPE	TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO	X(2)	1017	2112	2113	1. Value must be 2 characters 2. Value must be in Coverage Type List (VVL) 3. Mandatory
TPL090	TPL.006.090	INSURANCE-CARRIER-NAIC-CODE	Insurance Carrier NAIC Code	OpSituational	The National Association of Insurance Commissioners (NAIC) code of the TPL Insurance carrier.	N/A	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	X(10)	1615	7281	7290	1. Value must be 10 characters or less 2. Value must not contain a pipe or asterisk symbols 3. OpSituational
TPL091	TPL.006.091	INSURANCE-CARRIER-NAME	Insurance Carrier Name	OpSituational	The name of the TPL Insurance carrier.	N/A	TPL00006	TPL-ENTITY-CONTACT-INFORMATION	X(30)	1716	7291	8320	1. Value must be 30 characters or less 2. Value must not contain a pipe or asterisk symbols 3. OpSituational
~~TPL092~~	~~TPL.006.092~~	~~NATIONAL-HEALTH-CARE-ENTITY-ID-TYPE~~	~~National Health Care Entity ID Type~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~TPL00006~~	~~TPL-ENTITY-CONTACT-INFORMATION~~	~~X(1)~~	~~18~~	~~821~~	~~821~~	~~1. Not Applicable~~
~~TPL093~~	~~TPL.006.093~~	~~NATIONAL-HEALTH-CARE-ENTITY-ID~~	~~National Health Care Entity ID~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~TPL00006~~	~~TPL-ENTITY-CONTACT-INFORMATION~~	~~X(10)~~	~~19~~	~~822~~	~~831~~	~~1. Not Applicable~~
~~TPL094~~	~~TPL.006.094~~	~~NATIONAL-HEALTH-CARE-ENTITY-NAME~~	~~National Health Care Entity Name~~	~~Not Applicable~~	~~[No longer essential - Both data element and associated requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]~~	~~N/A~~	~~TPL00006~~	~~TPL-ENTITY-CONTACT-INFORMATION~~	~~X(50)~~	~~20~~	~~832~~	~~881~~	~~1. Not Applicable~~
TPL095	TPL.001.095	FILE-SUBMISSION-METHOD	File Submission Method	Mandatory	The file submission method (e.g., TFFR, RHFR, IT, or CSO) used by the state to build and submit the file. This should correspond with the state's	FILE-SUBMISSION-METHOD	TPL00001	FILE-HEADER-RECORD-TPL	X(2)	14	79	80	1. Value must be 2 characters 2. Value must be in File Submission Method List (VVL) 3. Mandatory

						declared file submission method for the same file type and time period.								

T-MSIS Data Dictionary – FTX File Changes Between Versions 2.4.0 and 4.0.0

FTX001	FTX.001.001	RECORD-ID	Record ID	Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	FTX00001	FILE-HEADER-RECORD-FTX	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "FTX00001"
FTX002	FTX.001.002	DATA-DICTIONARY-VERSION	Data Dictionary Version	Mandatory	A data element to capture the version of the T-MSIS data dictionary that was used to build the file.	DATA-DICTIONARY-VERSION	FTX00001	FILE-HEADER-RECORD-FTX	X(10)	2	9	18	1. Value must be 10 characters or less 2. Value must be in Data Dictionary Version List (VVL) 3. Value must not include the pipe ("|") symbol 4. Mandatory
FTX003	FTX.001.003	SUBMISSION-TRANSACTION-TYPE	Submission Transaction Type	Mandatory	A data element to identify the whether the transactions in the file are original submissions of the data, a resubmission of a previously submitted file, or corrections of edit rejects.	SUBMISSION-TRANSACTION-TYPE	FTX00001	FILE-HEADER-RECORD-FTX	X(1)	3	19	19	1. Value must be 1 character 2. Value must be in Submission Transaction Type List (VVL) 3. Mandatory
FTX004	FTX.001.004	FILE-ENCODING-SPECIFICATION	File Encoding Specification	Mandatory	Denotes which supported file encoding standard was used to create the file.	FILE-ENCODING-SPECIFICATION	FTX00001	FILE-HEADER-RECORD-FTX	X(3)	4	20	22	1. Value must be 3 characters 2. Value must be in File Encoding Specification List (VVL) 3. Mandatory
FTX005	FTX.001.005	DATA-MAPPING-DOCUMENT-VERSION	Data Mapping Document Version	Mandatory	Identifies the version of the T-MSIS data mapping document used to build a state submission file.	N/A	FTX00001	FILE-HEADER-RECORD-FTX	X(9)	5	23	31	1. Value must be 9 characters or less 2. Mandatory

FTX006	FTX.001.006	FILE-NAME	File Name	Mandatory	A code to identify the subject area to which the records in its file relate. Each T-MSIS submission file should only contain records for one subject area (i.e., Eligible, Third-party liability, Provider, Managed Care Plan Information, Inpatient, Long-Term Care, Other, Pharmacy Claim, and Financial Transactions).	N/A	FTX00001	FILE-HEADER-RECORD-FTX	X(8)	6	32	39	1. Value must equal "FINTRANS" 2. Mandatory
FTX007	FTX.001.007	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	FTX00001	FILE-HEADER-RECORD-FTX	X(2)	7	40	41	1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory
FTX008	FTX.001.008	DATE-FILE-CREATED	Date File Created	Mandatory	The date on which the file was created.	N/A	FTX00001	FILE-HEADER-RECORD-FTX	9(8)	8	42	49	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" 3. Value must be less than current date 4. Value must be equal to or after the value of associated End of Time Period 5. Mandatory
FTX009	FTX.001.009	START-OF-TIME-PERIOD	Start of Time Period	Mandatory	newly acquired SSN for at least one monthly submission of the Eligible File so that T-MSIS can associated the temporary MSIS Identification Number and the social security number.	N/A	FTX00001	FILE-HEADER-RECORD-FTX	9(8)	9	50	57	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be equal to or earlier than associated Date File Created 3. Value must be before associated End of Time Period 4. Mandatory 5. Value of the CC component must be "20"

FTX010	FTX.001.010	END-OF-TIME-PERIOD	End of Time Period	Mandatory	This value must be the last day of the reporting month, regardless of the actual date span.	N/A	FTX00001	FILE-HEADER-RECORD-FTX	9(8)	10	58	65	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be "20" 3. Value must be equal to or earlier than associated Date File Created 4. Value must be equal to or after associated Start of Time Period 5. Mandatory
FTX011	FTX.001.011	FILE-STATUS-INDICATOR	File Status Indicator	Mandatory	A code to indicate whether the records in the file are test or production records.	FILE-STATUS-INDICATOR	FTX00001	FILE-HEADER-RECORD-FTX	X(1)	11	66	66	1. Value must be 1 character 2. Value must be in File Status Indicator List (VVL) 3. For production files, value must be equal to "P" 4. Mandatory
FTX012	FTX.001.012	SSN-INDICATOR	SSN Indicator	Mandatory	with the temporary MSIS Identification Number and the SSN field should be space-filled, or blank. When the SSN becomes known, the MSIS Identification Number field should continue to be populated with the temporary MSIS Identification Number and the SSN field should be populated with the	SSN-INDICATOR	FTX00001	FILE-HEADER-RECORD-FTX	X(1)	12	67	67	1. Value must be 1 character 2. Value must be in SSN Indicator List (VVL) 3. Mandatory
FTX013	FTX.001.013	TOT-REC-CNT	Total Record Count	Mandatory	A count of all records in the file except for the file header record. This count will be used as a control total to help assure that the file did not become corrupted during transmission.	N/A	FTX00001	FILE-HEADER-RECORD-FTX	9(11)	13	68	78	1. Value must be 11 digits or less 2. Value must be a positive integer 3. Value must be between 0:99999999999 (inclusive) 4. Value must equal the number of records included in the file submission except for the file header record. 5. Mandatory

FTX014	FTX.001.014	SEQUENCE-NUMBER	Sequence Number	Mandatory	To enable states to sequentially number files, when related, follow-on files are necessary (i.e. update files, replace files). This should begin with 1 for the original Create submission type and be incremented by one for each Replacement or Update submission for the same reporting period and file type (subject area).	N/A	FTX00001	FILE-HEADER-RECORD-FTX	X(4)	14	79	82	1. Value must be 4 characters or less 2. Value must between 1 and 9999 3. Value must be equal to the largest of any prior values for the same reporting period and file type, plus 1 (i.e. incremented by 1) 4. Value must not contain a pipe symbol 5. Mandatory
FTX015	FTX.001.015	STATE-NOTATION	State Notation	Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	FTX00001	FILE-HEADER-RECORD-FTX	X(500)	15	83	582	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
FTX017	FTX.002.017	RECORD-ID	Record ID	Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "FTX00002"
FTX018	FTX.002.018	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(2)	2	9	10	1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory
FTX019	FTX.002.019	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	9(11)	3	11	21	1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory

FTX020	FTX.002.020	ICN-ORIG	Original ICN	Conditional	A unique item control number assigned by the states payment system that identifies an original or adjustment claim/transaction.	N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(50)	4	22	71	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional
FTX021	FTX.002.021	ICN-ADJ	Adjustment ICN	Conditional	A unique claim/transaction number assigned by the state's payment system that identifies the adjustment claim/transaction for an original item control number.	N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(50)	5	72	121	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
FTX023	FTX.002.023	ADJUSTMENT-IND	Adjustment Indicator	Mandatory	Indicates the type of adjustment record.	ADJUSTMENT-IND	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(1)	6	122	122	1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Mandatory
FTX024	FTX.002.024	PAYMENT-OR-RECOUPMENT-DATE	Payment Or Recoupment Date	Mandatory	The date that the payment or recoupment was executed by the payer.	N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	9(8)	7	123	130	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Mandatory 3. Value of the CC component must be equal to "20"
FTX025	FTX.002.025	PAYMENT-OR-RECOUPMENT-AMOUNT	Payment Or Recoupment Amount	Mandatory	The dollar amount being paid to the payee or recouped from the payee for a previous payment. A recoupment should be reported as a negative amount.	N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	S9(11)V99	8	131	143	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Mandatory
FTX026	FTX.002.026	CHECK-EFF-DATE	Check Effective Date	Conditional	The date a check is issued to the payee. In the case of electronic funds transfer, it is the date the transfer is made.	N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	9(8)	9	144	151	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Check Number 3. Conditional 4. Value of the CC component must be equal to "20"

FTX027	FTX.002.027	CHECK-NUM	Check Number	Conditional	The check or electronic funds transfer number.	N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(15)	10	152	166	1. Value must be 15 characters or less 2. When populated. value must have an associated Check Effective Date 3. Value must not contain a pipe or asterisk symbols 4. Conditional
FTX028	FTX.002.028	PAYER-ID	Payer ID	Mandatory	This is the identifier that corresponds with the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking the action of either making a payment or taking a recoupment, as opposed to the payee who is the object of the transaction. The payer is the entity that is either making a payment or recouping a payment from another entity or individual. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. This will typically correspond to the X12 820 Premium Payer.	N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(30)	11	167	196	1. Value must be 30 characters or less 2. Mandatory
FTX029	FTX.002.029	PAYER-ID-TYPE	Payer ID Type	Mandatory	This is a qualifier that indicates what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid or CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted as a submitting state code.	PAYER-ID-TYPE	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(2)	12	197	198	1. Value must be 2 characters 2. Value must be in Payer ID Type List (VVL) 3. Mandatory 4. When value equals "01" then Payer ID must equal Submitting State (FTX.001.007) 5. When value equals "02" then Payer ID must equal State Plan Identification Number (MCR.002.019) 6. When value equals "04" then Payer ID must equal must equal Submitting State Provider Identifier (PRV.002.019)

FTX030	FTX.002.030	PAYER-ID-TYPE-OTHER-TEXT	Payer ID Type Other Text	Conditional	This is a description of what the payer ID represents when the payer ID was reported with a payer type of "Other".	N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(100)	13	199	298	1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional
FTX031	FTX.002.031	PAYER-MCR-PLAN-TYPE	Payer MCR Plan Type	Conditional	This describes the type of managed care plan or care coordination model of the payer, when applicable. The valid value list is comprised of the standard managed care plan type list from the MCR and ELG files and a complementary list of care coordination models.	MANAGED-CARE-PLAN-TYPE	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(2)	14	299	300	1. Value must be 2 characters 2. Value must be in Managed Care Plan Type List (VVL) 3. If Payer ID Type equals "02", then value must be populated 4. If Payer ID Type does not equal "02", then value must not be populated 5. Conditional
FTX032	FTX.002.032	PAYER-MCR-PLAN-TYPE-OTHER-TEXT	Payer MCR Plan Type Other Text	Conditional	This is a description of what type of managed care plan or care coordination model the payer ID was reported with a PAYER-MCR-PLAN-OR-OTHER-TYPE of "Other".	N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(100)	15	301	400	1. Value must be 100 characters or less 2. Value must be populated when Payer MCR Plan Type equals "95" 3. Conditional
FTX033	FTX.002.033	PAYEE-ID	Payee Identifier	Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment. This will typically correspond to the X12 820 Premium Receiver.	N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(30)	16	401	430	1. Value must be 30 characters or less 2. Mandatory

FTX034	FTX.002.034	PAYEE-ID-TYPE	Payee Identifier Type	Mandatory	This is a qualifier that indicates what type of ID the payee ID is. For example, if the payee ID represents a provider ID, then the payee ID type will indicate that the payee ID should be interpreted as a provider ID.	PAYEE-ID-TYPE	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(2)	17	431	432	1. Value must be 2 characters 2. Value must be in Payee Identifier Type List (VVL) 3. If value equals "01", then Payee Identifier must equal Submitting State (FTX.001.007) 4. If value equals "02", then Payee Identifier must equal State Plan Identification Number (MCR.002.019) 5. If value in [04,05], then Payee Identifier must equal Submitting State Provider Identifier (PRV.002.019) 6. If value equals "06", then Payee Identifier must equal Provider Identifier (PRV.005.081) where Provider Identifier Type (PRV.005.077) equals "2" 7. If value equals "07", then Payee Identifier must equal Insurance Carrier Identification Number (TPL.006.075) 8. If value equals "08", then Payee Identifier must equal MSIS Identification Number (ELG.002.019) 9. Mandatory
FTX035	FTX.002.035	PAYEE-ID-TYPE-OTHER-TEXT	Payee ID Type Other Text	Conditional	This is a description of what the PAYEE-ID-TYPE represents when the PAYEE-ID-TYPE was reported with a payee ID type of "Other".	N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(100)	18	433	532	1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional
FTX036	FTX.002.036	PAYEE-MCR-PLAN-TYPE	Payee MCR Plan Type	Conditional	This describes the type of managed care plan or care coordination model of the payee, when applicable. The valid value code set is comprised of the standard managed care plan type list from the MCR and ELG files and a complementary list of care coordination models.	MANAGED-CARE-PLAN-TYPE	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(2)	19	533	534	1. Value must be 2 characters 2. Value must be in Managed Care Plan Type List (VVL) 3. If Payee ID Type is in [02,03], then value must be populated 4. If Payee ID Type is not [02,03], then value must not be populated 5. Conditional

FTX037	FTX.002.037	PAYEE-MCR-PLAN-TYPE-OTHER-TEXT	Payee MCR Plan Type Other Text	Conditional	This is a description of what type of managed care plan or care coordination model the payee ID was reported with a payee MCR plan or other care coordination model type of "Other".	N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(100)	20	535	634	1. Value must be 100 characters or less 2. Value must be populated when Payee MCR Plan Type equals "95" 3. Conditional
FTX038	FTX.002.038	PAYEE-TAX-ID	Payee Tax ID	Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment. This will typically belong to the entity identified as the X12 820 Premium Receiver.	N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(30)	21	635	664	1. Value must be 30 characters or less 2. Mandatory 3. If Payee Tax ID Type equals "01", then value must be 9-digits and meet the requirements of a valid SSN per SSA requirements
FTX039	FTX.002.039	PAYEE-TAX-ID-TYPE	Payee Tax ID Type	Mandatory	This is a qualifier that indicates what type of tax ID the payee tax ID is. For example, if the payee tax ID represents a SSN, then the payee tax ID type will indicate that the payee tax ID should be interpreted as a SSN.	PAYEE-TAX-ID-TYPE	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(2)	22	665	666	1. Value must be 2 characters 2. Value must be in Payee Tax ID Type List (VVL) 3. Mandatory
FTX040	FTX.002.040	PAYEE-TAX-ID-TYPE-OTHER-TEXT	Payee Tax ID Type Other Text	Conditional	This is a description of what the PAYEE-TAX-ID-TYPE represents when the PAYEE-TAX-ID-TYPE was reported with a payee tax ID type of "Other".	N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(100)	23	667	766	1. Value must be 100 characters or less 2. Value must be populated when Payee Tax Identifier Type equals "95" 3. Conditional
FTX041	FTX.002.041	CONTRACT-ID	Contract Identifier	Conditional	Managed care plan contract ID	N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(100)	24	767	866	1. Value must be 100 characters or less 2. Conditional 3. If Subcapitation Indicator equals "01", then value must be populated

FTX042	FTX.002.042	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique "key" value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/	N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(20)	25	867	886	1. Value must be 20 characters or less 2. Mandatory 3. Value must match MSIS Identification Number (ELG.021.019) 4. When Adjustment Indicator does not equal "1", there must be a valid record of type Enrollment Time Span where the Capitation Period Start Date is equal to or greater than Enrollment Start Date and Capitation Period End Date is less than or equal to Enrollment End Date
FTX043	FTX.002.043	CAPITATION-PERIOD-START-DATE	Capitation Period Start Date	Mandatory	The date representing the beginning of the period covered by the capitation or sub-capitation payment or recoupment; for example, the first day of the calendar month of beneficiary enrollment in the managed care plan that the payment is intended to cover (whether or not the beneficiary actually receives services during that month).	N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	9(8)	26	887	894	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Capitation Period End Date 3. Value of the CC component must be equal to "20" 4. Mandatory
FTX044	FTX.002.044	CAPITATION-PERIOD-END-DATE	Capitation Period End Date	Mandatory	The date representing the end of the period covered by the capitation or sub-capitation payment or recoupment; for example, the last day of the calendar month of beneficiary enrollment in the managed care plan that the payment is intended to cover (whether or not the beneficiary actually receives services during that month).	N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	9(8)	27	895	902	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be after or the same as the associated Capitation Period Start Date 3. Value of the CC component must be equal to "20" 4. Mandatory

FTX045	FTX.002.045	CATEGORY-FOR-FEDERAL-REIMBURSEMENT	Category for Federal Reimbursement	Mandatory	A code to indicate the Federal funding source for the payment.	CATEGORY-FOR-FEDERAL-REIMBURSEMENT	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(2)	28	903	904	1. Value must be 2 characters 2. Value must be in Category for Federal Reimbursement List (VVL) 3. Mandatory
FTX046	FTX.002.046	MBESCBES-CATEGORY-OF-SERVICE	MBESCBES Category of Service	Conditional	A code indicating the category of service for the paid claim. The category of service is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.) that states use to report their expenditures and request federal financial participation.	21.P-FORM, 21BASE-FORM, 64.21U-FORM, 64.10BASE-FORM, 64.9P-FORM, 64.9A-FORM, 64.9BASE-FORM, 64.21UP-FORM	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(5)	31	956	960	1. Value must be 5 characters or less 2. When MBESCBES Form equals "21.P", value must be in 21.P Form List (VVL) 3. When MBESCBES Form equals "21BASE", value must be in 21BASE Form List (VVL) 4. When MBESCBES Form equals "64.21U", value must be in 64.21U Form List (VVL) 5. When MBESCBES Form equals "64.10BASE", value must be in 64.10BASE Form List (VVL) 6. When MBESCBES Form equals "64.9P", value must be in 64.9P Form List (VVL) 7. When MBESCBES Form equals "64.9A", value must be in 64.9A Form List (VVL) 8. When MBESCBES Form equals "64.9BASE", value must be in 64.9BASE Form List (VVL) 9. When MBESCBES Form equals "64.21UP", value must be in 64.21UP Form List (VVL) 10. If Subcapitation Indicator equals "01", then value must be populated 11. Conditional 12. When populated, an associated MBESCBES Form Group and MBESCBES Form must be populated

FTX047	FTX.002.047	MBESCBES-FORM	MBESCBES Form	Conditional	The MBES or CBES form to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.). This should be determined by the state's MBES/CBES reporting process. The MBES or CBES form reported here will determine what the meaning of the corresponding MBES/CBES category of service value is.	MBESCBES-FORMGP-1, MBESCBES-FORMGP-2, MBESCBES-FORMGP-3	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(50)	30	906	955	1. Value must be 50 characters or less 2. When MBESCBES Form Group equals "1", value must be in MBESCBES Form Group 1 List (VVL) 3. When MBESCBES Form Group equals "2", value must be in MBESCBES Form Group 2 List (VVL) 4. When MBESCBES Form Group equals "3", value must be in MBESCBES Form Group 3 List (VVL) 5. If Subcapitation Indicator equals "01", then value must be populated 6. Conditional
FTX048	FTX.002.048	MBESCBES-FORM-GROUP	MBESCBES Form Group	Conditional	Indicates group of MBES/CBES forms that this payment applies to (e.g., the CMS-64.9 Base form is for Title XIX-funded Medicaid, the CMS-64.21 form is for Title XXI-funded Medicaid-expansion CHIP (M-CHIP), and the CMS-21 Base form is for Title XXI-funded separate CHIP (S-CHIP)).	MBESCBES-FORM-GROUP	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(1)	29	905	905	1. Value must be 1 character 2. Value must be in MBESCBES Form Group List (VVL) 3. If Subcapitation Indicator equals "01", then value must be populated 4. Conditional
FTX049	FTX.002.049	WAIVER-ID	Waiver ID	Conditional	Field specifying the waiver or demonstration which authorized payment. These IDs must be the approved, full federal waiver ID number assigned during the state submission and CMS approval process. Waiver IDs should actually only be the "core" part of the waiver IDs, without including suffixes for renewals or amendments.	N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(20)	32	961	980	1. Value must be 20 characters or less 2. Value must be associated with a populated Waiver Type 3. (1115 demonstration) If value begins with "11-W-" or "21-W-", the associated Claim Waiver Type value must be 01 or in [21-30] 4. (1115 demonstration) If value begins with"11-W-" or "21-W-", then the value must include slash “/” in the 11th position followed by the last digit of the CMS Region [0-9] in the 12th position 5. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation followed by a period (.), the associated

													Waiver Type value must be in [02-20,32,33] 6. Conditional
FTX050	FTX.002.050	WAIVER-TYPE	Waiver Type	Conditional	A code for specifying waiver type under which the eligible individual is covered during the month and receiving services/under which transaction is submitted.	WAIVER-TYPE	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(2)	33	981	982	1. Value must be 2 characters 2. Value must be in Waiver Type List (VVL) 3. Value must have a corresponding value in Waiver ID 4. Value must match Eligible Waiver Type (ELG.012.173) for the enrollee for the same time period 5. Conditional
FTX051	FTX.002.051	FUNDING-CODE	Funding Code	Conditional	A code to indicate the source of non-federal share funds.	FUNDING-CODE	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(2)	34	983	984	1. Value must be 1 character 2. Value must be in Funding Code List (VVL) 3. If Subcapitation Indicator equals "01", then value must be populated 4. Conditional
FTX052	FTX.002.052	FUNDING-SOURCE-NONFEDERAL-SHARE	Funding Source Nonfederal Share	Conditional	A code to indicate the type of non-federal share used by the state to finance its expenditure to the provider. In the event of two sources, states are to report the portion which represents the largest proportion not funded by the Federal government.	FUNDING-SOURCE-NONFEDERAL-SHARE	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(2)	35	985	986	1. Value must be 2 characters 2. Value must be in Funding Source Nonfederal Share List (VVL) 3. If Subcapitation Indicator equals "01", then value must be populated 4. Conditional

FTX053	FTX.002.053	SDP-IND	State Directed Payment Indicator	Mandatory	Indicates whether the financial transaction from an MC plan to a provider or other entity is a type of State Directed Payment.	SDP-IND	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(1)	36	987	987	1. Value must be 1 character 2. Value must be in State Directed Payment Indicator List (VVL) 3. Mandatory
FTX054	FTX.002.054	SOURCE-LOCATION	Source Location	Mandatory	The field denotes the claims/transaction processing system in which the claims/transactions were originally processed.	SOURCE-LOCATION	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(2)	37	988	989	1. Value must be 2 characters 2. Value must be in Source Location List (VVL) 3. Mandatory
FTX055	FTX.002.055	SPA-NUMBER	SPA Number	Conditional	State plan amendment (SPA) ID number using the following format: SS-YY-NNNN-xxxx where: SS = State (use the two character postal abbreviation for your state); YY = Calendar Year (last two characters of the calendar year of the state plan amendment); NNNN = SPA number (a four character number beginning with 0001) States should track their submissions to assign sequential numbers to their submissions. The system will not permit reuse of a previously used SPA ID for a package that has been formally submitted; xxxx = an Situational entry for specific SPA types	N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(15)	38	990	1004	1. Value must be 15 characters or less 2. Conditional
FTX056	FTX.002.056	SUBCAPITATION-IND	Subcapitation Ind	Mandatory	Indicates whether the transaction represents a sub-capitation payment between a managed care plan and a sub-capitated entity or sub-capitated network provider or not. A sub-capitation payment could also be between a sub-capitated entity and another sub-capitated entity or sub-capitated network provider.	SUBCAPITATION-IND	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(1)	39	1005	1005	1. Value must be 1 character 2. Value must be in Subcaptitation Indicator List (VVL) 3. Mandatory
FTX057	FTX.002.057	PAYMENT-CAT-XREF	Payment Cat Xref	Conditional	Cross-reference to the applicable payment category in the managed care plan's contract with the state Medicaid/CHIP agency or their fiscal intermediary.	N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(50)	40	1006	1055	1. Value must be 50 characters or less 2. If Subcapitation Indicator equals "01", then value must be populated 3. Conditional

FTX058	FTX.002.058	RATE-CELL-DESCRIPTION-TEXT	Rate Cell Description Text	Conditional	This is the description of the rate cell from the rate setting process that applies to the capitation payment. For example, a rate cell may represent the monthly capitation rate paid for adults with chronic conditions who live in a rural area. If the rate paid for this capitation payment is based on the rate cell for adults with chronic conditions who live in a rural area, then the rate cell description could be "Adults with chronic conditions living in a rural area."	N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(100)	41	1056	1155	1. Value must be 100 characters or less 2. Conditional
FTX059	FTX.002.059	EXPENDITURE-AUTHORITY-TYPE	Expenditure Authority Type	Conditional	Expenditure Authority Type is the federal statute or regulation under which the expenditure is authorized/justified. The federal statute or regulation is usually referenced in either the Medicaid or CHIP State Plan or waiver documentation. For waivers, do not reference the federal statute or regulation being waived by the waiver. For waivers, referring to the waiver authority is sufficient. If the federal statute or regulation is not available in the list of valid values, choose the value for "Other" and report the authority in the Expenditure Authority Type Text.	EXPENDITURE-AUTHORITY-TYPE	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(2)	42	1156	1157	1. Value must be 2 characters 2. Value must be in Expenditure Authority Type List (VVL) 3. If Subcapitation Indicator equals "01", then value must be populated 4. Conditional
FTX060	FTX.002.060	EXPENDITURE-AUTHORITY-TYPE-OTHER-TEXT	Expenditure Authority Type Other Text	Conditional	This field is only to be used if Expenditure Authority Type "Other" valid value is selected. Enter a specific text description of the "Other" expenditure authority type.	N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(100)	43	1158	1257	1. Value must be 100 characters or less 2. If Expenditure Authority Type equals "95", then value must be populated 3. Conditional
FTX061	FTX.002.061	MEMO	Memo	Conditional	This represents any notes from the state's ledger/accounting system associated with the payment/recoupment.	N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(500)	44	1258	1757	1. Value must be 500 characters or less 2. Conditional

FTX062	FTX.002.062	STATE-NOTATION	State Notation	Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	FTX00002	INDIVIDUAL-CAPITATION-PMPM	X(500)	45	1758	2257	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
FTX064	FTX.003.064	RECORD-ID	Record ID	Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "FTX00003"
FTX065	FTX.003.065	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(2)	2	9	10	1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory
FTX066	FTX.003.066	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	9(11)	3	11	21	1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
FTX067	FTX.003.067	ICN-ORIG	Original ICN	Mandatory	A unique item control number assigned by the states payment system that identifies an original or adjustment claim/transaction.	N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(50)	4	22	71	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory

FTX068	FTX.003.068	ICN-ADJ	Adjustment ICN	Conditional	A unique claim/transaction number assigned by the state's payment system that identifies the adjustment claim/transaction for an original item control number.	N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(50)	5	72	121	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
FTX070	FTX.003.070	ADJUSTMENT-IND	Adjustment Indicator	Mandatory	Indicates the type of adjustment record.	ADJUSTMENT-IND	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(1)	6	122	122	1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Mandatory
FTX071	FTX.003.071	PAYMENT-OR-RECOUPMENT-DATE	Payment Date	Mandatory	The date that the payment or recoupment was executed by the payer.	N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	9(8)	7	123	130	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Mandatory 3. Value of the CC component must be equal to "20"
FTX072	FTX.003.072	PAYMENT-AMOUNT	Payment Amount	Mandatory	The dollar amount being paid to the payee.	N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	S9(11)V99	8	131	143	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Mandatory
FTX073	FTX.003.073	CHECK-EFF-DATE	Check Effective Date	Conditional	The date a check is issued to the payee. In the case of electronic funds transfer, it is the date the transfer is made.	N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	9(8)	9	144	151	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Check Number 3. Conditional 4. Value of the CC component must be equal to "20"

FTX074	FTX.003.074	CHECK-NUM	Check Number	Conditional	The check or electronic funds transfer number.	N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(15)	10	152	166	1. Value must be 15 characters or less 2. When populated. value must have an associated Check Effective Date 3. Value must not contain a pipe or asterisk symbols 4. Conditional
FTX075	FTX.003.075	PAYER-ID	Payer ID	Mandatory	This is the identifier that corresponds with the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking the action of either making a payment or taking a recoupment, as opposed to the payee who is the object of the transaction. The payer is the entity that is either making a payment or recouping a payment from another entity or individual. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. This will typically correspond to the X12 820 Premium Payer.	N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(30)	11	167	196	1. Value must be 30 characters or less 2. Mandatory
FTX076	FTX.003.076	PAYER-ID-TYPE	Payer ID Type	Mandatory	This is a qualifier that indicates what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid or CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted as a submitting state code.	PAYER-ID-TYPE	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(2)	12	197	198	1. Value must be 2 characters 2. Value must be in Payer ID Type List (VVL) 3. Mandatory 4. When value equals "01" then Payer ID must equal Submitting State (FTX.001.007)
FTX077	FTX.003.077	PAYER-ID-TYPE-OTHER-TEXT	Payer ID Type Other Text	Conditional	This is a description of what the payer ID represents when the payer ID was reported with a payer type of "Other".	N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(100)	13	199	298	1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional

FTX078	FTX.003.078	PAYEE-ID	Payee Identifier	Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment. This will typically correspond to the X12 820 Premium Receiver.	N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(30)	14	299	328	1. Value must be 30 characters or less 2. Mandatory
FTX079	FTX.003.079	PAYEE-ID-TYPE	Payee Identifier Type	Mandatory	This is a qualifier that indicates what type of ID the payee ID is. For example, if the payee ID represents a provider ID, then the payee ID type will indicate that the payee ID should be interpreted as a provider ID.	PAYEE-ID-TYPE	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(2)	15	329	330	1. Value must be 2 characters 2. Value must be in Payee Identifier Type List (VVL) 3. If value equals "01", then Payee Identifier must equal Submitting State (FTX.001.007) 4. If value equals "02", then Payee Identifier must equal State Plan Identification Number (MCR.002.019) 5. If value in [04,05], then Payee Identifier must equal Submitting State Provider Identifier (PRV.002.019) 6. If value equals "06", then Payee Identifier must equal Provider Identifier (PRV.005.081) where Provider Identifier Type (PRV.005.077) equals "2" 7. If value equals "07", then Payee Identifier must equal Insurance Carrier Identification Number (TPL.006.075) 8. If value equals "08", then Payee Identifier must equal MSIS Identification Number (ELG.002.019) 9. Mandatory

FTX080	FTX.003.080	PAYEE-ID-TYPE-OTHER-TEXT	Payee ID Type Other Text	Conditional	This is a description of what the PAYEE-ID-TYPE represents when the PAYEE-ID-TYPE was reported with a payee ID type of "Other".	N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(100)	16	331	430	1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional
FTX081	FTX.003.081	PAYEE-TAX-ID	Payee Tax ID	Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment. This will typically belong to the entity identified as the X12 820 Premium Receiver.	N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(30)	17	431	460	1. Value must be 30 characters or less 2. Mandatory 3. If Payee Tax ID Type equals "01", then value must be 9-digits and meet the requirements of a valid SSN per SSA requirements
FTX082	FTX.003.082	PAYEE-TAX-ID-TYPE	Payee Tax ID Type	Mandatory	This is a qualifier that indicates what type of tax ID the payee tax ID is. For example, if the payee tax ID represents a SSN, then the payee tax ID type will indicate that the payee tax ID should be interpreted as a SSN.	PAYEE-TAX-ID-TYPE	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(2)	18	461	462	1. Value must be 2 characters 2. Value must be in Payee Tax ID Type List (VVL) 3. Mandatory
FTX083	FTX.003.083	PAYEE-TAX-ID-TYPE-OTHER-TEXT	Payee Tax ID Type Other Text	Conditional	This is a description of what the PAYEE-TAX-ID-TYPE represents when the PAYEE-TAX-ID-TYPE was reported with a payee tax ID type of "Other".	N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(100)	19	463	562	1. Value must be 100 characters or less 2. Value must be populated when Payee Tax Identifier Type equals "95" 3. Conditional
FTX084	FTX.003.084	INSURANCE-CARRIER-ID-NUM	Insurance Carrier Identification Number	Mandatory	The state-assigned identification number of the Third Party Liability (TPL) Entity.	N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(12)	20	563	574	1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory

FTX085	FTX.003.085	INSURANCE-PLAN-ID	Insurance Plan Identifier	Conditional	The ID number issued by the Insurance carrier providing third party liability insurance coverage to beneficiaries. Typically the Plan ID/Plan Number is on the beneficiaries' insurance card.	N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(20)	21	575	594	1. Value must not contain a pipe or asterisk symbol 2. Value must be 20 characters or less 3. Conditional
FTX086	FTX.003.086	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique “key” value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/	N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(20)	22	595	614	1. Value must be 20 characters or less 2. Mandatory 3. Value must match MSIS Identification Number (ELG.021.019) 4. When Adjustment Indicator does not equal "1", there must be a valid record of type Enrollment Time Span where the Payment Period Start Date is equal to or greater than Enrollment Start Date and Payment Period End Date is less than or equal to Enrollment End Date.
FTX087	FTX.003.087	MEMBER-ID	Member Identifier	Conditional	Member identification number as it appears on the card issued by the TPL insurance carrier.	N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(20)	23	615	634	1. Value must be 20 characters or less 2. Conditional

FTX088	FTX.003.088	PREMIUM-PERIOD-START-DATE	Premium Period Start Date	Mandatory	The date representing the beginning of the period covered by the premium payment or recoupment; for example, the first day of the calendar month of beneficiary coverage in the insurance plan that the payment is intended to cover (whether or not the beneficiary actually receives services during that month).	N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	9(8)	24	635	642	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Coverage Period End Date 3. Value of the CC component must be equal to "20" 4. Mandatory
FTX089	FTX.003.089	PREMIUM-PERIOD-END-DATE	Premium Period End Date	Mandatory	The date representing the end of the period covered by the premium payment or recoupment; for example, the last day of the calendar month of beneficiary coverage in the insurance plan that the payment is intended to cover (whether or not the beneficiary actually receives services during that month).	N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	9(8)	25	643	650	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be after or the same as the associated Premium Period Start Date 3. Value of the CC component must be equal to "20" 4. Mandatory
FTX090	FTX.003.090	CATEGORY-FOR-FEDERAL-REIMBURSEMENT	Category for Federal Reimbursement	Mandatory	A code to indicate the Federal funding source for the payment.	CATEGORY-FOR-FEDERAL-REIMBURSEMENT	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(2)	26	651	652	1. Value must be 2 characters 2. Value must be in Category for Federal Reimbursement List (VVL) 3. Mandatory

FTX091	FTX.003.091	MBESCBES-CATEGORY-OF-SERVICE	MBESCBES Category of Service	Mandatory	A code indicating the category of service for the paid claim. The category of service is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.) that states use to report their expenditures and request federal financial participation.	21.P-FORM, 21BASE-FORM, 64.21U-FORM, 64.10BASE-FORM, 64.9P-FORM, 64.9A-FORM, 64.9BASE-FORM, 64.21UP-FORM	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(5)	29	704	708	1. Value must be 5 characters or less 2. When MBESCBES Form equals "21.P", value must be in 21.P Form List (VVL) 3. When MBESCBES Form equals "21BASE", value must be in 21BASE Form List (VVL) 4. When MBESCBES Form equals "64.21U", value must be in 64.21U Form List (VVL) 5. When MBESCBES Form equals "64.10BASE", value must be in 64.10BASE Form List (VVL) 6. When MBESCBES Form equals "64.9P", value must be in 64.9P Form List (VVL) 7. When MBESCBES Form equals "64.9A", value must be in 64.9A Form List (VVL) 8. When MBESCBES Form equals "64.9BASE", value must be in 64.9BASE Form List (VVL) 9. When MBESCBES Form equals "64.21UP", value must be in 64.21UP Form List (VVL) 10. Mandatory
FTX092	FTX.003.092	MBESCBES-FORM	MBESCBES Form	Mandatory	The MBES or CBES form to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.). This should be determined by the state's MBES/CBES reporting process. The MBES or CBES form reported here will determine what the meaning of the corresponding MBES/CBES category of service value is.	MBESCBES-FORMGP-1, MBESCBES-FORMGP-2, MBESCBES-FORMGP-3	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(50)	28	654	703	1. Value must be 50 characters or less 2. When MBESCBES Form Group equals "1", value must be in MBESCBES Form Group 1 List (VVL) 3. When MBESCBES Form Group equals "2", value must be in MBESCBES Form Group 2 List (VVL) 4. When MBESCBES Form Group equals "3", value must be in MBESCBES Form Group 3 List (VVL) 5. Mandatory

FTX093	FTX.003.093	MBESCBES-FORM-GROUP	MBESCBES Form Group	Mandatory	Indicates group of MBES/CBES forms that this payment applies to (e.g., the CMS-64.9 Base form is for Title XIX-funded Medicaid, the CMS-64.21 form is for Title XXI-funded Medicaid-expansion CHIP (M-CHIP), and the CMS-21 Base form is for Title XXI-funded separate CHIP (S-CHIP)).	MBESCBES-FORM-GROUP	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(1)	27	653	653	1. Value must be 1 character 2. Value must be in MBESCBES Form Group List (VVL) 3. Mandatory
FTX094	FTX.003.094	WAIVER-ID	Waiver ID	Conditional	Field specifying the waiver or demonstration which authorized payment. These IDs must be the approved, full federal waiver ID number assigned during the state submission and CMS approval process. Waiver IDs should actually only be the "core" part of the waiver IDs, without including suffixes for renewals or amendments.	N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(20)	30	709	728	1. Value must be 20 characters or less 2. Value must be associated with a populated Waiver Type 3. (1115 demonstration) If value begins with "11-W-" or "21-W-", the associated Claim Waiver Type value must be 01 or in [21-30] 4. (1115 demonstration) If value begins with"11-W-" or "21-W-", then the value must include slash “/” in the 11th position followed by the last digit of the CMS Region [0-9] in the 12th position 5. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation followed by a period (.), the associated Waiver Type value must be in [02-20,32,33] 6. Conditional
FTX095	FTX.003.095	WAIVER-TYPE	Waiver Type	Conditional	A code for specifying waiver type under which the eligible individual is covered during the month and receiving services/under which transaction is submitted.	WAIVER-TYPE	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(2)	31	729	730	1. Value must be 2 characters 2. Value must be in Waiver Type List (VVL) 3. Value must have a corresponding value in Waiver ID 4. Value must match Eligible Waiver Type (ELG.012.173) for the enrollee for the same time period 5. Conditional

FTX096	FTX.003.096	FUNDING-CODE	Funding Code	Mandatory	A code to indicate the source of non-federal share funds.	FUNDING-CODE	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(2)	32	731	732	1. Value must be 1 character 2. Value must be in Funding Code List (VVL) 3. Mandatory
FTX097	FTX.003.097	FUNDING-SOURCE-NONFEDERAL-SHARE	Funding Source Nonfederal Share	Mandatory	A code to indicate the type of non-federal share used by the state to finance its expenditure to the provider. In the event of two sources, states are to report the portion which represents the largest proportion not funded by the Federal government.	FUNDING-SOURCE-NONFEDERAL-SHARE	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(2)	33	733	734	1. Value must be 2 characters 2. Value must be in Funding Source Nonfederal Share List (VVL) 3. Mandatory
FTX098	FTX.003.098	SOURCE-LOCATION	Source Location	Mandatory	The field denotes the claims/transaction processing system in which the claims/transactions were originally processed.	SOURCE-LOCATION	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(2)	34	735	736	1. Value must be 2 characters 2. Value must be in Source Location List (VVL) 3. Mandatory
FTX099	FTX.003.099	SPA-NUMBER	SPA Number	Conditional	State plan amendment (SPA) ID number using the following format: SS-YY-NNNN-xxxx where: SS = State (use the two character postal abbreviation for your state); YY = Calendar Year (last two characters of the calendar year of the state plan amendment); NNNN = SPA number (a four character number beginning with 0001) States should track their submissions to assign sequential numbers to their submissions. The system will not permit reuse of a previously used SPA ID for a package that has been formally = an Situational entry for specific SPA types	N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(15)	35	737	751	1. Value must be 15 characters or less 2. Conditional

FTX100	FTX.003.100	EXPENDITURE-AUTHORITY-TYPE	Expenditure Authority Type	Mandatory	Expenditure Authority Type is the federal statute or regulation under which the expenditure is authorized/justified. The federal statute or regulation is usually referenced in either the Medicaid or CHIP State Plan or waiver documentation. For waivers, do not reference the federal statute or regulation being waived by the waiver. For waivers, referring to the waiver authority is sufficient. If the federal statute or regulation is not available in the list of valid values, choose the value for "Other" and report the authority in the Expenditure Authority Type Text.	EXPENDITURE-AUTHORITY-TYPE	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(2)	36	752	753	1. Value must be 2 characters 2. Value must be in Expenditure Authority Type List (VVL) 3. Mandatory
FTX101	FTX.003.101	EXPENDITURE-AUTHORITY-TYPE-OTHER-TEXT	Expenditure Authority Type Other Text	Conditional	This field is only to be used if Expenditure Authority Type "Other" valid value is selected. Enter a specific text description of the "Other" expenditure authority type.	N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(100)	37	754	853	1. Value must be 100 characters or less 2. If Expenditure Authority Type equals "95", then value must be populated 3. Conditional
FTX102	FTX.003.102	MEMO	Memo	Conditional	This represents any notes from the state's ledger/accounting system associated with the payment/recoupment.	N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(500)	38	854	1353	1. Value must be 500 characters or less 2. Conditional
FTX103	FTX.003.103	STATE-NOTATION	State Notation	Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	FTX00003	INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT	X(500)	39	1354	1853	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational

FTX105	FTX.004.105	RECORD-ID	Record ID	Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "FTX00004"
FTX106	FTX.004.106	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(2)	2	9	10	1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory
FTX107	FTX.004.107	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	9(11)	3	11	21	1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
FTX108	FTX.004.108	ICN-ORIG	Original ICN	Mandatory	A unique item control number assigned by the states payment system that identifies an original or adjustment claim/transaction.	N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(50)	4	22	71	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
FTX109	FTX.004.109	ICN-ADJ	Adjustment ICN	Conditional	A unique claim/transaction number assigned by the state's payment system that identifies the adjustment claim/transaction for an original item control number.	N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(50)	5	72	121	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated

FTX111	FTX.004.111	ADJUSTMENT-IND	Adjustment Indicator	Mandatory	Indicates the type of adjustment record.	ADJUSTMENT-IND	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(1)	6	122	122	1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Mandatory
FTX112	FTX.004.112	PAYMENT-DATE	Payment Date	Mandatory	The date that the payment or recoupment was executed by the payer.	N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	9(8)	7	123	130	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value of the CC component must be equal to "20" 3. Mandatory
FTX113	FTX.004.113	PAYMENT-AMOUNT	Payment Amount	Mandatory	The dollar amount being paid to the payee.	N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	S9(11)V99	8	131	143	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Mandatory
FTX114	FTX.004.114	CHECK-EFF-DATE	Check Effective Date	Conditional	The date a check is issued to the payee. In the case of electronic funds transfer, it is the date the transfer is made.	N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	9(8)	9	144	151	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Check Number 3. Conditional 4. Value of the CC component must be equal to "20"
FTX115	FTX.004.115	CHECK-NUM	Check Number	Conditional	The check or electronic funds transfer number.	N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(15)	10	152	166	1. Value must be 15 characters or less 2. When populated. value must have an associated Check Effective Date 3. Value must not contain a pipe or asterisk symbols 4. Conditional

FTX116	FTX.004.116	PAYER-ID	Payer ID	Mandatory	This is the identifier that corresponds with the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking the action of either making a payment or taking a recoupment, as opposed to the payee who is the object of the transaction. The payer is the entity that is either making a payment or recouping a payment from another entity or individual. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. This will typically correspond to the X12 820 Premium Payer.	N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(30)	11	167	196	1. Value must be 30 characters or less 2. Mandatory
FTX117	FTX.004.117	PAYER-ID-TYPE	Payer ID Type	Mandatory	This is a qualifier that indicates what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid or CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted as a submitting state code.	PAYER-ID-TYPE	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(2)	12	197	198	1. Value must be 2 characters 2. Value must be in Payer ID Type List (VVL) 3. Mandatory 4. When value equals "01" then Payer ID must equal Submitting State (FTX.001.007)
FTX118	FTX.004.118	PAYER-ID-TYPE-OTHER-TEXT	Payer ID Type Other Text	Conditional	This is a description of what the payer ID represents when the payer ID was reported with a payer type of "Other".	N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(100)	13	199	298	1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional

FTX119	FTX.004.119	PAYEE-ID	Payee Identifier	Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment. This will typically correspond to the X12 820 Premium Receiver.	N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(30)	14	299	328	1. Value must be 30 characters or less 2. Mandatory
FTX120	FTX.004.120	PAYEE-ID-TYPE	Payee Identifier Type	Mandatory	This is a qualifier that indicates what type of ID the payee ID is. For example, if the payee ID represents a provider ID, then the payee ID type will indicate that the payee ID should be interpreted as a provider ID.	PAYEE-ID-TYPE	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(2)	15	329	330	1. Value must be 2 characters 2. Value must be in Payee Identifier Type List (VVL) 3. If value equals "01", then Payee Identifier must equal Submitting State (FTX.001.007) 4. If value equals "02", then Payee Identifier must equal State Plan Identification Number (MCR.002.019) 5. If value in [04,05], then Payee Identifier must equal Submitting State Provider Identifier (PRV.002.019) 6. If value equals "06", then Payee Identifier must equal Provider Identifier (PRV.005.081) where Provider Identifier Type (PRV.005.077) equals "2" 7. If value equals "07", then Payee Identifier must equal Insurance Carrier Identification Number (TPL.006.075) 8. If value equals "08", then Payee Identifier must equal MSIS Identification Number (ELG.002.019) 9. Mandatory

FTX121	FTX.004.121	PAYEE-ID-TYPE-OTHER-TEXT	Payee ID Type Other Text	Conditional	This is a description of what the PAYEE-ID-TYPE represents when the PAYEE-ID-TYPE was reported with a payee ID type of "Other".	N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(100)	16	331	430	1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional
FTX122	FTX.004.122	PAYEE-TAX-ID	Payee Tax ID	Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment. This will typically belong to the entity identified as the X12 820 Premium Receiver.	N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(30)	17	431	460	1. Value must be 30 characters or less 2. Mandatory 3. If Payee Tax ID Type equals "01", then value must be 9-digits and meet the requirements of a valid SSN per SSA requirements
FTX123	FTX.004.123	PAYEE-TAX-ID-TYPE	Payee Tax ID Type	Mandatory	This is a qualifier that indicates what type of tax ID the payee tax ID is. For example, if the payee tax ID represents a SSN, then the payee tax ID type will indicate that the payee tax ID should be interpreted as a SSN.	PAYEE-TAX-ID-TYPE	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(2)	18	461	462	1. Value must be 2 characters 2. Value must be in Payee Tax ID Type List (VVL) 3. Mandatory
FTX124	FTX.004.124	PAYEE-TAX-ID-TYPE-OTHER-TEXT	Payee Tax ID Type Other Text	Conditional	This is a description of what the PAYEE-TAX-ID-TYPE represents when the PAYEE-TAX-ID-TYPE was reported with a payee tax ID type of "Other".	N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(100)	19	463	562	1. Value must be 100 characters or less 2. Value must be populated when Payee Tax Identifier Type equals "95" 3. Conditional
FTX125	FTX.004.125	INSURANCE-CARRIER-ID-NUM	Insurance Carrier Identification Number	Mandatory	The state-assigned identification number of the Third Party Liability (TPL) Entity.	N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(12)	20	563	574	1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
FTX126	FTX.004.126	INSURANCE-PLAN-ID	Insurance Plan Identifier	Conditional	The ID number issued by the Insurance carrier providing third party liability insurance coverage to beneficiaries. Typically the Plan ID/Plan Number is on the beneficiaries' insurance card.	N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(20)	21	575	594	1. Value must not contain a pipe or asterisk symbol 2. Value must be 20 characters or less 3. Conditional

FTX127	FTX.004.127	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Conditional	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique “key” value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/ MSIS-IDENTIFICATION-NUM is conditional in the FTX00004 segment because some members of a private group policy may not be eligible for Medicaid or CHIP, though at least one member of the group policy must be eligible for Medicaid or CHIP. There should be one FTX00004 segment for each member of the group policy for which the premium assistance payment is being paid, regardless of whether the member of the group policy was eligible for and enrolled in Medicaid or CHIP.	N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(20)	22	595	614	1. Value must be 20 characters or less 2. Conditional 3. Value must match MSIS Identification Number (ELG.021.019) 4. When Adjustment Indicator does not equal "1", there must be a valid record of type Enrollment Time Span where the Premium Period Start Date is equal to or greater than Enrollment Start Date and Premium Period End Date is less than or equal to Enrollment End Date

FTX128	FTX.004.128	SSN	SSN	Conditional	The SSN of the member of the group insurance policy. Each FTX00004 segment represents a different member of a given group insurance policy. Typically all members of the group insurance policy will have both an MSIS ID and an SSN. Under some circumstances, it's possible that or more members of a group insurance policy do not have an MSIS ID, but do have an SSN, if they are included on the group insurance policy but not eligible for Medicaid or CHIP. It's also possible that one or more members of a group insurance policy do not have an SSN. If a member of a group insurance policy does not have an SSN, leave this field blank.	N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(9)	23	615	623	1. Value must be 9-digit number 2. Conditional
FTX129	FTX.004.129	MEMBER-ID	Member Identifier	Conditional	Member identification number as it appears on the card issued by the TPL insurance carrier.	N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(20)	24	624	643	1. Value must be 20 characters or less 2. Conditional
FTX130	FTX.004.130	GROUP-NUM	Group Num	Conditional	The group number of the TPL health insurance policy.	N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(16)	25	644	659	1. Value must be 16 characters or less 2. Value must not contain a pipe symbol 3. Conditional
FTX131	FTX.004.131	POLICY-OWNER-CODE	Policy Owner Code	Conditional	This code identifies the relationship of the policy holder to the Medicaid/CHIP beneficiary.	POLICY-OWNER-CODE	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(2)	26	660	661	1. Value must be 2 characters 2. Value must be in Policy Owner Code List (VVL) 3. Conditional
FTX132	FTX.004.132	PREMIUM-PERIOD-START-DATE	Premium Period Start Date	Mandatory	The date representing the beginning of the period covered by the premium payment or recoupment; for example, the first day of the calendar month of beneficiary coverage in the insurance plan that the payment is intended to cover (whether or not the beneficiary actually receives services during that month).	N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	9(8)	27	662	669	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Premium Period End Date 3. Value of the CC component must be equal to "20" 4. Mandatory

FTX133	FTX.004.133	PREMIUM-PERIOD-END-DATE	Premium Period End Date	Mandatory	The date representing the end of the period covered by the premium payment or recoupment; for example, the last day of the calendar month of beneficiary coverage in the insurance plan that the payment is intended to cover (whether or not the beneficiary actually receives services during that month).	N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	9(8)	28	670	677	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be after or the same as the associated Premium Period Start Date 3. Value of the CC component must be equal to "20" 4. Mandatory
FTX134	FTX.004.134	CATEGORY-FOR-FEDERAL-REIMBURSEMENT	Category for Federal Reimbursement	Conditional	A code to indicate the Federal funding source for the payment.	CATEGORY-FOR-FEDERAL-REIMBURSEMENT	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(2)	29	678	679	1. Value must be 2 characters 2. Value must be in Category for Federal Reimbursement List (VVL) 3. If Policy Owner Code equals "01", then value must be populated 4. Conditional

FTX135	FTX.004.135	MBESCBES-CATEGORY-OF-SERVICE	MBESCBES Category of Service	Conditional	A code indicating the category of service for the paid claim. The category of service is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.) that states use to report their expenditures and request federal financial participation.	21.P-FORM, 21BASE-FORM, 64.21U-FORM, 64.10BASE-FORM, 64.9P-FORM, 64.9A-FORM, 64.9BASE-FORM, 64.21UP-FORM	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(5)	32	731	735	1. Value must be 5 characters or less 2. When MBESCBES Form equals "21.P", value must be in 21.P Form List (VVL) 3. When MBESCBES Form equals "21BASE", value must be in 21BASE Form List (VVL) 4. When MBESCBES Form equals "64.21U", value must be in 64.21U Form List (VVL) 5. When MBESCBES Form equals "64.10BASE", value must be in 64.10BASE Form List (VVL) 6. When MBESCBES Form equals "64.9P", value must be in 64.9P Form List (VVL) 7. When MBESCBES Form equals "64.9A", value must be in 64.9A Form List (VVL) 8. When MBESCBES Form equals "64.9BASE", value must be in 64.9BASE Form List (VVL) 9. When MBESCBES Form equals "64.21UP", value must be in 64.21UP Form List (VVL) 10. If Policy Owner Code equals "01", then value must be populated 11. Conditional 12. When populated, an associated MBESCBES Form Group and MBESCBES Form must be populated

FTX136	FTX.004.136	MBESCBES-FORM	MBESCBES Form	Conditional	The MBES or CBES form to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.). This should be determined by the state's MBES/CBES reporting process. The MBES or CBES form reported here will determine what the meaning of the corresponding MBES/CBES category of service value is.	MBESCBES-FORMGP-1, MBESCBES-FORMGP-2, MBESCBES-FORMGP-3	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(50)	31	681	730	1. Value must be 50 characters or less 2. When MBESCBES Form Group equals "1", value must be in MBESCBES Form Group 1 List (VVL) 3. When MBESCBES Form Group equals "2", value must be in MBESCBES Form Group 2 List (VVL) 4. When MBESCBES Form Group equals "3", value must be in MBESCBES Form Group 3 List (VVL) 5. If Policy Owner Code equals "01", then value must be populated 6. Conditional
FTX137	FTX.004.137	MBESCBES-FORM-GROUP	MBESCBES Form Group	Conditional	Indicates group of MBES/CBES forms that this payment applies to (e.g., the CMS-64.9 Base form is for Title XIX-funded Medicaid, the CMS-64.21 form is for Title XXI-funded Medicaid-expansion CHIP (M-CHIP), and the CMS-21 Base form is for Title XXI-funded separate CHIP (S-CHIP)).	MBESCBES-FORM-GROUP	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(1)	30	680	680	1. Value must be 1 character 2. Value must be in MBESCBES Form Group List (VVL) 3. If Policy Owner Code equals "01", then value must be populated 4. Conditional
FTX138	FTX.004.138	WAIVER-ID	Waiver ID	Conditional	Field specifying the waiver or demonstration which authorized payment. These IDs must be the approved, full federal waiver ID number assigned during the state submission and CMS approval process. Waiver IDs should actually only be the "core" part of the waiver IDs, without including suffixes for renewals or amendments.	N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(20)	33	736	755	1. Value must be 20 characters or less 2. Value must be associated with a populated Waiver Type 3. (1115 demonstration) If value begins with "11-W-" or "21-W-", the associated Claim Waiver Type value must be 01 or in [21-30] 4. (1115 demonstration) If value begins with"11-W-" or "21-W-", then the value must include slash “/” in the 11th position followed by the last digit of the CMS Region [0-9] in the 12th position 5. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation followed by a period (.), the associated

													Waiver Type value must be in [02-20,32,33] 6. Conditional
FTX139	FTX.004.139	WAIVER-TYPE	Waiver Type	Conditional	A code for specifying waiver type under which the eligible individual is covered during the month and receiving services/under which transaction is submitted.	WAIVER-TYPE	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(2)	34	756	757	1. Value must be 2 characters 2. Value must be in Waiver Type List (VVL) 3. Value must have a corresponding value in Waiver ID 4. Value must match Eligible Waiver Type (ELG.012.173) for the enrollee for the same time period 5. Conditional
FTX140	FTX.004.140	FUNDING-CODE	Funding Code	Conditional	A code to indicate the source of non-federal share funds.	FUNDING-CODE	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(2)	35	758	759	1. Value must be 1 character 2. Value must be in Funding Code List (VVL) 3. If Policy Owner Code equals "01", then value must be populated 4. Conditional
FTX141	FTX.004.141	FUNDING-SOURCE-NONFEDERAL-SHARE	Funding Source Nonfederal Share	Mandatory	A code to indicate the type of non-federal share used by the state to finance its expenditure to the provider. In the event of two sources, states are to report the portion which represents the largest proportion not funded by the Federal government.	FUNDING-SOURCE-NONFEDERAL-SHARE	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(2)	36	760	761	1. Value must be 2 characters 2. Value must be in Funding Source Nonfederal Share List (VVL) 3. If Policy Owner Code equals "01", then value must be populated 4. Mandatory

FTX142	FTX.004.142	SOURCE-LOCATION	Source Location	Mandatory	The field denotes the claims/transaction processing system in which the claims/transactions were originally processed.	SOURCE-LOCATION	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(2)	37	762	763	1. Value must be 2 characters 2. Value must be in Source Location List (VVL) 3. Mandatory
FTX143	FTX.004.143	SPA-NUMBER	SPA Number	Conditional	State plan amendment (SPA) ID number using the following format: SS-YY-NNNN-xxxx where: SS = State (use the two character postal abbreviation for your state); YY = Calendar Year (last two characters of the calendar year of the state plan amendment); NNNN = SPA number (a four character number beginning with 0001) States should track their submissions to assign sequential numbers to their submissions. The system will not permit reuse of a previously used SPA ID for a package that has been formally = an Situational entry for specific SPA types	N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(15)	38	764	778	1. Value must be 15 characters or less 2. Conditional
FTX144	FTX.004.144	EXPENDITURE-AUTHORITY-TYPE	Expenditure Authority Type	Conditional	Expenditure Authority Type is the federal statute or regulation under which the expenditure is authorized/justified. The federal statute or regulation is usually referenced in either the Medicaid or CHIP State Plan or waiver documentation. For waivers, do not reference the federal statute or regulation being waived by the waiver. For waivers, referring to the waiver authority is sufficient. If the federal statute or regulation is not available in the list of valid values, choose the value for "Other" and report the authority in the Expenditure Authority Type Text.	EXPENDITURE-AUTHORITY-TYPE	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(2)	39	779	780	1. Value must be 2 characters 2. Value must be in Expenditure Authority Type List (VVL) 3. If Policy Owner Code equals "01", then value must be populated 4. Conditional

FTX145	FTX.004.145	EXPENDITURE-AUTHORITY-TYPE-OTHER-TEXT	Expenditure Authority Type Other Text	Conditional	This field is only to be used if Expenditure Authority Type "Other" valid value is selected. Enter a specific text description of the "Other" expenditure authority type.	N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(100)	40	781	880	1. Value must be 100 characters or less 2. If Expenditure Authority Type equals "95", then value must be populated 3. Conditional
FTX146	FTX.004.146	MEMO	Memo	Conditional	This represents any notes from the state's ledger/accounting system associated with the payment/recoupment.	N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(500)	41	881	1380	1. Value must be 500 characters or less 2. Conditional
FTX147	FTX.004.147	STATE-NOTATION	State Notation	Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	FTX00004	GROUP-INSURANCE-PREMIUM-PAYMENT	X(500)	42	1381	1880	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
FTX149	FTX.005.149	RECORD-ID	Record ID	Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	FTX00005	COST-SHARING-OFFSET	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "FTX00005"
FTX150	FTX.005.150	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	FTX00005	COST-SHARING-OFFSET	X(2)	2	9	10	1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory

FTX151	FTX.005.151	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	FTX00005	COST-SHARING-OFFSET	9(11)	3	11	21	1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
FTX152	FTX.005.152	ICN-ORIG	Original ICN	Mandatory	A unique item control number assigned by the states payment system that identifies an original or adjustment claim/transaction.	N/A	FTX00005	COST-SHARING-OFFSET	X(50)	4	22	71	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
FTX153	FTX.005.153	ICN-ADJ	Adjustment ICN	Conditional	A unique claim/transaction number assigned by the state's payment system that identifies the adjustment claim/transaction for an original item control number.	N/A	FTX00005	COST-SHARING-OFFSET	X(50)	5	72	121	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
FTX155	FTX.005.155	ADJUSTMENT-IND	Adjustment Indicator	Mandatory	Indicates the type of adjustment record.	ADJUSTMENT-IND	FTX00005	COST-SHARING-OFFSET	X(1)	6	122	122	1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Mandatory
FTX156	FTX.005.156	PAYMENT-OR-RECOUPMENT-DATE	Payment Or Recoupment Date	Mandatory	The date that the payment or recoupment was executed by the payer.	N/A	FTX00005	COST-SHARING-OFFSET	9(8)	7	123	130	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Mandatory 3. Value of the CC component must be equal to "20"
FTX157	FTX.005.157	PAYMENT-OR-RECOUPMENT-AMOUNT	Payment Or Recoupment Amount	Mandatory	The dollar amount being paid to the payee or recouped from the payee for a previous payment. A recoupment should be reported as a negative amount.	N/A	FTX00005	COST-SHARING-OFFSET	S9(11)V99	8	131	143	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Mandatory

FTX158	FTX.005.158	CHECK-EFF-DATE	Check Effective Date	Conditional	The date a check is issued to the payee. In the case of electronic funds transfer, it is the date the transfer is made.	N/A	FTX00005	COST-SHARING-OFFSET	9(8)	9	144	151	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Check Number 3. Conditional 4. Value of the CC component must be equal to "20"
FTX159	FTX.005.159	CHECK-NUM	Check Number	Conditional	The check or electronic funds transfer number.	N/A	FTX00005	COST-SHARING-OFFSET	X(15)	10	152	166	1. Value must be 15 characters or less 2. When populated. value must have an associated Check Effective Date 3. Value must not contain a pipe or asterisk symbols 4. Conditional
FTX160	FTX.005.160	PAYER-ID	Payer ID	Mandatory	This is the identifier that corresponds with the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking the action of either making a payment or taking a recoupment, as opposed to the payee who is the object of the transaction. The payer is the entity that is either making a payment or recouping a payment from another entity or individual. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. For beneficiary Cost Sharing Offset, the payer is always the state and the payee is always a beneficiary.	N/A	FTX00005	COST-SHARING-OFFSET	X(30)	11	167	196	1. Value must be 30 characters or less 2. Value must equal Submitting State (FTX.001.007) 3. Mandatory
FTX161	FTX.005.161	PAYER-ID-TYPE	Payer ID Type	Mandatory	This is a qualifier that indicates what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid or CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted as a submitting state code.	PAYER-ID-TYPE	FTX00005	COST-SHARING-OFFSET	X(2)	12	197	198	1. Value must be 2 characters 2. Value must be in Payer ID Type List (VVL) 3. Mandatory 4. When value equals "01" then Payer ID must equal Submitting State (FTX.001.007)

FTX162	FTX.005.162	PAYER-ID-TYPE-OTHER-TEXT	Payer ID Type Other Text	Conditional	This is a description of what the payer ID represents when the payer ID was reported with a payer type of "Other".	N/A	FTX00005	COST-SHARING-OFFSET	X(100)	13	199	298	1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional
FTX163	FTX.005.163	PAYEE-ID	Payee Identifier	Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment. For beneficiary Cost Sharing Offset, the beneficiary is always the payee.	N/A	FTX00005	COST-SHARING-OFFSET	X(30)	14	299	328	1. Value must be 30 characters or less 2. Value must equal MSIS Identification Number (ELG.002.019) 3. Mandatory
FTX164	FTX.005.164	PAYEE-ID-TYPE	Payee Identifier Type	Mandatory	This is a qualifier that indicates what type of ID the payee ID is. For example, if the payee ID represents a provider ID, then the payee ID type will indicate that the payee ID should be interpreted as a provider ID.	PAYEE-ID-TYPE	FTX00005	COST-SHARING-OFFSET	X(2)	15	329	330	1. Value must be 2 characters 2. Value must be in Payee Identifier Type List (VVL) 3. If value equals "01", then Payee Identifier must equal Submitting State (FTX.001.007) 4. If value equals "02", then Payee Identifier must equal State Plan Identification Number (MCR.002.019) 5. If value in [04,05], then Payee Identifier must equal Submitting State Provider Identifier (PRV.002.019) 6. If value equals "06", then Payee Identifier must equal Provider Identifier (PRV.005.081) where Provider Identifier Type (PRV.005.077) equals "2" 7. If value equals "07", then Payee Identifier must equal Insurance Carrier Identification Number (TPL.006.075) 8. If value equals "08", then Payee Identifier

													must equal MSIS Identification Number (ELG.002.019) 9. Mandatory
FTX165	FTX.005.165	PAYEE-ID-TYPE-OTHER-TEXT	Payee ID Type Other Text	Conditional	This is a description of what the PAYEE-ID-TYPE represents when the PAYEE-ID-TYPE was reported with a payee ID type of "Other".	N/A	FTX00005	COST-SHARING-OFFSET	X(100)	16	331	430	1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional
FTX166	FTX.005.166	PAYEE-MCR-PLAN-TYPE	Payee MCR Plan Type	Conditional	This describes the type of managed care plan or care coordination model of the payee, when applicable. The valid value code set is comprised of the standard managed care plan type list from the MCR and ELG files and a complementary list of care coordination models.	MANAGED-CARE-PLAN-TYPE	FTX00005	COST-SHARING-OFFSET	X(2)	17	431	432	1. Value must be 2 characters 2. Value must be in Managed Care Plan Type List (VVL) 3. If Payee ID Type is in [02,03], then value must be populated 4. If Payee ID Type is not [02,03], then value must not be populated 5. Conditional
FTX167	FTX.005.167	PAYEE-MCR-PLAN-TYPE-OTHER-TEXT	Payee MCR Plan Type Other Text	Conditional	This is a description of what type of managed care plan or care coordination model the payee ID was reported with a payee MCR plan or other care coordination model type of "Other".	N/A	FTX00005	COST-SHARING-OFFSET	X(100)	18	433	532	1. Value must be 100 characters or less 2. Value must be populated when Payee MCR Plan Type equals "95" 3. Conditional

FTX168	FTX.005.168	PAYEE-TAX-ID	Payee Tax ID	Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment.	N/A	FTX00005	COST-SHARING-OFFSET	X(30)	19	533	562	1. Value must be 30 characters or less 2. Mandatory 3. If Payee Tax ID Type equals "01", then value must be 9-digits and meet the requirements of a valid SSN per SSA requirements
FTX169	FTX.005.169	PAYEE-TAX-ID-TYPE	Payee Tax ID Type	Mandatory	This is a qualifier that indicates what type of tax ID the payee tax ID is. For example, if the payee tax ID represents a SSN, then the payee tax ID type will indicate that the payee tax ID should be interpreted as a SSN.	PAYEE-TAX-ID-TYPE	FTX00005	COST-SHARING-OFFSET	X(2)	20	563	564	1. Value must be 2 characters 2. Value must be in Payee Tax ID Type List (VVL) 3. Mandatory
FTX170	FTX.005.170	PAYEE-TAX-ID-TYPE-OTHER-TEXT	Payee Tax ID Type Other Text	Conditional	This is a description of what the PAYEE-TAX-ID-TYPE represents when the PAYEE-TAX-ID-TYPE was reported with a payee tax ID type of "Other".	N/A	FTX00005	COST-SHARING-OFFSET	X(100)	21	565	664	1. Value must be 100 characters or less 2. Value must be populated when Payee Tax Identifier Type equals "95" 3. Conditional
FTX171	FTX.005.171	CONTRACT-ID	Contract Identifier	Conditional	Managed care plan contract ID	N/A	FTX00005	COST-SHARING-OFFSET	X(100)	22	665	764	1. Value must be 100 characters or less 2. Conditional 3. If Offset Transaction Type equals "1", value must be populated
FTX172	FTX.005.172	INSURANCE-PLAN-ID	Insurance Plan Identifier	Conditional	The ID number issued by the Insurance carrier providing third party liability insurance coverage to beneficiaries. Typically the Plan ID/Plan Number is on the beneficiaries' insurance card.	N/A	FTX00005	COST-SHARING-OFFSET	X(20)	23	765	784	1. Value must not contain a pipe or asterisk symbol 2. Value must be 20 characters or less 3. Conditional

FTX173	FTX.005.173	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Mandatory	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique “key” value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/	N/A	FTX00005	COST-SHARING-OFFSET	X(20)	24	785	804	1. Value must be 20 characters or less 2. Mandatory 3. Value must match MSIS Identification Number (ELG.021.019) 4. When Adjustment Indicator does not equal "1", there must be a valid record of type Enrollment Time Span where the Coverage Period Start Date is equal to or greater than Enrollment Start Date and Coverage Period End Date is less than or equal to Enrollment End Date
FTX174	FTX.005.174	COVERAGE-PERIOD-START-DATE	Coverage Period Start Date	Mandatory	The date representing the beginning of the period covered by the capitation payment or premium payment that the beneficiary is offsetting; for example, the first day of the calendar month of beneficiary enrollment in the managed care plan to which the off-setting amount is applied. If returning money to the beneficiary, this is the date representing the beginning of the period for which the beneficiary had previously made an offsetting payment that is now being returned to them.	N/A	FTX00005	COST-SHARING-OFFSET	9(8)	25	805	812	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Cost Settlement Period End Date 3. Value of the CC component must be equal to "20" 4. Mandatory

FTX175	FTX.005.175	COVERAGE-PERIOD-END-DATE	Coverage Period End Date	Mandatory	The date representing the end of the period covered by the capitation payment or premium payment that the beneficiary is offsetting; for example, the last day of the calendar month of beneficiary enrollment in the managed care plan to which the off-setting amount is applied. If returning money to the beneficiary, this is the date representing the end of the period for which the beneficiary had previously made an offsetting payment that is now being returned to them.	N/A	FTX00005	COST-SHARING-OFFSET	9(8)	26	813	820	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be after or the same as the associated Cost Settlement Period Start Date 3. Value of the CC component must be equal to "20" 4. Mandatory
FTX176	FTX.005.176	CATEGORY-FOR-FEDERAL-REIMBURSEMENT	Category for Federal Reimbursement	Mandatory	A code to indicate the Federal funding source for the payment.	CATEGORY-FOR-FEDERAL-REIMBURSEMENT	FTX00005	COST-SHARING-OFFSET	X(2)	27	821	822	1. Value must be 2 characters 2. Value must be in Category for Federal Reimbursement List (VVL) 3. Mandatory

FTX177	FTX.005.177	MBESCBES-CATEGORY-OF-SERVICE	MBESCBES Category of Service	Mandatory	A code indicating the category of service for the paid claim. The category of service is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.) that states use to report their expenditures and request federal financial participation.	21.P-FORM, 21BASE-FORM, 64.21U-FORM, 64.10BASE-FORM, 64.9P-FORM, 64.9A-FORM, 64.9BASE-FORM, 64.21UP-FORM	FTX00005	COST-SHARING-OFFSET	X(5)	30	874	878	1. Value must be 5 characters or less 2. When MBESCBES Form equals "21.P", value must be in 21.P Form List (VVL) 3. When MBESCBES Form equals "21BASE", value must be in 21BASE Form List (VVL) 4. When MBESCBES Form equals "64.21U", value must be in 64.21U Form List (VVL) 5. When MBESCBES Form equals "64.10BASE", value must be in 64.10BASE Form List (VVL) 6. When MBESCBES Form equals "64.9P", value must be in 64.9P Form List (VVL) 7. When MBESCBES Form equals "64.9A", value must be in 64.9A Form List (VVL) 8. When MBESCBES Form equals "64.9BASE", value must be in 64.9BASE Form List (VVL) 9. When MBESCBES Form equals "64.21UP", value must be in 64.21UP Form List (VVL) 10. Mandatory
FTX178	FTX.005.178	MBESCBES-FORM	MBESCBES Form	Mandatory	The MBES or CBES form to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.). This should be determined by the state's MBES/CBES reporting process. The MBES or CBES form reported here will determine what the meaning of the corresponding MBES/CBES category of service value is.	MBESCBES-FORMGP-1, MBESCBES-FORMGP-2, MBESCBES-FORMGP-3	FTX00005	COST-SHARING-OFFSET	X(50)	29	824	873	1. Value must be 50 characters or less 2. When MBESCBES Form Group equals "1", value must be in MBESCBES Form Group 1 List (VVL) 3. When MBESCBES Form Group equals "2", value must be in MBESCBES Form Group 2 List (VVL) 4. When MBESCBES Form Group equals "3", value must be in MBESCBES Form Group 3 List (VVL) 5. Mandatory

FTX179	FTX.005.179	MBESCBES-FORM-GROUP	MBESCBES Form Group	Mandatory	Indicates group of MBES/CBES forms that this payment applies to (e.g., the CMS-64.9 Base form is for Title XIX-funded Medicaid, the CMS-64.21 form is for Title XXI-funded Medicaid-expansion CHIP (M-CHIP), and the CMS-21 Base form is for Title XXI-funded separate CHIP (S-CHIP)).	MBESCBES-FORM-GROUP	FTX00005	COST-SHARING-OFFSET	X(1)	28	823	823	1. Value must be 1 character 2. Value must be in MBESCBES Form Group List (VVL) 3. Mandatory
FTX180	FTX.005.180	WAIVER-ID	Waiver ID	Conditional	Field specifying the waiver or demonstration which authorized payment. These IDs must be the approved, full federal waiver ID number assigned during the state submission and CMS approval process. Waiver IDs should actually only be the "core" part of the waiver IDs, without including suffixes for renewals or amendments.	N/A	FTX00005	COST-SHARING-OFFSET	X(20)	31	879	898	1. Value must be 20 characters or less 2. Value must be associated with a populated Waiver Type 3. (1115 demonstration) If value begins with "11-W-" or "21-W-", the associated Claim Waiver Type value must be 01 or in [21-30] 4. (1115 demonstration) If value begins with"11-W-" or "21-W-", then the value must include slash “/” in the 11th position followed by the last digit of the CMS Region [0-9] in the 12th position 5. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation followed by a period (.), the associated Waiver Type value must be in [02-20,32,33] 6. Conditional
FTX181	FTX.005.181	WAIVER-TYPE	Waiver Type	Conditional	A code for specifying waiver type under which the eligible individual is covered during the month and receiving services/under which transaction is submitted.	WAIVER-TYPE	FTX00005	COST-SHARING-OFFSET	X(2)	32	899	900	1. Value must be 2 characters 2. Value must be in Waiver Type List (VVL) 3. Value must have a corresponding value in Waiver ID 4. Conditional
FTX182	FTX.005.182	FUNDING-CODE	Funding Code	Mandatory	A code to indicate the source of non-federal share funds.	FUNDING-CODE	FTX00005	COST-SHARING-OFFSET	X(2)	33	901	902	1. Value must be 1 character 2. Value must be in Funding Code List (VVL) 3. Mandatory

FTX183	FTX.005.183	FUNDING-SOURCE-NONFEDERAL-SHARE	Funding Source Nonfederal Share	Mandatory	A code to indicate the type of non-federal share used by the state to finance its expenditure to the provider. In the event of two sources, states are to report the portion which represents the largest proportion not funded by the Federal government.	FUNDING-SOURCE-NONFEDERAL-SHARE	FTX00005	COST-SHARING-OFFSET	X(2)	34	903	904	1. Value must be 2 characters 2. Value must be in Funding Source Nonfederal Share (VVL) 3. Mandatory
FTX184	FTX.005.184	OFFSET-TRANS-TYPE	Offset Trans Type	Conditional	This indicates the type of payment that the beneficiary cost-sharing is/was offsetting.	OFFSET-TRANS-TYPE	FTX00005	COST-SHARING-OFFSET	X(1)	35	905	905	1. Value must be 1 character 2. Value must be in Offset Transaction Type List (VVL) 3. Conditional
FTX185	FTX.005.185	SOURCE-LOCATION	Source Location	Mandatory	The field denotes the claims/transaction processing system in which the claims/transactions were originally processed.	SOURCE-LOCATION	FTX00005	COST-SHARING-OFFSET	X(2)	36	906	907	1. Value must be 2 characters 2. Value must be in Source Location List (VVL) 3. Mandatory
FTX186	FTX.005.186	SPA-NUMBER	SPA Number	Conditional	State plan amendment (SPA) ID number using the following format: SS-YY-NNNN-xxxx where: SS = State (use the two character postal abbreviation for your state); YY = Calendar Year (last two characters of the calendar year of the state plan amendment); NNNN = SPA number (a four character number beginning with 0001) States should track their submissions to assign sequential numbers to their submissions. The system will not permit reuse of a previously used SPA ID for a package that has been formally = an Situational entry for specific SPA types	N/A	FTX00005	COST-SHARING-OFFSET	X(15)	37	908	922	1. Value must be 15 characters or less 2. Conditional

FTX187	FTX.005.187	EXPENDITURE-AUTHORITY-TYPE	Expenditure Authority Type	Mandatory	Expenditure Authority Type is the federal statute or regulation under which the expenditure is authorized/justified. The federal statute or regulation is usually referenced in either the Medicaid or CHIP State Plan or waiver documentation. For waivers, do not reference the federal statute or regulation being waived by the waiver. For waivers, referring to the waiver authority is sufficient. If the federal statute or regulation is not available in the list of valid values, choose the value for "Other" and report the authority in the Expenditure Authority Type Text.	EXPENDITURE-AUTHORITY-TYPE	FTX00005	COST-SHARING-OFFSET	X(2)	38	923	924	1. Value must be 2 characters 2. Value must be in Expenditure Authority Type List (VVL) 3. Mandatory
FTX188	FTX.005.188	EXPENDITURE-AUTHORITY-TYPE-OTHER-TEXT	Expenditure Authority Type Other Text	Conditional	This field is only to be used if Expenditure Authority Type "Other" valid value is selected. Enter a specific text description of the "Other" expenditure authority type.	N/A	FTX00005	COST-SHARING-OFFSET	X(100)	39	925	1024	1. Value must be 100 characters or less 2. If Expenditure Authority Type equals "95", then value must be populated 3. Conditional
FTX189	FTX.005.189	MEMO	Memo	Conditional	This represents any notes from the state's ledger/accounting system associated with the payment/recoupment.	N/A	FTX00005	COST-SHARING-OFFSET	X(500)	40	1025	1524	1. Value must be 500 characters or less 2. Conditional
FTX190	FTX.005.190	STATE-NOTATION	State Notation	Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	FTX00005	COST-SHARING-OFFSET	X(500)	41	1525	2024	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
FTX192	FTX.006.192	RECORD-ID	Record ID	Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the	RECORD-ID	FTX00006	VALUE-BASED-PAYMENT	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "FTX00005"

					segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).							
FTX193	FTX.006.193	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	FTX00006	VALUE-BASED-PAYMENT	X(2)	2	9	10	1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory
FTX194	FTX.006.194	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	FTX00006	VALUE-BASED-PAYMENT	9(11)	3	11	21	1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
FTX195	FTX.006.195	ICN-ORIG	Original ICN	Mandatory	A unique item control number assigned by the states payment system that identifies an original or adjustment claim/transaction.	N/A	FTX00006	VALUE-BASED-PAYMENT	X(50)	4	22	71	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
FTX196	FTX.006.196	ICN-ADJ	Adjustment ICN	Conditional	A unique claim/transaction number assigned by the state's payment system that identifies the adjustment claim/transaction for an original item control number.	N/A	FTX00006	VALUE-BASED-PAYMENT	X(50)	5	72	121	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated

FTX198	FTX.006.198	ADJUSTMENT-IND	Adjustment Indicator	Mandatory	Indicates the type of adjustment record.	ADJUSTMENT-IND	FTX00006	VALUE-BASED-PAYMENT	X(1)	6	122	122	1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Mandatory
FTX199	FTX.006.199	PAYMENT-OR-RECOUPMENT-DATE	Payment Or Recoupment Date	Mandatory	The date that the payment or recoupment was executed by the payer.	N/A	FTX00006	VALUE-BASED-PAYMENT	9(8)	7	123	130	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Mandatory 3. Value of the CC component must be equal to "20"
FTX200	FTX.006.200	PAYMENT-OR-RECOUPMENT-AMOUNT	Payment Or Recoupment Amount	Mandatory	The dollar amount being paid to the payee or recouped from the payee for a previous payment. A recoupment should be reported as a negative amount.	N/A	FTX00006	VALUE-BASED-PAYMENT	S9(11)V99	8	131	143	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Mandatory
FTX201	FTX.006.201	CHECK-EFF-DATE	Check Effective Date	Conditional	The date a check is issued to the payee. In the case of electronic funds transfer, it is the date the transfer is made.	N/A	FTX00006	VALUE-BASED-PAYMENT	9(8)	9	144	151	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Check Number 3. Conditional 4. Value of the CC component must be equal to "20"
FTX202	FTX.006.202	CHECK-NUM	Check Number	Conditional	The check or electronic funds transfer number.	N/A	FTX00006	VALUE-BASED-PAYMENT	X(15)	10	152	166	1. Value must be 15 characters or less 2. When populated. value must have an associated Check Effective Date 3. Value must not contain a pipe or asterisk symbols 4. Conditional

FTX203	FTX.006.203	PAYER-ID	Payer ID	Mandatory	This is the identifier that corresponds with the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking the action of either making a payment or taking a recoupment, as opposed to the payee who is the object of the transaction. The payer is the entity that is either making a payment or recouping a payment from another entity or individual. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped.	N/A	FTX00006	VALUE-BASED-PAYMENT	X(30)	11	167	196	1. Value must be 30 characters or less 2. Mandatory
FTX204	FTX.006.204	PAYER-ID-TYPE	Payer ID Type	Mandatory	This is a qualifier that indicates what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid or CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted as a submitting state code.	PAYER-ID-TYPE	FTX00006	VALUE-BASED-PAYMENT	X(2)	12	197	198	1. Value must be 2 characters 2. Value must be in Payer ID Type List (VVL) 3. Mandatory 4. When value equals "01" then Payer ID must equal Submitting State (FTX.001.007) 5. When value equals "02" then Payer ID must equal State Plan Identification Number (MCR.002.019) 6. When value equals "04" then Payer ID must equal must equal Submitting State Provider Identifier (PRV.002.019)
FTX205	FTX.006.205	PAYER-ID-TYPE-OTHER-TEXT	Payer ID Type Other Text	Conditional	This is a description of what the payer ID represents when the payer ID was reported with a payer type of "Other".	N/A	FTX00006	VALUE-BASED-PAYMENT	X(100)	13	199	298	1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional

FTX206	FTX.006.206	PAYEE-ID	Payee Identifier	Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment.	N/A	FTX00006	VALUE-BASED-PAYMENT	X(30)	14	299	328	1. Value must be 30 characters or less 2. Mandatory
FTX207	FTX.006.207	PAYEE-ID-TYPE	Payee Identifier Type	Mandatory	This is a qualifier that indicates what type of ID the payee ID is. For example, if the payee ID represents a provider ID, then the payee ID type will indicate that the payee ID should be interpreted as a provider ID.	PAYEE-ID-TYPE	FTX00006	VALUE-BASED-PAYMENT	X(2)	15	329	330	1. Value must be 2 characters 2. Value must be in Payee Identifier Type List (VVL) 3. If value equals "01", then Payee Identifier must equal Submitting State (FTX.001.007) 4. If value equals "02", then Payee Identifier must equal State Plan Identification Number (MCR.002.019) 5. If value in [04,05], then Payee Identifier must equal Submitting State Provider Identifier (PRV.002.019) 6. If value equals "06", then Payee Identifier must equal Provider Identifier (PRV.005.081) where Provider Identifier Type (PRV.005.077) equals "2" 7. If value equals "07", then Payee Identifier must equal Insurance Carrier Identification Number (TPL.006.075) 8. If value equals "08", then Payee Identifier must equal MSIS Identification Number (ELG.002.019) 9. Mandatory
FTX208	FTX.006.208	PAYEE-ID-TYPE-OTHER-TEXT	Payee ID Type Other Text	Conditional	This is a description of what the PAYEE-ID-TYPE represents when the PAYEE-ID-TYPE was reported with a payee ID type of "Other".	N/A	FTX00006	VALUE-BASED-PAYMENT	X(100)	16	331	430	1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional

FTX209	FTX.006.209	PAYEE-MCR-PLAN-TYPE	Payee MCR Plan Type	Conditional	This describes the type of managed care plan or care coordination model of the payee, when applicable. The valid value code set is comprised of the standard managed care plan type list from the MCR and ELG files and a complementary list of care coordination models.	MANAGED-CARE-PLAN-TYPE	FTX00006	VALUE-BASED-PAYMENT	X(2)	17	431	432	1. Value must be 2 characters 2. Value must be in Managed Care Plan Type List (VVL) 3. If Payee ID Type is in [02,03], then value must be populated 4. If Payee ID Type is not [02,03], then value must not be populated 5. Conditional
FTX210	FTX.006.210	PAYEE-MCR-PLAN-TYPE-OTHER-TEXT	Payee MCR Plan Type Other Text	Conditional	This is a description of what type of managed care plan or care coordination model the payee ID was reported with a payee MCR plan or other care coordination model type of "Other".	N/A	FTX00006	VALUE-BASED-PAYMENT	X(100)	18	433	532	1. Value must be 100 characters or less 2. Value must be populated when Payee MCR Plan Type equals "95" 3. Conditional
FTX211	FTX.006.211	PAYEE-TAX-ID	Payee Tax ID	Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment.	N/A	FTX00006	VALUE-BASED-PAYMENT	X(30)	19	533	562	1. Value must be 30 characters or less 2. Mandatory 3. If Payee Tax ID Type equals "01", then value must be 9-digits and meet the requirements of a valid SSN per SSA requirements
FTX212	FTX.006.212	PAYEE-TAX-ID-TYPE	Payee Tax ID Type	Mandatory	This is a qualifier that indicates what type of tax ID the payee tax ID is. For example, if the payee tax ID represents a SSN, then the payee tax ID type will indicate that the payee tax ID should be interpreted as a SSN.	PAYEE-TAX-ID-TYPE	FTX00006	VALUE-BASED-PAYMENT	X(2)	20	563	564	1. Value must be 2 characters 2. Value must be in Payee Tax ID Type List (VVL) 3. Mandatory
FTX213	FTX.006.213	PAYEE-TAX-ID-TYPE-OTHER-TEXT	Payee Tax ID Type Other Text	Conditional	This is a description of what the PAYEE-TAX-ID-TYPE represents when the PAYEE-TAX-ID-TYPE was reported with a payee tax ID type of "Other".	N/A	FTX00006	VALUE-BASED-PAYMENT	X(100)	21	565	664	1. Value must be 100 characters or less 2. Value must be populated when Payee Tax Identifier Type equals "95" 3. Conditional

FTX214	FTX.006.214	CONTRACT-ID	Contract Identifier	Conditional	Managed care plan contract ID	N/A	FTX00006	VALUE-BASED-PAYMENT	X(100)	22	665	764	1. Value must be 100 characters or less 2. Conditional 3. If Payee ID Type is in [02,03], then value must be populated
FTX215	FTX.006.215	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Conditional	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique “key” value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/	N/A	FTX00006	VALUE-BASED-PAYMENT	X(20)	23	765	784	1. Value must be 20 characters or less 2. Conditional 3. When populated, value must match MSIS Identification Number (ELG.002.019) 4. When Adjustment Indicator does not equal "1", there must be a valid record of type Enrollment Time Span where the Performance Period Start Date is equal to or greater than Enrollment Start Date and Performance Period End Date is less than or equal to Enrollment End Date
FTX216	FTX.006.216	PERFORMANCE-PERIOD-START-DATE	Performance Period Start Date	Mandatory	The date representing the beginning of the performance period that the value-based dollar amount is rewarding or penalizing.	N/A	FTX00006	VALUE-BASED-PAYMENT	9(8)	24	785	792	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Performance Period End Date 3. Value of the CC component must be equal to "20" 4. Mandatory

FTX217	FTX.006.217	PERFORMANCE-PERIOD-END-DATE	Performance Period End Date	Mandatory	The date representing the end of the performance period that the value-based dollar amount is rewarding or penalizing.	N/A	FTX00006	VALUE-BASED-PAYMENT	9(8)	25	793	800	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be after or the same as the associated Performance Period Start Date 3. Value of the CC component must be equal to "20" 4. Mandatory
FTX218	FTX.006.218	CATEGORY-FOR-FEDERAL-REIMBURSEMENT	Category for Federal Reimbursement	Mandatory	A code to indicate the Federal funding source for the payment.	CATEGORY-FOR-FEDERAL-REIMBURSEMENT	FTX00006	VALUE-BASED-PAYMENT	X(2)	26	801	802	1. Value must be 2 characters 2. Value must be in Category for Federal Reimbursement List (VVL) 3. Mandatory
FTX219	FTX.006.219	MBESCBES-CATEGORY-OF-SERVICE	MBESCBES Category of Service	Mandatory	A code indicating the category of service for the paid claim. The category of service is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.) that states use to report their expenditures and request federal financial participation.	21.P-FORM, 21BASE-FORM, 64.21U-FORM, 64.10BASE-FORM, 64.9P-FORM, 64.9A-FORM, 64.9BASE-FORM, 64.21UP-FORM	FTX00006	VALUE-BASED-PAYMENT	X(5)	29	854	858	1. Value must be 5 characters or less 2. When MBESCBES Form equals "21.P", value must be in 21.P Form List (VVL) 3. When MBESCBES Form equals "21BASE", value must be in 21BASE Form List (VVL) 4. When MBESCBES Form equals "64.21U", value must be in 64.21U Form List (VVL) 5. When MBESCBES Form equals "64.10BASE", value must be in 64.10BASE Form List (VVL) 6. When MBESCBES Form equals "64.9P", value must be in 64.9P Form List (VVL) 7. When MBESCBES Form equals "64.9A", value must be in 64.9A Form List (VVL) 8. When MBESCBES Form equals "64.9BASE", value must be in 64.9BASE Form List (VVL) 9. When MBESCBES Form equals "64.21UP", value must be in 64.21UP Form List (VVL) 10. Mandatory

FTX220	FTX.006.220	MBESCBES-FORM	MBESCBES Form	Mandatory	The MBES or CBES form to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.). This should be determined by the state's MBES/CBES reporting process. The MBES or CBES form reported here will determine what the meaning of the corresponding MBES/CBES category of service value is.	MBESCBES-FORMGP-1, MBESCBES-FORMGP-2, MBESCBES-FORMGP-3	FTX00006	VALUE-BASED-PAYMENT	X(50)	28	804	853	1. Value must be 50 characters or less 2. When MBESCBES Form Group equals "1", value must be in MBESCBES Form Group 1 List (VVL) 3. When MBESCBES Form Group equals "2", value must be in MBESCBES Form Group 2 List (VVL) 4. When MBESCBES Form Group equals "3", value must be in MBESCBES Form Group 3 List (VVL) 5. Mandatory
FTX221	FTX.006.221	MBESCBES-FORM-GROUP	MBESCBES Form Group	Mandatory	Indicates group of MBES/CBES forms that this payment applies to (e.g., the CMS-64.9 Base form is for Title XIX-funded Medicaid, the CMS-64.21 form is for Title XXI-funded Medicaid-expansion CHIP (M-CHIP), and the CMS-21 Base form is for Title XXI-funded separate CHIP (S-CHIP)).	MBESCBES-FORM-GROUP	FTX00006	VALUE-BASED-PAYMENT	X(1)	27	803	803	1. Value must be 1 character 2. Value must be in MBESCBES Form Group List (VVL) 3. Mandatory
FTX222	FTX.006.222	WAIVER-ID	Waiver ID	Conditional	Field specifying the waiver or demonstration which authorized payment. These IDs must be the approved, full federal waiver ID number assigned during the state submission and CMS approval process. Waiver IDs should actually only be the "core" part of the waiver IDs, without including suffixes for renewals or amendments.	N/A	FTX00006	VALUE-BASED-PAYMENT	X(20)	30	859	878	1. Value must be 20 characters or less 2. Value must be associated with a populated Waiver Type 3. (1115 demonstration) If value begins with "11-W-" or "21-W-", the associated Claim Waiver Type value must be 01 or in [21-30] 4. (1115 demonstration) If value begins with"11-W-" or "21-W-", then the value must include slash “/” in the 11th position followed by the last digit of the CMS Region [0-9] in the 12th position 5. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation followed by a period (.), the associated Waiver Type value must be in [02-20,32,33] 6. Conditional

FTX223	FTX.006.223	WAIVER-TYPE	Waiver Type	Conditional	A code for specifying waiver type under which the eligible individual is covered during the month and receiving services/under which transaction is submitted.	WAIVER-TYPE	FTX00006	VALUE-BASED-PAYMENT	X(2)	31	879	880	1. Value must be 2 characters 2. Value must be in Waiver Type List (VVL) 3. Value must have a corresponding value in Waiver ID 4. Conditional
FTX224	FTX.006.224	FUNDING-CODE	Funding Code	Mandatory	A code to indicate the source of non-federal share funds.	FUNDING-CODE	FTX00006	VALUE-BASED-PAYMENT	X(2)	32	881	882	1. Value must be 1 character 2. Value must be in Funding Code List (VVL) 3. Mandatory
FTX225	FTX.006.225	FUNDING-SOURCE-NONFEDERAL-SHARE	Funding Source Nonfederal Share	Mandatory	A code to indicate the type of non-federal share used by the state to finance its expenditure to the provider. In the event of two sources, states are to report the portion which represents the largest proportion not funded by the Federal government.	FUNDING-SOURCE-NONFEDERAL-SHARE	FTX00006	VALUE-BASED-PAYMENT	X(2)	33	883	884	1. Value must be 2 characters 2. Value must be in Funding Source Nonfederal Share (VVL) 3. Mandatory
FTX226	FTX.006.226	SDP-IND	State Directed Payment Indicator	Mandatory	Indicates whether the financial transaction from an MC plan to a provider or other entity is a type of State Directed Payment.	SDP-IND	FTX00006	VALUE-BASED-PAYMENT	X(1)	34	885	885	1. Value must be 1 character 2. Value must be in State Directed Payment Indicator List (VVL) 3. Mandatory
FTX227	FTX.006.227	SOURCE-LOCATION	Source Location	Mandatory	The field denotes the claims/transaction processing system in which the claims/transactions were originally processed.	SOURCE-LOCATION	FTX00006	VALUE-BASED-PAYMENT	X(2)	35	886	887	1. Value must be 2 characters 2. Value must be in Source Location List (VVL) 3. Mandatory

FTX228	FTX.006.228	SPA-NUMBER	SPA Number	Conditional	State plan amendment (SPA) ID number using the following format: SS-YY-NNNN-xxxx where: SS = State (use the two character postal abbreviation for your state); YY = Calendar Year (last two characters of the calendar year of the state plan amendment); NNNN = SPA number (a four character number beginning with 0001) States should track their submissions to assign sequential numbers to their submissions. The system will not permit reuse of a previously used SPA ID for a package that has been formally = an Situational entry for specific SPA types	N/A	FTX00006	VALUE-BASED-PAYMENT	X(15)	36	888	902	1. Value must be 15 characters or less 2. Conditional
FTX229	FTX.006.229	VALUE-BASED-PAYMENT-MODEL-TYPE	Value Based Payment Model Type	Conditional	This is the type of value-based payment model to which the financial transaction applies. These values come from the “Alternative Payment Model (APM) Framework Final White Paper”, produced by the Healthcare Learning and Action Network. https://hcp-lan.org/work products/apm-whitepaper.pdf	VALUE-BASED-PAYMENT-MODEL-TYPE	FTX00006	VALUE-BASED-PAYMENT	X(2)	37	903	904	1. Value must be 2 characters 2. Value must be in Value Based Payment Model Type List (VVL) 3. Conditional
FTX230	FTX.006.230	PAYMENT-CAT-XREF	Payment Cat Xref	Conditional	Cross-reference to the applicable payment category in the managed care plan's contract with the state Medicaid/CHIP agency or their fiscal intermediary.	N/A	FTX00006	VALUE-BASED-PAYMENT	X(50)	38	905	954	1. Value must be 50 characters or less 2. Conditional

FTX231	FTX.006.231	EXPENDITURE-AUTHORITY-TYPE	Expenditure Authority Type	Mandatory	Expenditure Authority Type is the federal statute or regulation under which the expenditure is authorized/justified. The federal statute or regulation is usually referenced in either the Medicaid or CHIP State Plan or waiver documentation. For waivers, do not reference the federal statute or regulation being waived by the waiver. For waivers, referring to the waiver authority is sufficient. If the federal statute or regulation is not available in the list of valid values, choose the value for "Other" and report the authority in the Expenditure Authority Type Text.	EXPENDITURE-AUTHORITY-TYPE	FTX00006	VALUE-BASED-PAYMENT	X(2)	39	955	956	1. Value must be 2 characters 2. Value must be in Expenditure Authority Type List (VVL) 3. Mandatory
FTX232	FTX.006.232	EXPENDITURE-AUTHORITY-TYPE-OTHER-TEXT	Expenditure Authority Type Other Text	Conditional	This field is only to be used if Expenditure Authority Type "Other" valid value is selected. Enter a specific text description of the "Other" expenditure authority type.	N/A	FTX00006	VALUE-BASED-PAYMENT	X(100)	40	957	1056	1. Value must be 100 characters or less 2. If Expenditure Authority Type equals "95", then value must be populated 3. Conditional
FTX233	FTX.006.233	MEMO	Memo	Conditional	This represents any notes from the state's ledger/accounting system associated with the payment/recoupment.	N/A	FTX00006	VALUE-BASED-PAYMENT	X(500)	41	1057	1556	1. Value must be 500 characters or less 2. Conditional
FTX234	FTX.006.234	STATE-NOTATION	State Notation	Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	FTX00006	VALUE-BASED-PAYMENT	X(500)	42	1557	2056	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
FTX236	FTX.007.236	RECORD-ID	Record ID	Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the	RECORD-ID	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "FTX00007"

					segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).								
FTX237	FTX.007.237	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(2)	2	9	10	1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory
FTX238	FTX.007.238	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	9(11)	3	11	21	1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
FTX239	FTX.007.239	ICN-ORIG	Original ICN	Mandatory	A unique item control number assigned by the states payment system that identifies an original or adjustment claim/transaction.	N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(50)	4	22	71	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory

FTX240	FTX.007.240	ICN-ADJ	Adjustment ICN	Conditional	A unique claim/transaction number assigned by the state's payment system that identifies the adjustment claim/transaction for an original item control number.	N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(50)	5	72	121	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
FTX242	FTX.007.242	ADJUSTMENT-IND	Adjustment Indicator	Mandatory	Indicates the type of adjustment record.	ADJUSTMENT-IND	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(1)	6	122	122	1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Mandatory
FTX243	FTX.007.243	PAYMENT-OR-RECOUPMENT-DATE	Payment Or Recoupment Date	Mandatory	The date that the payment or recoupment was executed by the payer.	N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	9(8)	7	123	130	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Mandatory 3. Value of the CC component must be equal to "20"
FTX244	FTX.007.244	PAYMENT-OR-RECOUPMENT-AMOUNT	Payment Or Recoupment Amount	Mandatory	The dollar amount being paid to the payee or recouped from the payee for a previous payment. A recoupment should be reported as a negative amount.	N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	S9(11)V99	8	131	143	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Mandatory
FTX245	FTX.007.245	CHECK-EFF-DATE	Check Effective Date	Conditional	The date a check is issued to the payee. In the case of electronic funds transfer, it is the date the transfer is made.	N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	9(8)	9	144	151	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Check Number 3. Conditional 4. Value of the CC component must be equal to "20"

FTX246	FTX.007.246	CHECK-NUM	Check Number	Conditional	The check or electronic funds transfer number.	N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(15)	10	152	166	1. Value must be 15 characters or less 2. When populated. value must have an associated Check Effective Date 3. Value must not contain a pipe or asterisk symbols 4. Conditional
FTX247	FTX.007.247	PAYER-ID	Payer ID	Mandatory	This is the identifier that corresponds with the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking the action of either making a payment or taking a recoupment, as opposed to the payee who is the object of the transaction. The payer is the entity that is either making a payment or recouping a payment from another entity or individual. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped.	N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(30)	11	167	196	1. Value must be 30 characters or less 2. Mandatory
FTX248	FTX.007.248	PAYER-ID-TYPE	Payer ID Type	Mandatory	This is a qualifier that indicates what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid or CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted as a submitting state code.	PAYER-ID-TYPE	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(2)	12	197	198	1. Value must be 2 characters 2. Value must be in Payer ID Type List (VVL) 3. Mandatory 4. When value equals "01" then Payer ID must equal Submitting State (FTX.001.007) 5. When value equals "02" then Payer ID must equal State Plan Identification Number (MCR.002.019) 6. When value equals "04" then Payer ID must equal must equal Submitting State Provider Identifier (PRV.002.019)

FTX249	FTX.007.249	PAYER-ID-TYPE-OTHER-TEXT	Payer ID Type Other Text	Conditional	This is a description of what the payer ID represents when the payer ID was reported with a payer type of "Other".	N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(100)	13	199	298	1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional
FTX250	FTX.007.250	PAYEE-ID	Payee Identifier	Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment.	N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(30)	14	299	328	1. Value must be 30 characters or less 2. Mandatory
FTX251	FTX.007.251	PAYEE-ID-TYPE	Payee Identifier Type	Mandatory	This is a qualifier that indicates what type of ID the payee ID is. For example, if the payee ID represents a provider ID, then the payee ID type will indicate that the payee ID should be interpreted as a provider ID.	PAYEE-ID-TYPE	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(2)	15	329	330	1. Value must be 2 characters 2. Value must be in Payee Identifier Type List (VVL) 3. If value equals "01", then Payee Identifier must equal Submitting State (FTX.001.007) 4. If value equals "02", then Payee Identifier must equal State Plan Identification Number (MCR.002.019) 5. If value in [04,05], then Payee Identifier must equal Submitting State Provider Identifier (PRV.002.019) 6. If value equals "06", then Payee Identifier must equal Provider Identifier (PRV.005.081) where Provider Identifier Type (PRV.005.077) equals "2" 7. If value equals "07", then Payee Identifier must equal Insurance Carrier Identification Number (TPL.006.075) 8. If value equals "08", then Payee Identifier must equal MSIS Identification Number

													(ELG.002.019) 9. Mandatory
FTX252	FTX.007.252	PAYEE-ID-TYPE-OTHER-TEXT	Payee ID Type Other Text	Conditional	This is a description of what the PAYEE-ID-TYPE represents when the PAYEE-ID-TYPE was reported with a payee ID type of "Other".	N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(100)	16	331	430	1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional
FTX253	FTX.007.253	PAYEE-MCR-PLAN-TYPE	Payee MCR Plan Type	Conditional	This describes the type of managed care plan or care coordination model of the payee, when applicable. The valid value code set is comprised of the standard managed care plan type list from the MCR and ELG files and a complementary list of care coordination models.	MANAGED-CARE-PLAN-TYPE	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(2)	17	431	432	1. Value must be 2 characters 2. Value must be in Managed Care Plan Type List (VVL) 3. If Payee ID Type is in [02,03], then value must be populated 4. If Payee ID Type is not [02,03], then value must not be populated 5. Conditional

FTX254	FTX.007.254	PAYEE-MCR-PLAN-TYPE-OTHER-TEXT	Payee MCR Plan Type Other Text	Conditional	This is a description of what type of managed care plan or care coordination model the payee ID was reported with a payee MCR plan or other care coordination model type of "Other".	N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(100)	18	433	532	1. Value must be 100 characters or less 2. Value must be populated when Payee MCR Plan Type equals "95" 3. Conditional
FTX255	FTX.007.255	PAYEE-TAX-ID	Payee Tax ID	Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment.	N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(30)	19	533	562	1. Value must be 30 characters or less 2. Mandatory 3. If Payee Tax ID Type equals "01", then value must be 9-digits and meet the requirements of a valid SSN per SSA requirements
FTX256	FTX.007.256	PAYEE-TAX-ID-TYPE	Payee Tax ID Type	Mandatory	This is a qualifier that indicates what type of tax ID the payee tax ID is. For example, if the payee tax ID represents a SSN, then the payee tax ID type will indicate that the payee tax ID should be interpreted as a SSN.	PAYEE-TAX-ID-TYPE	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(2)	20	563	564	1. Value must be 2 characters 2. Value must be in Payee Tax ID Type List (VVL) 3. Mandatory
FTX257	FTX.007.257	PAYEE-TAX-ID-TYPE-OTHER-TEXT	Payee Tax ID Type Other Text	Conditional	This is a description of what the PAYEE-TAX-ID-TYPE represents when the PAYEE-TAX-ID-TYPE was reported with a payee tax ID type of "Other".	N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(100)	21	565	664	1. Value must be 100 characters or less 2. Value must be populated when Payee Tax Identifier Type equals "95" 3. Conditional
FTX258	FTX.007.258	CONTRACT-ID	Contract Identifier	Mandatory	Managed care plan contract ID	N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(100)	22	665	764	1. Value must be 100 characters or less 2. Mandatory

FTX259	FTX.007.259	PAYMENT-PERIOD-START-DATE	Payment Period Start Date	Mandatory	The date representing the start of the time period that the payment is expected to be used by the provider.	N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	9(8)	23	765	772	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Payment Period End Date 3. Mandatory 4. Value of the CC component must be equal to "20"
FTX260	FTX.007.260	PAYMENT-PERIOD-END-DATE	Payment Period End Date	Mandatory	The date representing the end of the time period that the payment is expected to be used by the provider.	N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	9(8)	24	773	780	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be after or the same as the associated Payment Period Start Date 3. Value of the CC component must be equal to "20" 4. Mandatory
FTX261	FTX.007.261	PAYMENT-PERIOD-TYPE	Payment Period Type	Mandatory	A qualifier that identifies what the payment period begin and end dates represent. For example, the payment period begin an end dates may correspond to a range of service dates from claims or encounters or they may represent a period of beneficiary eligibility or enrollment.	PAYMENT-PERIOD-TYPE	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(2)	25	781	782	1. Value must be 2 characters 2. Value must be in Payment Period Type List (VVL) 3. Mandatory
FTX262	FTX.007.262	PAYMENT-PERIOD-TYPE-OTHER-TEXT	Payment Period Type Other Text	Conditional	This is a description of the type of financial transaction when the PAYMENT-PERIOD-TYPE is "Other".	N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(100)	26	783	882	1. Value must be 100 characters or less 2. Value must be populated when Payment Period Type equals "95" 3. Conditional
FTX263	FTX.007.263	CATEGORY-FOR-FEDERAL-REIMBURSEMENT	Category for Federal Reimbursement	Mandatory	A code to indicate the Federal funding source for the payment.	CATEGORY-FOR-FEDERAL-REIMBURSEMENT	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(2)	27	883	884	1. Value must be 2 characters 2. Value must be in Category for Federal Reimbursement List (VVL) 3. Mandatory

FTX264	FTX.007.264	MBESCBES-CATEGORY-OF-SERVICE	MBESCBES Category of Service	Mandatory	A code indicating the category of service for the paid claim. The category of service is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.) that states use to report their expenditures and request federal financial participation.	21.P-FORM, 21BASE-FORM, 64.21U-FORM, 64.10BASE-FORM, 64.9P-FORM, 64.9A-FORM, 64.9BASE-FORM, 64.21UP-FORM	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(5)	30	936	940	1. Value must be 5 characters or less 2. When MBESCBES Form equals "21.P", value must be in 21.P Form List (VVL) 3. When MBESCBES Form equals "21BASE", value must be in 21BASE Form List (VVL) 4. When MBESCBES Form equals "64.21U", value must be in 64.21U Form List (VVL) 5. When MBESCBES Form equals "64.10BASE", value must be in 64.10BASE Form List (VVL) 6. When MBESCBES Form equals "64.9P", value must be in 64.9P Form List (VVL) 7. When MBESCBES Form equals "64.9A", value must be in 64.9A Form List (VVL) 8. When MBESCBES Form equals "64.9BASE", value must be in 64.9BASE Form List (VVL) 9. When MBESCBES Form equals "64.21UP", value must be in 64.21UP Form List (VVL) 10. Mandatory
FTX265	FTX.007.265	MBESCBES-FORM	MBESCBES Form	Mandatory	The MBES or CBES form to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.). This should be determined by the state's MBES/CBES reporting process. The MBES or CBES form reported here will determine what the meaning of the corresponding MBES/CBES category of service value is.	MBESCBES-FORMGP-1, MBESCBES-FORMGP-2, MBESCBES-FORMGP-3	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(50)	29	886	935	1. Value must be 50 characters or less 2. When MBESCBES Form Group equals "1", value must be in MBESCBES Form Group 1 List (VVL) 3. When MBESCBES Form Group equals "2", value must be in MBESCBES Form Group 2 List (VVL) 4. When MBESCBES Form Group equals "3", value must be in MBESCBES Form Group 3 List (VVL) 5. Mandatory

FTX266	FTX.007.266	MBESCBES-FORM-GROUP	MBESCBES Form Group	Mandatory	Indicates group of MBES/CBES forms that this payment applies to (e.g., the CMS-64.9 Base form is for Title XIX-funded Medicaid, the CMS-64.21 form is for Title XXI-funded Medicaid-expansion CHIP (M-CHIP), and the CMS-21 Base form is for Title XXI-funded separate CHIP (S-CHIP)).	MBESCBES-FORM-GROUP	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(1)	28	885	885	1. Value must be 1 character 2. Value must be in MBESCBES Form Group List (VVL) 3. Mandatory
FTX267	FTX.007.267	WAIVER-ID	Waiver ID	Conditional	Field specifying the waiver or demonstration which authorized payment. These IDs must be the approved, full federal waiver ID number assigned during the state submission and CMS approval process. Waiver IDs should actually only be the "core" part of the waiver IDs, without including suffixes for renewals or amendments.	N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(20)	31	941	960	1. Value must be 20 characters or less 2. Value must be associated with a populated Waiver Type 3. (1115 demonstration) If value begins with "11-W-" or "21-W-", the associated Claim Waiver Type value must be 01 or in [21-30] 4. (1115 demonstration) If value begins with"11-W-" or "21-W-", then the value must include slash “/” in the 11th position followed by the last digit of the CMS Region [0-9] in the 12th position 5. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation followed by a period (.), the associated Waiver Type value must be in [02-20,32,33] 6. Conditional
FTX268	FTX.007.268	WAIVER-TYPE	Waiver Type	Conditional	A code for specifying waiver type under which the eligible individual is covered during the month and receiving services/under which transaction is submitted.	WAIVER-TYPE	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(2)	32	961	962	1. Value must be 2 characters 2. Value must be in Waiver Type List (VVL) 3. Value must have a corresponding value in Waiver ID 4. Conditional
FTX269	FTX.007.269	FUNDING-CODE	Funding Code	Mandatory	A code to indicate the source of non-federal share funds.	FUNDING-CODE	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-	X(2)	33	963	964	1. Value must be 1 character 2. Value must be in Funding Code List (VVL) 3. Mandatory

								PAYMENT-TERM					
FTX270	FTX.007.270	FUNDING-SOURCE-NONFEDERAL-SHARE	Funding Source Nonfederal Share	Mandatory	A code to indicate the type of non-federal share used by the state to finance its expenditure to the provider. In the event of two sources, states are to report the portion which represents the largest proportion not funded by the Federal government.	FUNDING-SOURCE-NONFEDERAL-SHARE	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(2)	34	965	966	1. Value must be 2 characters 2. Value must be in Funding Source Nonfederal Share (VVL) 3. Mandatory
FTX271	FTX.007.271	SOURCE-LOCATION	Source Location	Mandatory	The field denotes the claims/transaction processing system in which the claims/transactions were originally processed.	SOURCE-LOCATION	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(2)	35	967	968	1. Value must be 2 characters 2. Value must be in Source Location List (VVL) 3. Mandatory
FTX272	FTX.007.272	SPA-NUMBER	SPA Number	Conditional	State plan amendment (SPA) ID number using the following format: SS-YY-NNNN-xxxx where: SS = State (use the two character postal abbreviation for your state); YY = Calendar Year (last two characters of the calendar year of the state plan amendment); NNNN = SPA number (a four character number beginning with 0001) States should track their submissions to assign sequential numbers to their submissions. The system will not permit reuse of a previously used SPA ID for a package that has been formally = an Situational entry for specific SPA types	N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(15)	36	969	983	1. Value must be 15 characters or less 2. Conditional

FTX273	FTX.007.273	PAYMENT-CAT-XREF	Payment Cat Xref	Conditional	Cross-reference to the applicable payment category in the managed care plan's contract with the state Medicaid/CHIP agency or their fiscal intermediary.	N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(50)	37	984	1033	1. Value must be 50 characters or less 2. Conditional
FTX274	FTX.007.274	EXPENDITURE-AUTHORITY-TYPE	Expenditure Authority Type	Mandatory	Expenditure Authority Type is the federal statute or regulation under which the expenditure is authorized/justified. The federal statute or regulation is usually referenced in either the Medicaid or CHIP State Plan or waiver documentation. For waivers, do not reference the federal statute or regulation being waived by the waiver. For waivers, referring to the waiver authority is sufficient. If the federal statute or regulation is not available in the list of valid values, choose the value for "Other" and report the authority in the Expenditure Authority Type Text.	EXPENDITURE-AUTHORITY-TYPE	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(2)	38	1034	1035	1. Value must be 2 characters 2. Value must be in Expenditure Authority Type List (VVL) 3. Mandatory
FTX275	FTX.007.275	EXPENDITURE-AUTHORITY-TYPE-OTHER-TEXT	Expenditure Authority Type Other Text	Conditional	This field is only to be used if Expenditure Authority Type "Other" valid value is selected. Enter a specific text description of the "Other" expenditure authority type.	N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(100)	39	1036	1135	1. Value must be 100 characters or less 2. If Expenditure Authority Type equals "95", then value must be populated 3. Conditional
FTX276	FTX.007.276	MEMO	Memo	Conditional	This represents any notes from the state's ledger/accounting system associated with the payment/recoupment.	N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(500)	40	1136	1635	1. Value must be 500 characters or less 2. Conditional

FTX277	FTX.007.277	STATE-NOTATION	State Notation	Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	FTX00007	STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM	X(500)	41	1636	2135	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
FTX279	FTX.008.279	RECORD-ID	Record ID	Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).	RECORD-ID	FTX00008	COST-SETTLEMENT-PAYMENT	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "FTX00008"
FTX280	FTX.008.280	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	FTX00008	COST-SETTLEMENT-PAYMENT	X(2)	2	9	10	1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory
FTX281	FTX.008.281	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	FTX00008	COST-SETTLEMENT-PAYMENT	9(11)	3	11	21	1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
FTX282	FTX.008.282	ICN-ORIG	Original ICN	Mandatory	A unique item control number assigned by the states payment system that identifies an original or adjustment claim/transaction.	N/A	FTX00008	COST-SETTLEMENT-PAYMENT	X(50)	4	22	71	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory

FTX283	FTX.008.283	ICN-ADJ	Adjustment ICN	Conditional	A unique claim/transaction number assigned by the state's payment system that identifies the adjustment claim/transaction for an original item control number.	N/A	FTX00008	COST-SETTLEMENT-PAYMENT	X(50)	5	72	121	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated
FTX285	FTX.008.285	ADJUSTMENT-IND	Adjustment Indicator	Mandatory	Indicates the type of adjustment record.	ADJUSTMENT-IND	FTX00008	COST-SETTLEMENT-PAYMENT	X(1)	6	122	122	1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Mandatory
FTX286	FTX.008.286	PAYMENT-OR-RECOUPMENT-DATE	Payment Or Recoupment Date	Mandatory	The date that the payment or recoupment was executed by the payer.	N/A	FTX00008	COST-SETTLEMENT-PAYMENT	9(8)	7	123	130	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Mandatory 3. Value of the CC component must be equal to "20"
FTX287	FTX.008.287	PAYMENT-OR-RECOUPMENT-AMOUNT	Payment Or Recoupment Amount	Mandatory	The dollar amount being paid to the payee or recouped from the payee for a previous payment. A recoupment should be reported as a negative amount.	N/A	FTX00008	COST-SETTLEMENT-PAYMENT	S9(11)V99	8	131	143	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Mandatory
FTX288	FTX.008.288	CHECK-EFF-DATE	Check Effective Date	Conditional	The date a check is issued to the payee. In the case of electronic funds transfer, it is the date the transfer is made.	N/A	FTX00008	COST-SETTLEMENT-PAYMENT	9(8)	9	144	151	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Check Number 3. Conditional 4. Value of the CC component must be equal to "20"

FTX289	FTX.008.289	CHECK-NUM	Check Number	Conditional	The check or electronic funds transfer number.	N/A	FTX00008	COST-SETTLEMENT-PAYMENT	X(15)	10	152	166	1. Value must be 15 characters or less 2. When populated. value must have an associated Check Effective Date 3. Value must not contain a pipe or asterisk symbols 4. Conditional
FTX290	FTX.008.290	PAYER-ID	Payer ID	Mandatory	This is the identifier that corresponds with the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking the action of either making a payment or taking a recoupment, as opposed to the payee who is the object of the transaction. The payer is the entity that is either making a payment or recouping a payment from another entity or individual. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped.	N/A	FTX00008	COST-SETTLEMENT-PAYMENT	X(30)	11	167	196	1. Value must be 30 characters or less 2. Mandatory
FTX291	FTX.008.291	PAYER-ID-TYPE	Payer ID Type	Mandatory	This is a qualifier that indicates what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid or CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted as a submitting state code.	PAYER-ID-TYPE	FTX00008	COST-SETTLEMENT-PAYMENT	X(2)	12	197	198	1. Value must be 2 characters 2. Value must be in Payer ID Type List (VVL) 3. Mandatory 4. When value equals "01" then Payer ID must equal Submitting State (FTX.001.007) 5. When value equals "02" then Payer ID must equal State Plan Identification Number (MCR.002.019) 6. When value equals "04" then Payer ID must equal must equal Submitting State Provider Identifier (PRV.002.019)

FTX292	FTX.008.292	PAYER-ID-TYPE-OTHER-TEXT	Payer ID Type Other Text	Conditional	This is a description of what the payer ID represents when the payer ID was reported with a payer type of "Other".	N/A	FTX00008	COST-SETTLEMENT-PAYMENT	X(100)	13	199	298	1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional
FTX293	FTX.008.293	PAYEE-ID	Payee Identifier	Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment.	N/A	FTX00008	COST-SETTLEMENT-PAYMENT	X(30)	14	299	328	1. Value must be 30 characters or less 2. Mandatory
FTX294	FTX.008.294	PAYEE-ID-TYPE	Payee Identifier Type	Mandatory	This is a qualifier that indicates what type of ID the payee ID is. For example, if the payee ID represents a provider ID, then the payee ID type will indicate that the payee ID should be interpreted as a provider ID.	PAYEE-ID-TYPE	FTX00008	COST-SETTLEMENT-PAYMENT	X(2)	15	329	330	1. Value must be 2 characters 2. Value must be in Payee Identifier Type List (VVL) 3. If value equals "01", then Payee Identifier must equal Submitting State (FTX.001.007) 4. If value equals "02", then Payee Identifier must equal State Plan Identification Number (MCR.002.019) 5. If value in [04,05], then Payee Identifier must equal Submitting State Provider Identifier (PRV.002.019) 6. If value equals "06", then Payee Identifier must equal Provider Identifier (PRV.005.081) where Provider Identifier Type (PRV.005.077) equals "2" 7. If value equals "07", then Payee Identifier must equal Insurance Carrier Identification Number (TPL.006.075) 8. If value equals "08", then Payee Identifier must equal MSIS Identification Number (ELG.002.019) 9. Mandatory

FTX295	FTX.008.295	PAYEE-ID-TYPE-OTHER-TEXT	Payee ID Type Other Text	Conditional	This is a description of what the PAYEE-ID-TYPE represents when the PAYEE-ID-TYPE was reported with a payee ID type of "Other".	N/A	FTX00008	COST-SETTLEMENT-PAYMENT	X(100)	16	331	430	1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional
FTX296	FTX.008.296	PAYEE-MCR-PLAN-TYPE	Payee MCR Plan Type	Conditional	This describes the type of managed care plan or care coordination model of the payee, when applicable. The valid value code set is comprised of the standard managed care plan type list from the MCR and ELG files and a complementary list of care coordination models.	MANAGED-CARE-PLAN-TYPE	FTX00008	COST-SETTLEMENT-PAYMENT	X(2)	17	431	432	1. Value must be 2 characters 2. Value must be in Managed Care Plan Type List (VVL) 3. If Payee ID Type is in [02,03], then value must be populated 4. If Payee ID Type is not [02,03], then value must not be populated 5. Conditional
FTX297	FTX.008.297	PAYEE-MCR-PLAN-TYPE-OTHER-TEXT	Payee MCR Plan Type Other Text	Conditional	This is a description of what type of managed care plan or care coordination model the payee ID was reported with a payee MCR plan or other care coordination model type of "Other".	N/A	FTX00008	COST-SETTLEMENT-PAYMENT	X(100)	18	433	532	1. Value must be 100 characters or less 2. Value must be populated when Payee MCR Plan Type equals "95" 3. Conditional
FTX298	FTX.008.298	PAYEE-TAX-ID	Payee Tax ID	Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment.	N/A	FTX00008	COST-SETTLEMENT-PAYMENT	X(30)	19	533	562	1. Value must be 30 characters or less 2. Mandatory 3. If Payee Tax ID Type equals "01", then value must be 9-digits and meet the requirements of a valid SSN per SSA requirements
FTX299	FTX.008.299	PAYEE-TAX-ID-TYPE	Payee Tax ID Type	Mandatory	This is a qualifier that indicates what type of tax ID the payee tax ID is. For example, if the payee tax ID represents a SSN, then the payee tax ID type will indicate that the payee tax ID should be interpreted as a SSN.	PAYEE-TAX-ID-TYPE	FTX00008	COST-SETTLEMENT-PAYMENT	X(2)	20	563	564	1. Value must be 2 characters 2. Value must be in Payee Tax ID Type List (VVL) 3. Mandatory

FTX300	FTX.008.300	PAYEE-TAX-ID-TYPE-OTHER-TEXT	Payee Tax ID Type Other Text	Conditional	This is a description of what the PAYEE-TAX-ID-TYPE represents when the PAYEE-TAX-ID-TYPE was reported with a payee tax ID type of "Other".	N/A	FTX00008	COST-SETTLEMENT-PAYMENT	X(100)	21	565	664	1. Value must be 100 characters or less 2. Value must be populated when Payee Tax Identifier Type equals "95" 3. Conditional
FTX301	FTX.008.301	COST-SETTLEMENT-PERIOD-START-DATE	Cost Settlement Period Start Date	Mandatory	The date representing the beginning of the cost-settlement period. For example, if the cost-settlement is for the first calendar quarter of the year, then the cost settlement begin date would be March 1 of that year.	N/A	FTX00008	COST-SETTLEMENT-PAYMENT	9(8)	22	665	672	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Cost Settlement Period End Date 3. Value of the CC component must be equal to "20" 4. Mandatory
FTX302	FTX.008.302	COST-SETTLEMENT-PERIOD-END-DATE	Cost Settlement Period End Date	Mandatory	The date representing the end of the cost-settlement period. For example, if the cost-settlement is for the first calendar quarter of the year, then the cost settlement end date would be March 31 of that year.	N/A	FTX00008	COST-SETTLEMENT-PAYMENT	9(8)	23	673	680	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be after or the same as the associated Cost Settlement Period Start Date 3. Value of the CC component must be equal to "20" 4. Mandatory
FTX303	FTX.008.303	CATEGORY-FOR-FEDERAL-REIMBURSEMENT	Category for Federal Reimbursement	Mandatory	A code to indicate the Federal funding source for the payment.	CATEGORY-FOR-FEDERAL-REIMBURSEMENT	FTX00008	COST-SETTLEMENT-PAYMENT	X(2)	24	681	682	1. Value must be 2 characters 2. Value must be in Category for Federal Reimbursement List (VVL) 3. Mandatory

FTX304	FTX.008.304	MBESCBES-CATEGORY-OF-SERVICE	MBESCBES Category of Service	Mandatory	A code indicating the category of service for the paid claim. The category of service is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.) that states use to report their expenditures and request federal financial participation.	21.P-FORM, 21BASE-FORM, 64.21U-FORM, 64.10BASE-FORM, 64.9P-FORM, 64.9A-FORM, 64.9BASE-FORM, 64.21UP-FORM	FTX00008	COST-SETTLEMENT-PAYMENT	X(5)	27	734	738	1. Value must be 5 characters or less 2. When MBESCBES Form equals "21.P", value must be in 21.P Form List (VVL) 3. When MBESCBES Form equals "21BASE", value must be in 21BASE Form List (VVL) 4. When MBESCBES Form equals "64.21U", value must be in 64.21U Form List (VVL) 5. When MBESCBES Form equals "64.10BASE", value must be in 64.10BASE Form List (VVL) 6. When MBESCBES Form equals "64.9P", value must be in 64.9P Form List (VVL) 7. When MBESCBES Form equals "64.9A", value must be in 64.9A Form List (VVL) 8. When MBESCBES Form equals "64.9BASE", value must be in 64.9BASE Form List (VVL) 9. When MBESCBES Form equals "64.21UP", value must be in 64.21UP Form List (VVL) 10. Mandatory
FTX305	FTX.008.305	MBESCBES-FORM	MBESCBES Form	Mandatory	The MBES or CBES form to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.). This should be determined by the state's MBES/CBES reporting process. The MBES or CBES form reported here will determine what the meaning of the corresponding MBES/CBES category of service value is.	MBESCBES-FORMGP-1, MBESCBES-FORMGP-2, MBESCBES-FORMGP-3	FTX00008	COST-SETTLEMENT-PAYMENT	X(50)	26	684	733	1. Value must be 50 characters or less 2. When MBESCBES Form Group equals "1", value must be in MBESCBES Form Group 1 List (VVL) 3. When MBESCBES Form Group equals "2", value must be in MBESCBES Form Group 2 List (VVL) 4. When MBESCBES Form Group equals "3", value must be in MBESCBES Form Group 3 List (VVL) 5. Mandatory

FTX306	FTX.008.306	MBESCBES-FORM-GROUP	MBESCBES Form Group	Mandatory	Indicates group of MBES/CBES forms that this payment applies to (e.g., the CMS-64.9 Base form is for Title XIX-funded Medicaid, the CMS-64.21 form is for Title XXI-funded Medicaid-expansion CHIP (M-CHIP), and the CMS-21 Base form is for Title XXI-funded separate CHIP (S-CHIP)).	MBESCBES-FORM-GROUP	FTX00008	COST-SETTLEMENT-PAYMENT	X(1)	25	683	683	1. Value must be 1 character 2. Value must be in MBESCBES Form Group List (VVL) 3. Mandatory
FTX307	FTX.008.307	WAIVER-ID	Waiver ID	Conditional	Field specifying the waiver or demonstration which authorized payment. These IDs must be the approved, full federal waiver ID number assigned during the state submission and CMS approval process. Waiver IDs should actually only be the "core" part of the waiver IDs, without including suffixes for renewals or amendments.	N/A	FTX00008	COST-SETTLEMENT-PAYMENT	X(20)	28	739	758	1. Value must be 20 characters or less 2. Value must be associated with a populated Waiver Type 3. (1115 demonstration) If value begins with "11-W-" or "21-W-", the associated Claim Waiver Type value must be 01 or in [21-30] 4. (1115 demonstration) If value begins with"11-W-" or "21-W-", then the value must include slash “/” in the 11th position followed by the last digit of the CMS Region [0-9] in the 12th position 5. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation followed by a period (.), the associated Waiver Type value must be in [02-20,32,33] 6. Conditional
FTX308	FTX.008.308	WAIVER-TYPE	Waiver Type	Conditional	A code for specifying waiver type under which the eligible individual is covered during the month and receiving services/under which transaction is submitted.	WAIVER-TYPE	FTX00008	COST-SETTLEMENT-PAYMENT	X(2)	29	759	760	1. Value must be 2 characters 2. Value must be in Waiver Type List (VVL) 3. Value must have a corresponding value in Waiver ID 4. Conditional
FTX309	FTX.008.309	FUNDING-CODE	Funding Code	Mandatory	A code to indicate the source of non-federal share funds.	FUNDING-CODE	FTX00008	COST-SETTLEMENT-PAYMENT	X(2)	30	761	762	1. Value must be 1 character 2. Value must be in Funding Code List (VVL) 3. Mandatory

FTX310	FTX.008.310	FUNDING-SOURCE-NONFEDERAL-SHARE	Funding Source Nonfederal Share	Mandatory	A code to indicate the type of non-federal share used by the state to finance its expenditure to the provider. In the event of two sources, states are to report the portion which represents the largest proportion not funded by the Federal government.	FUNDING-SOURCE-NONFEDERAL-SHARE	FTX00008	COST-SETTLEMENT-PAYMENT	X(2)	31	763	764	1. Value must be 2 characters 2. Value must be in Funding Source Nonfederal Share (VVL) 3. Mandatory
FTX311	FTX.008.311	SOURCE-LOCATION	Source Location	Mandatory	The field denotes the claims/transaction processing system in which the claims/transactions were originally processed.	SOURCE-LOCATION	FTX00008	COST-SETTLEMENT-PAYMENT	X(2)	32	765	766	1. Value must be 2 characters 2. Value must be in Source Location List (VVL) 3. Mandatory
FTX312	FTX.008.312	SPA-NUMBER	SPA Number	Conditional	State plan amendment (SPA) ID number using the following format: SS-YY-NNNN-xxxx where: SS = State (use the two character postal abbreviation for your state); YY = Calendar Year (last two characters of the calendar year of the state plan amendment); NNNN = SPA number (a four character number beginning with 0001) States should track their submissions to assign sequential numbers to their submissions. The system will not permit reuse of a previously used SPA ID for a package that has been formally = an Situational entry for specific SPA types	N/A	FTX00008	COST-SETTLEMENT-PAYMENT	X(15)	33	767	781	1. Value must be 15 characters or less 2. Conditional

FTX313	FTX.008.313	EXPENDITURE-AUTHORITY-TYPE	Expenditure Authority Type	Mandatory	Expenditure Authority Type is the federal statute or regulation under which the expenditure is authorized/justified. The federal statute or regulation is usually referenced in either the Medicaid or CHIP State Plan or waiver documentation. For waivers, do not reference the federal statute or regulation being waived by the waiver. For waivers, referring to the waiver authority is sufficient. If the federal statute or regulation is not available in the list of valid values, choose the value for "Other" and report the authority in the Expenditure Authority Type Text.	EXPENDITURE-AUTHORITY-TYPE	FTX00008	COST-SETTLEMENT-PAYMENT	X(2)	34	782	783	1. Value must be 2 characters 2. Value must be in Expenditure Authority Type List (VVL) 3. Mandatory
FTX314	FTX.008.314	EXPENDITURE-AUTHORITY-TYPE-OTHER-TEXT	Expenditure Authority Type Other Text	Conditional	This field is only to be used if Expenditure Authority Type "Other" valid value is selected. Enter a specific text description of the "Other" expenditure authority type.	N/A	FTX00008	COST-SETTLEMENT-PAYMENT	X(100)	35	784	883	1. Value must be 100 characters or less 2. If Expenditure Authority Type equals "95", then value must be populated 3. Conditional
FTX315	FTX.008.315	MEMO	Memo	Conditional	This represents any notes from the state's ledger/accounting system associated with the payment/recoupment.	N/A	FTX00008	COST-SETTLEMENT-PAYMENT	X(500)	36	884	1383	1. Value must be 500 characters or less 2. Conditional
FTX316	FTX.008.316	STATE-NOTATION	State Notation	Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	FTX00008	COST-SETTLEMENT-PAYMENT	X(500)	37	1384	1883	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
FTX318	FTX.009.318	RECORD-ID	Record ID	Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the	RECORD-ID	FTX00009	FQHC-WRAP-PAYMENT	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "FTX00009"

					segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).								
FTX319	FTX.009.319	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	FTX00009	FQHC-WRAP-PAYMENT	X(2)	2	9	10	1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory
FTX320	FTX.009.320	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	FTX00009	FQHC-WRAP-PAYMENT	9(11)	3	11	21	1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
FTX321	FTX.009.321	ICN-ORIG	Original ICN	Mandatory	A unique item control number assigned by the states payment system that identifies an original or adjustment claim/transaction.	N/A	FTX00009	FQHC-WRAP-PAYMENT	X(50)	4	22	71	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
FTX322	FTX.009.322	ICN-ADJ	Adjustment ICN	Conditional	A unique claim/transaction number assigned by the state's payment system that identifies the adjustment claim/transaction for an original item control number.	N/A	FTX00009	FQHC-WRAP-PAYMENT	X(50)	5	72	121	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated

FTX324	FTX.009.324	ADJUSTMENT-IND	Adjustment Indicator	Mandatory	Indicates the type of adjustment record.	ADJUSTMENT-IND	FTX00009	FQHC-WRAP-PAYMENT	X(1)	6	122	122	1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Mandatory
FTX325	FTX.009.325	PAYMENT-OR-RECOUPMENT-DATE	Payment Or Recoupment Date	Mandatory	The date that the payment or recoupment was executed by the payer.	N/A	FTX00009	FQHC-WRAP-PAYMENT	9(8)	7	123	130	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Mandatory 3. Value of the CC component must be equal to "20"
FTX326	FTX.009.326	PAYMENT-OR-RECOUPMENT-AMOUNT	Payment Or Recoupment Amount	Mandatory	The dollar amount being paid to the payee or recouped from the payee for a previous payment. A recoupment should be reported as a negative amount.	N/A	FTX00009	FQHC-WRAP-PAYMENT	S9(11)V99	8	131	143	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Mandatory
FTX327	FTX.009.327	CHECK-EFF-DATE	Check Effective Date	Conditional	The date a check is issued to the payee. In the case of electronic funds transfer, it is the date the transfer is made.	N/A	FTX00009	FQHC-WRAP-PAYMENT	9(8)	9	144	151	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Check Number 3. Conditional 4. Value of the CC component must be equal to "20"
FTX328	FTX.009.328	CHECK-NUM	Check Number	Conditional	The check or electronic funds transfer number.	N/A	FTX00009	FQHC-WRAP-PAYMENT	X(15)	10	152	166	1. Value must be 15 characters or less 2. When populated. value must have an associated Check Effective Date 3. Value must not contain a pipe or asterisk symbols 4. Conditional

FTX329	FTX.009.329	PAYER-ID	Payer ID	Mandatory	This is the identifier that corresponds with the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking the action of either making a payment or taking a recoupment, as opposed to the payee who is the object of the transaction. The payer is the entity that is either making a payment or recouping a payment from another entity or individual. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped.	N/A	FTX00009	FQHC-WRAP-PAYMENT	X(30)	11	167	196	1. Value must be 30 characters or less 2. Mandatory
FTX330	FTX.009.330	PAYER-ID-TYPE	Payer ID Type	Mandatory	This is a qualifier that indicates what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid or CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted as a submitting state code.	PAYER-ID-TYPE	FTX00009	FQHC-WRAP-PAYMENT	X(2)	12	197	198	1. Value must be 2 characters 2. Value must be in Payer ID Type List (VVL) 3. Mandatory 4. When value equals "01" then Payer ID must equal Submitting State (FTX.001.007) 5. When value equals "02" then Payer ID must equal State Plan Identification Number (MCR.002.019) 6. When value equals "04" then Payer ID must equal must equal Submitting State Provider Identifier (PRV.002.019)
FTX331	FTX.009.331	PAYER-ID-TYPE-OTHER-TEXT	Payer ID Type Other Text	Conditional	This is a description of what the payer ID represents when the payer ID was reported with a payer type of "Other".	N/A	FTX00009	FQHC-WRAP-PAYMENT	X(100)	13	199	298	1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional

FTX332	FTX.009.332	PAYEE-ID	Payee Identifier	Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment.	N/A	FTX00009	FQHC-WRAP-PAYMENT	X(30)	14	299	328	1. Value must be 30 characters or less 2. Mandatory
FTX333	FTX.009.333	PAYEE-ID-TYPE	Payee Identifier Type	Mandatory	This is a qualifier that indicates what type of ID the payee ID is. For example, if the payee ID represents a provider ID, then the payee ID type will indicate that the payee ID should be interpreted as a provider ID.	PAYEE-ID-TYPE	FTX00009	FQHC-WRAP-PAYMENT	X(2)	15	329	330	1. Value must be 2 characters 2. Value must be in Payee Identifier Type List (VVL) 3. If value equals "01", then Payee Identifier must equal Submitting State (FTX.001.007) 4. If value equals "02", then Payee Identifier must equal State Plan Identification Number (MCR.002.019) 5. If value in [04,05], then Payee Identifier must equal Submitting State Provider Identifier (PRV.002.019) 6. If value equals "06", then Payee Identifier must equal Provider Identifier (PRV.005.081) where Provider Identifier Type (PRV.005.077) equals "2" 7. If value equals "07", then Payee Identifier must equal Insurance Carrier Identification Number (TPL.006.075) 8. If value equals "08", then Payee Identifier must equal MSIS Identification Number (ELG.002.019) 9. Mandatory
FTX334	FTX.009.334	PAYEE-ID-TYPE-OTHER-TEXT	Payee ID Type Other Text	Conditional	This is a description of what the PAYEE-ID-TYPE represents when the PAYEE-ID-TYPE was reported with a payee ID type of "Other".	N/A	FTX00009	FQHC-WRAP-PAYMENT	X(100)	16	331	430	1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional

FTX335	FTX.009.335	PAYEE-MCR-PLAN-TYPE	Payee MCR Plan Type	Conditional	This describes the type of managed care plan or care coordination model of the payee, when applicable. The valid value code set is comprised of the standard managed care plan type list from the MCR and ELG files and a complementary list of care coordination models.	MANAGED-CARE-PLAN-TYPE	FTX00009	FQHC-WRAP-PAYMENT	X(2)	17	431	432	1. Value must be 2 characters 2. Value must be in Managed Care Plan Type List (VVL) 3. If Payee ID Type is in [02,03], then value must be populated 4. If Payee ID Type is not [02,03], then value must not be populated 5. Conditional
FTX336	FTX.009.336	PAYEE-MCR-PLAN-TYPE-OTHER-TEXT	Payee MCR Plan Type Other Text	Conditional	This is a description of what type of managed care plan or care coordination model the payee ID was reported with a payee MCR plan or other care coordination model type of "Other".	N/A	FTX00009	FQHC-WRAP-PAYMENT	X(100)	18	433	532	1. Value must be 100 characters or less 2. Value must be populated when Payee MCR Plan Type equals "95" 3. Conditional
FTX337	FTX.009.337	PAYEE-TAX-ID	Payee Tax ID	Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment.	N/A	FTX00009	FQHC-WRAP-PAYMENT	X(30)	19	533	562	1. Value must be 30 characters or less 2. Mandatory 3. If Payee Tax ID Type equals "01", then value must be 9-digits and meet the requirements of a valid SSN per SSA requirements
FTX338	FTX.009.338	PAYEE-TAX-ID-TYPE	Payee Tax ID Type	Mandatory	This is a qualifier that indicates what type of tax ID the payee tax ID is. For example, if the payee tax ID represents a SSN, then the payee tax ID type will indicate that the payee tax ID should be interpreted as a SSN.	PAYEE-TAX-ID-TYPE	FTX00009	FQHC-WRAP-PAYMENT	X(2)	20	563	564	1. Value must be 2 characters 2. Value must be in Payee Tax ID Type List (VVL) 3. Mandatory
FTX339	FTX.009.339	PAYEE-TAX-ID-TYPE-OTHER-TEXT	Payee Tax ID Type Other Text	Conditional	This is a description of what the PAYEE-TAX-ID-TYPE represents when the PAYEE-TAX-ID-TYPE was reported with a payee tax ID type of "Other".	N/A	FTX00009	FQHC-WRAP-PAYMENT	X(100)	21	565	664	1. Value must be 100 characters or less 2. Value must be populated when Payee Tax Identifier Type equals "95" 3. Conditional

FTX340	FTX.009.340	WRAP-PERIOD-START-DATE	Wrap Period Start Date	Mandatory	The date representing the beginning of the FQHC wrap payment or recoupment period. For example, if the FQHC wrap payment is for the first calendar quarter of the year, then the FQHC wrap payment begin date would be March 1 of that year.	N/A	FTX00009	FQHC-WRAP-PAYMENT	9(8)	22	665	672	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Coverage Period End Date 3. Value of the CC component must be equal to "20" 4. Mandatory
FTX341	FTX.009.341	WRAP-PERIOD-END-DATE	Wrap Period End Date	Mandatory	The date representing the end of the FQHC wrap payment period. For example, if the FQHC wrap payment is for the first calendar quarter of the year, then the FQHC wrap payment end date would be March 31 of that year.	N/A	FTX00009	FQHC-WRAP-PAYMENT	9(8)	23	673	680	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be after or the same as the associated Wrap Period Start Date 3. Value of the CC component must be equal to "20" 4. Mandatory
FTX342	FTX.009.342	CATEGORY-FOR-FEDERAL-REIMBURSEMENT	Category for Federal Reimbursement	Mandatory	A code to indicate the Federal funding source for the payment.	CATEGORY-FOR-FEDERAL-REIMBURSEMENT	FTX00009	FQHC-WRAP-PAYMENT	X(2)	24	681	682	1. Value must be 2 characters 2. Value must be in Category for Federal Reimbursement List (VVL) 3. Mandatory

FTX343	FTX.009.343	MBESCBES-CATEGORY-OF-SERVICE	MBESCBES Category of Service	Mandatory	A code indicating the category of service for the paid claim. The category of service is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.) that states use to report their expenditures and request federal financial participation.	21.P-FORM, 21BASE-FORM, 64.21U-FORM, 64.10BASE-FORM, 64.9P-FORM, 64.9A-FORM, 64.9BASE-FORM, 64.21UP-FORM	FTX00009	FQHC-WRAP-PAYMENT	X(5)	27	734	738	1. Value must be 5 characters or less 2. When MBESCBES Form equals "21.P", value must be in 21.P Form List (VVL) 3. When MBESCBES Form equals "21BASE", value must be in 21BASE Form List (VVL) 4. When MBESCBES Form equals "64.21U", value must be in 64.21U Form List (VVL) 5. When MBESCBES Form equals "64.10BASE", value must be in 64.10BASE Form List (VVL) 6. When MBESCBES Form equals "64.9P", value must be in 64.9P Form List (VVL) 7. When MBESCBES Form equals "64.9A", value must be in 64.9A Form List (VVL) 8. When MBESCBES Form equals "64.9BASE", value must be in 64.9BASE Form List (VVL) 9. When MBESCBES Form equals "64.21UP", value must be in 64.21UP Form List (VVL) 10. Mandatory
FTX344	FTX.009.344	MBESCBES-FORM	MBESCBES Form	Mandatory	The MBES or CBES form to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.). This should be determined by the state's MBES/CBES reporting process. The MBES or CBES form reported here will determine what the meaning of the corresponding MBES/CBES category of service value is.	MBESCBES-FORMGP-1, MBESCBES-FORMGP-2, MBESCBES-FORMGP-3	FTX00009	FQHC-WRAP-PAYMENT	X(50)	26	684	733	1. Value must be 50 characters or less 2. When MBESCBES Form Group equals "1", value must be in MBESCBES Form Group 1 List (VVL) 3. When MBESCBES Form Group equals "2", value must be in MBESCBES Form Group 2 List (VVL) 4. When MBESCBES Form Group equals "3", value must be in MBESCBES Form Group 3 List (VVL) 5. Mandatory

FTX345	FTX.009.345	MBESCBES-FORM-GROUP	MBESCBES Form Group	Mandatory	Indicates group of MBES/CBES forms that this payment applies to (e.g., the CMS-64.9 Base form is for Title XIX-funded Medicaid, the CMS-64.21 form is for Title XXI-funded Medicaid-expansion CHIP (M-CHIP), and the CMS-21 Base form is for Title XXI-funded separate CHIP (S-CHIP)).	MBESCBES-FORM-GROUP	FTX00009	FQHC-WRAP-PAYMENT	X(1)	25	683	683	1. Value must be 1 character 2. Value must be in MBESCBES Form Group List (VVL) 3. Mandatory
FTX346	FTX.009.346	WAIVER-ID	Waiver ID	Conditional	Field specifying the waiver or demonstration which authorized payment. These IDs must be the approved, full federal waiver ID number assigned during the state submission and CMS approval process. Waiver IDs should actually only be the "core" part of the waiver IDs, without including suffixes for renewals or amendments.	N/A	FTX00009	FQHC-WRAP-PAYMENT	X(20)	28	739	758	1. Value must be 20 characters or less 2. Value must be associated with a populated Waiver Type 3. (1115 demonstration) If value begins with "11-W-" or "21-W-", the associated Claim Waiver Type value must be 01 or in [21-30] 4. (1115 demonstration) If value begins with"11-W-" or "21-W-", then the value must include slash “/” in the 11th position followed by the last digit of the CMS Region [0-9] in the 12th position 5. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation followed by a period (.), the associated Waiver Type value must be in [02-20,32,33] 6. Conditional
FTX347	FTX.009.347	WAIVER-TYPE	Waiver Type	Conditional	A code for specifying waiver type under which the eligible individual is covered during the month and receiving services/under which transaction is submitted.	WAIVER-TYPE	FTX00009	FQHC-WRAP-PAYMENT	X(2)	29	759	760	1. Value must be 2 characters 2. Value must be in Waiver Type List (VVL) 3. Value must have a corresponding value in Waiver ID 4. Conditional
FTX348	FTX.009.348	FUNDING-CODE	Funding Code	Mandatory	A code to indicate the source of non-federal share funds.	FUNDING-CODE	FTX00009	FQHC-WRAP-PAYMENT	X(2)	30	761	762	1. Value must be 1 character 2. Value must be in Funding Code List (VVL) 3. Mandatory

FTX349	FTX.009.349	FUNDING-SOURCE-NONFEDERAL-SHARE	Funding Source Nonfederal Share	Mandatory	A code to indicate the type of non-federal share used by the state to finance its expenditure to the provider. In the event of two sources, states are to report the portion which represents the largest proportion not funded by the Federal government.	FUNDING-SOURCE-NONFEDERAL-SHARE	FTX00009	FQHC-WRAP-PAYMENT	X(2)	31	763	764	1. Value must be 2 characters 2. Value must be in Funding Source Nonfederal Share (VVL) 3. Mandatory
FTX350	FTX.009.350	SOURCE-LOCATION	Source Location	Mandatory	The field denotes the claims/transaction processing system in which the claims/transactions were originally processed.	SOURCE-LOCATION	FTX00009	FQHC-WRAP-PAYMENT	X(2)	32	765	766	1. Value must be 2 characters 2. Value must be in Source Location List (VVL) 3. Mandatory
FTX351	FTX.009.351	SPA-NUMBER	SPA Number	Conditional	State plan amendment (SPA) ID number using the following format: SS-YY-NNNN-xxxx where: SS = State (use the two character postal abbreviation for your state); YY = Calendar Year (last two characters of the calendar year of the state plan amendment); NNNN = SPA number (a four character number beginning with 0001) States should track their submissions to assign sequential numbers to their submissions. The system will not permit reuse of a previously used SPA ID for a package that has been formally = an Situational entry for specific SPA types	N/A	FTX00009	FQHC-WRAP-PAYMENT	X(15)	33	767	781	1. Value must be 15 characters or less 2. Conditional

FTX352	FTX.009.352	EXPENDITURE-AUTHORITY-TYPE	Expenditure Authority Type	Mandatory	Expenditure Authority Type is the federal statute or regulation under which the expenditure is authorized/justified. The federal statute or regulation is usually referenced in either the Medicaid or CHIP State Plan or waiver documentation. For waivers, do not reference the federal statute or regulation being waived by the waiver. For waivers, referring to the waiver authority is sufficient. If the federal statute or regulation is not available in the list of valid values, choose the value for "Other" and report the authority in the Expenditure Authority Type Text.	EXPENDITURE-AUTHORITY-TYPE	FTX00009	FQHC-WRAP-PAYMENT	X(2)	34	782	783	1. Value must be 2 characters 2. Value must be in Expenditure Authority Type List (VVL) 3. Mandatory
FTX353	FTX.009.353	EXPENDITURE-AUTHORITY-TYPE-OTHER-TEXT	Expenditure Authority Type Other Text	Conditional	This field is only to be used if Expenditure Authority Type "Other" valid value is selected. Enter a specific text description of the "Other" expenditure authority type.	N/A	FTX00009	FQHC-WRAP-PAYMENT	X(100)	35	784	883	1. Value must be 100 characters or less 2. If Expenditure Authority Type equals "95", then value must be populated 3. Conditional
FTX354	FTX.009.354	MEMO	Memo	Conditional	This represents any notes from the state's ledger/accounting system associated with the payment/recoupment.	N/A	FTX00009	FQHC-WRAP-PAYMENT	X(500)	36	884	1383	1. Value must be 500 characters or less 2. Conditional
FTX355	FTX.009.355	STATE-NOTATION	State Notation	Situational	A free text field for the submitting state to enter whatever information it chooses.	N/A	FTX00009	FQHC-WRAP-PAYMENT	X(500)	37	1384	1883	1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Situational
FTX357	FTX.095.357	RECORD-ID	Record ID	Mandatory	The Record ID represents the type of segment being reported. The Record ID communicates how the contents of a given row of data should be interpreted depending on which segment type the Record ID represents. Each type of segment collects different data elements so each segment type has a distinct layout. The first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are the	RECORD-ID	FTX00095	MISCELLANEOUS-PAYMENT	X(8)	1	1	8	1. Value must be 8 characters 2. Mandatory 3. Value must be in Record ID List (VVL) 4. Value must equal "FTX00095"

					segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).								
FTX358	FTX.095.358	SUBMITTING-STATE	Submitting State	Mandatory	A code that uniquely identifies the U.S. State or Territory from which T-MSIS system data resources were received.	STATE	FTX00095	MISCELLANEOUS-PAYMENT	X(2)	2	9	10	1. Value must be 2 characters 2. Value must be in State Code List (VVL) 3. Mandatory
FTX359	FTX.095.359	RECORD-NUMBER	Record Number	Mandatory	A sequential number assigned by the submitter to identify each record segment row in the submission file. The Record Number, in conjunction with the Record Identifier, uniquely identifies a single record within the submission file.	N/A	FTX00095	MISCELLANEOUS-PAYMENT	9(11)	3	11	21	1. Value must be 11 digits or less 2. Value must be unique within record segment over all records associated with a given Record ID 3. Mandatory
FTX360	FTX.095.360	ICN-ORIG	Original ICN	Mandatory	A unique item control number assigned by the states payment system that identifies an original or adjustment claim/transaction.	N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(50)	4	22	71	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Mandatory
FTX361	FTX.095.361	ICN-ADJ	Adjustment ICN	Conditional	A unique claim/transaction number assigned by the state's payment system that identifies the adjustment claim/transaction for an original item control number.	N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(50)	5	72	121	1. Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value equals "0", then value must not be populated 4. Conditional 5. If associated Adjustment Indicator value equals "4", then value must be populated

FTX363	FTX.095.363	ADJUSTMENT-IND	Adjustment Indicator	Mandatory	Indicates the type of adjustment record.	ADJUSTMENT-IND	FTX00095	MISCELLANEOUS-PAYMENT	X(1)	6	122	122	1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Mandatory
FTX364	FTX.095.364	PAYMENT-OR-RECOUPMENT-DATE	Payment Or Recoupment Date	Mandatory	The date that the payment or recoupment was executed by the payer.	N/A	FTX00095	MISCELLANEOUS-PAYMENT	9(8)	7	123	130	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Mandatory 3. Value of the CC component must be equal to "20"
FTX365	FTX.095.365	PAYMENT-OR-RECOUPMENT-AMOUNT	Payment Or Recoupment Amount	Mandatory	The dollar amount being paid to the payee or recouped from the payee for a previous payment. A recoupment should be reported as a negative amount.	N/A	FTX00095	MISCELLANEOUS-PAYMENT	S9(11)V99	8	131	143	1. Value must be between -99999999999.99 and 99999999999.99 2. Value must be expressed as a number with 2-digit precision (e.g. 100.50) 3. Mandatory
FTX366	FTX.095.366	CHECK-EFF-DATE	Check Effective Date	Conditional	The date a check is issued to the payee. In the case of electronic funds transfer, it is the date the transfer is made.	N/A	FTX00095	MISCELLANEOUS-PAYMENT	9(8)	9	144	151	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Must have an associated Check Number 3. Conditional 4. Value of the CC component must be equal to "20"
FTX367	FTX.095.367	CHECK-NUM	Check Number	Conditional	The check or electronic funds transfer number.	N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(15)	10	152	166	1. Value must be 15 characters or less 2. When populated. value must have an associated Check Effective Date 3. Value must not contain a pipe or asterisk symbols 4. Conditional

FTX368	FTX.095.368	PAYER-ID	Payer ID	Mandatory	This is the identifier that corresponds with the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking the action of either making a payment or taking a recoupment, as opposed to the payee who is the object of the transaction. The payer is the entity that is either making a payment or recouping a payment from another entity or individual. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped.	N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(30)	11	167	196	1. Value must be 30 characters or less 2. Mandatory
FTX369	FTX.095.369	PAYER-ID-TYPE	Payer ID Type	Mandatory	This is a qualifier that indicates what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid or CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted as a submitting state code.	PAYER-ID-TYPE	FTX00095	MISCELLANEOUS-PAYMENT	X(2)	12	197	198	1. Value must be 2 characters 2. Value must be in Payer ID Type List (VVL) 3. Mandatory 4. When value equals "01" then Payer ID must equal Submitting State (FTX.001.007) 5. When value equals "02" then Payer ID must equal State Plan Identification Number (MCR.002.019) 6. When value equals "04" then Payer ID must equal must equal Submitting State Provider Identifier (PRV.002.019)
FTX370	FTX.095.370	PAYER-ID-TYPE-OTHER-TEXT	Payer ID Type Other Text	Conditional	This is a description of what the payer ID represents when the payer ID was reported with a payer type of "Other".	N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(100)	13	199	298	1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional

FTX371	FTX.095.371	PAYER-MCR-PLAN-TYPE	Payer MCR Plan Type	Conditional	This describes the type of managed care plan or care coordination model of the payer, when applicable. The valid value list is comprised of the standard managed care plan type list from the MCR and ELG files and a complementary list of care coordination models.	MANAGED-CARE-PLAN-TYPE	FTX00095	MISCELLANEOUS-PAYMENT	X(2)	14	299	300	1. Value must be 2 characters 2. Value must be in Managed Care Plan Type List (VVL) 3. If Payer ID Type equals "02", then value must be populated 4. If Payer ID Type does not equal "02", then value must not be populated 5. Conditional
FTX372	FTX.095.372	PAYER-MCR-PLAN-TYPE-OTHER-TEXT	Payer MCR Plan Type Other Text	Conditional	This is a description of what type of managed care plan or care coordination model the payer ID was reported with a PAYER-MCR-PLAN-OR-OTHER-TYPE of "Other".	N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(100)	15	301	400	1. Value must be 100 characters or less 2. Value must be populated when Payee MCR Plan Type equals "95" 3. Conditional
FTX373	FTX.095.373	PAYEE-ID	Payee Identifier	Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment.	N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(30)	16	401	430	1. Value must be 30 characters or less 2. Mandatory

FTX374	FTX.095.374	PAYEE-ID-TYPE	Payee Identifier Type	Mandatory	This is a qualifier that indicates what type of ID the payee ID is. For example, if the payee ID represents a provider ID, then the payee ID type will indicate that the payee ID should be interpreted as a provider ID.	PAYEE-ID-TYPE	FTX00095	MISCELLANEOUS-PAYMENT	X(2)	17	431	432	1. Value must be 2 characters 2. Value must be in Payee Identifier Type List (VVL) 3. If value equals "01", then Payee Identifier must equal Submitting State (FTX.001.007) 4. If value equals "02", then Payee Identifier must equal State Plan Identification Number (MCR.002.019) 5. If value in [04,05], then Payee Identifier must equal Submitting State Provider Identifier (PRV.002.019) 6. If value equals "06", then Payee Identifier must equal Provider Identifier (PRV.005.081) where Provider Identifier Type (PRV.005.077) equals "2" 7. If value equals "07", then Payee Identifier must equal Insurance Carrier Identification Number (TPL.006.075) 8. If value equals "08", then Payee Identifier must equal MSIS Identification Number (ELG.002.019) 9. Mandatory
FTX375	FTX.095.375	PAYEE-ID-TYPE-OTHER-TEXT	Payee ID Type Other Text	Conditional	This is a description of what the PAYEE-ID-TYPE represents when the PAYEE-ID-TYPE was reported with a payee ID type of "Other".	N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(100)	18	433	532	1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional
FTX376	FTX.095.376	PAYEE-MCR-PLAN-TYPE	Payee MCR Plan Type	Conditional	This describes the type of managed care plan or care coordination model of the payee, when applicable. The valid value code set is comprised of the standard managed care plan type list from the MCR and ELG files and a complementary list of care coordination models.	MANAGED-CARE-PLAN-TYPE	FTX00095	MISCELLANEOUS-PAYMENT	X(2)	19	533	534	1. Value must be 2 characters 2. Value must be in Managed Care Plan Type List (VVL) 3. If Payee ID Type is in [02,03], then value must be populated 4. If Payee ID Type is not [02,03], then value must not be populated 5. Conditional

FTX377	FTX.095.377	PAYEE-MCR-PLAN-TYPE-OTHER-TEXT	Payee MCR Plan Type Other Text	Conditional	This is a description of what type of managed care plan or care coordination model the payee ID was reported with a payee MCR plan or other care coordination model type of "Other".	N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(100)	20	535	634	1. Value must be 100 characters or less 2. Value must be populated when Payee MCR Plan Type equals "95" 3. Conditional
FTX378	FTX.095.378	PAYEE-TAX-ID	Payee Tax ID	Mandatory	This is the identifier that corresponds with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or entity that is either receiving a payment or having a previous payment recouped. The payee is the object of the transaction, as opposed to the payer who is the subject taking the action of either making a payment or taking a recoupment.	N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(30)	21	635	664	1. Value must be 30 characters or less 2. Mandatory 3. If Payee Tax ID Type equals "01", then value must be 9-digits and meet the requirements of a valid SSN per SSA requirements
FTX379	FTX.095.379	PAYEE-TAX-ID-TYPE	Payee Tax ID Type	Mandatory	This is a qualifier that indicates what type of tax ID the payee tax ID is. For example, if the payee tax ID represents a SSN, then the payee tax ID type will indicate that the payee tax ID should be interpreted as a SSN.	PAYEE-TAX-ID-TYPE	FTX00095	MISCELLANEOUS-PAYMENT	X(2)	22	665	666	1. Value must be 2 characters 2. Value must be in Payee Tax ID Type List (VVL) 3. Mandatory
FTX380	FTX.095.380	PAYEE-TAX-ID-TYPE-OTHER-TEXT	Payee Tax ID Type Other Text	Conditional	This is a description of what the PAYEE-TAX-ID-TYPE represents when the PAYEE-TAX-ID-TYPE was reported with a payee tax ID type of "Other".	N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(100)	23	667	766	1. Value must be 100 characters or less 2. Value must be populated when Payee Tax Identifier Type equals "95" 3. Conditional
FTX381	FTX.095.381	CONTRACT-ID	Contract Identifier	Conditional	Managed care plan contract ID	N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(100)	24	767	866	1. Value must be 100 characters or less 2. Conditional
FTX382	FTX.095.382	INSURANCE-CARRIER-ID-NUM	Insurance Carrier Identification Number	Conditional	The state-assigned identification number of the Third Party Liability (TPL) Entity.	N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(12)	25	867	878	1. Value must be 12 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Conditional

FTX383	FTX.095.383	MSIS-IDENTIFICATION-NUM	MSIS Identification Number	Conditional	A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual. Value may be an SSN, temporary SSN or State-assigned eligible individual identifier. MSIS Identification Numbers are a unique “key” value used to maintain referential integrity of data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 year of age who share the same MSIS Identification Number. https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-shared-msis-identification-numbers-eligibility/	N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(20)	26	879	898	1. Value must be 20 characters or less 2. Conditional 3. When populated, value must match MSIS Identification Number (ELG.002.019) 4. When Adjustment Indicator does not equal "1", there must be a valid record of type Enrollment Time Span where the Payment Period Start Date is equal to or greater than Enrollment Start Date and Period End Date is less than or equal to Enrollment End Date
FTX384	FTX.095.384	PAYMENT-PERIOD-START-DATE	Payment Period Start Date	Mandatory	The date representing the start of the time period that the payment is expected to be used by the provider.	N/A	FTX00095	MISCELLANEOUS-PAYMENT	9(8)	27	899	906	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Value must be before or the same as the associated Payment Period End Date 3. Value of the CC component must be equal to "20" 4. Mandatory
FTX385	FTX.095.385	PAYMENT-PERIOD-END-DATE	Payment Period End Date	Mandatory	The date representing the end of the time period that the payment is expected to be used by the provider.	N/A	FTX00095	MISCELLANEOUS-PAYMENT	9(8)	28	907	914	1. The date must be a valid calendar date in the form "CCYYMMDD" 2. Mandatory 3. Value must be after or the same as the associated Payment Period Start Date 4. Value of the CC component must be equal to "20"

FTX386	FTX.095.386	PAYMENT-PERIOD-TYPE	Payment Period Type	Mandatory	A qualifier that identifies what the payment period begin and end dates represent. For example, the payment period begin an end dates may correspond to a range of service dates from claims or encounters or they may represent a period of beneficiary eligibility or enrollment.	PAYMENT-PERIOD-TYPE	FTX00095	MISCELLANEOUS-PAYMENT	X(2)	29	915	916	1. Value must be 2 characters 2. Value must be in Payment Period Type List (VVL) 3. Mandatory
FTX387	FTX.095.387	PAYMENT-PERIOD-TYPE-OTHER-TEXT	Payment Period Type Other Text	Conditional	This is a description of the type of financial transaction when the PAYMENT-PERIOD-TYPE is "Other".	N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(100)	30	917	1016	1. Value must be 100 characters or less 2. Value must be populated when Payment Period Type equals "95" 3. Conditional
FTX388	FTX.095.388	TRANSACTION-TYPE	Transaction Type	Conditional	This is a code that classifies the type of financial transaction when the financial transaction does not fit into any other financial transaction segment type (e.g., FTX00002, FTX00003, FTX00004, etc.).	TRANSACTION-TYPE	FTX00095	MISCELLANEOUS-PAYMENT	X(2)	31	1017	1018	1. Value must be 2 characters 2. Value must be in Transaction Type List (VVL) 3. Conditional
FTX389	FTX.095.389	TRANSACTION-TYPE-OTHER-TEXT	Transaction Type Other Text	Conditional	This is a description of the type of financial transaction when the TRANSACTION-TYPE is "Other".	N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(100)	32	1019	1118	1. Value must be 100 characters or less 2. Value must be populated when Payee Identifier Type equals "95" 3. Conditional
FTX390	FTX.095.390	CATEGORY-FOR-FEDERAL-REIMBURSEMENT	Category for Federal Reimbursement	Mandatory	A code to indicate the Federal funding source for the payment.	CATEGORY-FOR-FEDERAL-REIMBURSEMENT	FTX00095	MISCELLANEOUS-PAYMENT	X(2)	33	1119	1120	1. Value must be 2 characters 2. Value must be in Category for Federal Reimbursement List (VVL) 3. Mandatory

FTX391	FTX.095.391	MBESCBES-CATEGORY-OF-SERVICE	MBESCBES Category of Service	Mandatory	A code indicating the category of service for the paid claim. The category of service is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.) that states use to report their expenditures and request federal financial participation.	21.P-FORM, 21BASE-FORM, 64.21U-FORM, 64.10BASE-FORM, 64.9P-FORM, 64.9A-FORM, 64.9BASE-FORM, 64.21UP-FORM	FTX00095	MISCELLANEOUS-PAYMENT	X(5)	36	1172	1176	1. Value must be 5 characters or less 2. When MBESCBES Form equals "21.P", value must be in 21.P Form List (VVL) 3. When MBESCBES Form equals "21BASE", value must be in 21BASE Form List (VVL) 4. When MBESCBES Form equals "64.21U", value must be in 64.21U Form List (VVL) 5. When MBESCBES Form equals "64.10BASE", value must be in 64.10BASE Form List (VVL) 6. When MBESCBES Form equals "64.9P", value must be in 64.9P Form List (VVL) 7. When MBESCBES Form equals "64.9A", value must be in 64.9A Form List (VVL) 8. When MBESCBES Form equals "64.9BASE", value must be in 64.9BASE Form List (VVL) 9. When MBESCBES Form equals "64.21UP", value must be in 64.21UP Form List (VVL) 10. Mandatory
FTX392	FTX.095.392	MBESCBES-FORM	MBESCBES Form	Mandatory	The MBES or CBES form to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, etc.). This should be determined by the state's MBES/CBES reporting process. The MBES or CBES form reported here will determine what the meaning of the corresponding MBES/CBES category of service value is.	MBESCBES-FORMGP-1, MBESCBES-FORMGP-2, MBESCBES-FORMGP-3	FTX00095	MISCELLANEOUS-PAYMENT	X(50)	35	1122	1171	1. Value must be 50 characters or less 2. When MBESCBES Form Group equals "1", value must be in MBESCBES Form Group 1 List (VVL) 3. When MBESCBES Form Group equals "2", value must be in MBESCBES Form Group 2 List (VVL) 4. When MBESCBES Form Group equals "3", value must be in MBESCBES Form Group 3 List (VVL) 5. Mandatory

FTX393	FTX.095.393	MBESCBES-FORM-GROUP	MBESCBES Form Group	Mandatory	Indicates group of MBES/CBES forms that this payment applies to (e.g., the CMS-64.9 Base form is for Title XIX-funded Medicaid, the CMS-64.21 form is for Title XXI-funded Medicaid-expansion CHIP (M-CHIP), and the CMS-21 Base form is for Title XXI-funded separate CHIP (S-CHIP)).	MBESCBES-FORM-GROUP	FTX00095	MISCELLANEOUS-PAYMENT	X(1)	34	1121	1121	1. Value must be 1 character 2. Value must be in MBESCBES Form Group List (VVL) 3. Mandatory
FTX394	FTX.095.394	WAIVER-ID	Waiver ID	Conditional	Field specifying the waiver or demonstration which authorized payment. These IDs must be the approved, full federal waiver ID number assigned during the state submission and CMS approval process. Waiver IDs should actually only be the "core" part of the waiver IDs, without including suffixes for renewals or amendments.	N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(20)	37	1177	1196	1. Value must be 20 characters or less 2. Value must be associated with a populated Waiver Type 3. (1115 demonstration) If value begins with "11-W-" or "21-W-", the associated Claim Waiver Type value must be 01 or in [21-30] 4. (1115 demonstration) If value begins with"11-W-" or "21-W-", then the value must include slash “/” in the 11th position followed by the last digit of the CMS Region [0-9] in the 12th position 5. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation followed by a period (.), the associated Waiver Type value must be in [02-20,32,33] 6. Conditional
FTX395	FTX.095.395	WAIVER-TYPE	Waiver Type	Conditional	A code for specifying waiver type under which the eligible individual is covered during the month and receiving services/under which transaction is submitted.	WAIVER-TYPE	FTX00095	MISCELLANEOUS-PAYMENT	X(2)	38	1197	1198	1. Value must be 2 characters 2. Value must be in Waiver Type List (VVL) 3. Value must have a corresponding value in Waiver ID 4. Conditional
FTX396	FTX.095.396	FUNDING-CODE	Funding Code	Mandatory	A code to indicate the source of non-federal share funds.	FUNDING-CODE	FTX00095	MISCELLANEOUS-PAYMENT	X(2)	39	1199	1200	1. Value must be 1 character 2. Value must be in Funding Code List (VVL) 3. Mandatory

FTX397	FTX.095.397	FUNDING-SOURCE-NONFEDERAL-SHARE	Funding Source Nonfederal Share	Mandatory	A code to indicate the type of non-federal share used by the state to finance its expenditure to the provider. In the event of two sources, states are to report the portion which represents the largest proportion not funded by the Federal government.	FUNDING-SOURCE-NONFEDERAL-SHARE	FTX00095	MISCELLANEOUS-PAYMENT	X(2)	40	1201	1202	1. Value must be 2 characters 2. Value must be in Funding Source Nonfederal Share (VVL) 3. Mandatory
FTX398	FTX.095.398	SDP-IND	State Directed Payment Indicator	Mandatory	Indicates whether the financial transaction from an MC plan to a provider or other entity is a type of State Directed Payment.	SDP-IND	FTX00095	MISCELLANEOUS-PAYMENT	X(1)	41	1203	1203	1. Value must be 1 character 2. Value must be in State Directed Payment Indicator List (VVL) 3. Mandatory
FTX399	FTX.095.399	SOURCE-LOCATION	Source Location	Mandatory	The field denotes the claims/transaction processing system in which the claims/transactions were originally processed.	SOURCE-LOCATION	FTX00095	MISCELLANEOUS-PAYMENT	X(2)	42	1204	1205	1. Value must be 2 characters 2. Value must be in Source Location List (VVL) 3. Mandatory
FTX400	FTX.095.400	SPA-NUMBER	SPA Number	Conditional	State plan amendment (SPA) ID number using the following format: SS-YY-NNNN-xxxx where: SS = State (use the two character postal abbreviation for your state); YY = Calendar Year (last two characters of the calendar year of the state plan amendment); NNNN = SPA number (a four character number beginning with 0001) States should track their submissions to assign sequential numbers to their submissions. The system will not permit reuse of a previously used SPA ID for a package that has been formally = an Situational entry for specific SPA types	N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(15)	43	1206	1220	1. Value must be 15 characters or less 2. Conditional
FTX401	FTX.095.401	PAYMENT-CAT-XREF	Payment Cat Xref	Conditional	Cross-reference to the applicable payment category in the managed care plan's contract with the state Medicaid/CHIP agency or their fiscal intermediary.	N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(50)	44	1221	1270	1. Value must be 50 characters or less 2. Conditional

FTX402	FTX.095.402	EXPENDITURE-AUTHORITY-TYPE	Expenditure Authority Type	Mandatory	Expenditure Authority Type is the federal statute or regulation under which the expenditure is authorized/justified. The federal statute or regulation is usually referenced in either the Medicaid or CHIP State Plan or waiver documentation. For waivers, do not reference the federal statute or regulation being waived by the waiver. For waivers, referring to the waiver authority is sufficient. If the federal statute or regulation is not available in the list of valid values, choose the value for "Other" and report the authority in the Expenditure Authority Type Text.	EXPENDITURE-AUTHORITY-TYPE	FTX00095	MISCELLANEOUS-PAYMENT	X(2)	45	1271	1272	1. Value must be 2 characters 2. Value must be in Expenditure Authority Type List (VVL) 3. Mandatory
FTX403	FTX.095.403	EXPENDITURE-AUTHORITY-TYPE-OTHER-TEXT	Expenditure Authority Type Other Text	Conditional	This field is only to be used if Expenditure Authority Type "Other" valid value is selected. Enter a specific text description of the "Other" expenditure authority type.	N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(100)	46	1273	1372	1. Value must be 100 characters or less 2. If Expenditure Authority Type equals "95", then value must be populated 3. Conditional
FTX404	FTX.095.404	MEMO	Memo	Conditional	This represents any notes from the state's ledger/accounting system associated with the payment/recoupment.	N/A	FTX00095	MISCELLANEOUS-PAYMENT	X(500)	47	1373	1872	1. Value must be 500 characters or less 2. Conditional