Centers for Medicaid and CHIP Services (CMCS)

Transformed Medicaid Statistical Information Sys
T-MSIS Data Dictionary Crosswalk (Change Log) - V

PRA Disclosure Statement: The Transformed Medicaid Statistical Informat
and to calculate quality measures and other metrics, including those reported thro
this provision by requiring states to include data elements the Secretary determine
required to respond to a collection of information unless it displays a valid OMB cor
search existing data resources, gather the data needed, and complete and review tl

tem (T-MSIS)
Version 2.4.0 through Version 4.0.0

ion System (T-MSIS) is used to assist the Centers for Medicare & Medicaid Services (CM
ugh the new Medicaid and CHIP Scoreboard. Section 4735 of the Balanced Budget Act of 1997 inc
s necessary for program integrity, program oversight, and administration. Under the Privacy Act o
ntrol number. The valid OMB control number for this information collection is 0938-0345 (Expires
he information collection. If you have comments concerning the accuracy of the time estimate(s) c

S) with monitoring and oversight of Medicaid and CHIP programs, to enable evaluation of
luded a statutory requirement for states to submit claims data, enrollee encounter data, and supp
f 1974 any personally identifying information obtained will be kept private to the extent of the law
: 03/31/2026). The time required to complete this information collection is estimated to average
or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA R

demonstrations under section 1115 of the Social Security Act
porting information. Section 6504 of the Affordable Care Act strengthened
w. According to the Paperwork Reduction Act of 1995, no persons are
10 hours per response, including the time to review instructions,
Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

T-MSIS Data Dictionary Crosswalk (Change Log

Date	Name And/Or Number
2021-04-09	CHIP-CODE (ELG054)
2021-05-21	BILLING-PROV-NUM (COT.002.112)
2021-05-21	PROCEDURE-CODE-1, PROCEDURE-CODE-2, PROCEDURE-CODE-3, PROCEDURE-CODE-4, PROCEDURE-CODE-5, PROCEDURE-CODE-6
2021-06-11	ELG.016.214
2021-06-11	TOT-BILLED-AMT
2021-07-23	TOT-BILLED-AMT (CIP.002.112)
2021-07-23	TOT-COPAY-AMT (CIP.002.115)
2021-08-13	MEDICAID-PAID-AMT
2021-10-15	CLAIM-STATUS-CATEGORY (CIP103)

2021-12-03	RACE (ELG213)
2021-12-17	ADJUDICATION-DATE

2021-12-17	BILLING-PROV-NUM (COT112)
2021-12-17	BILLING-PROV-NUM (COT112)
2021-12-17	BILLING-PROV-NUM (COT112)
2021-12-17	PRIMARY-LANGUAGE-CODE (ELG046)
2022-01-07	CIP025
2022-01-07	CLT024
2022-01-07	COT024
2022-01-07	CRX024
2022-01-07	ELG086

2022-01-07	ELG086
2022-01-07	ELG233
2022-01-07	ELG260
2022-01-28	ELG095
2022-02-18	COT191
2022-02-18	ELG224
2022-03-11	CIP228
2022-03-11	CLT179
2022-03-11	COT182

2022-03-11	CRX129
2022-04-01	ELG073
2022-05-13	CIP184, CLT006, COT006, CRX006, ELG006, MCR006, PRV006, TPL006, CIP127, CLT077, COT063, CRX054, ELG111, TPL044, TPL045, CIP093, CIP088, PRV043, PRV064, PRV076, PRV129, COT191
2022-05-13	CIP202, CLT144, COT126, CRX081

2022-05-13	CRX098
2022-05-13	CRX143
2022-05-13	CRX144
2022-05-13	ELG087
2022-05-13	ELG097
2022-05-13	ELG163

2022-06-24	1115A-DEMONSTRATION-IND
2022-06-24	1115A-DEMONSTRATION-IND
2022-06-24	1115A-DEMONSTRATION-IND
2022-06-24	1115A-DEMONSTRATION-IND
2022-06-24	ADMISSION-HOUR
2022-06-24	ADMITTING-DIAGNOSIS-CODE

2022-06-24	ADMITTING-DIAGNOSIS-CODE
2022-06-24	ADMITTING-DIAGNOSIS-CODE
2022-06-24	ADMITTING-PROV-NPI-NUM
2022-06-24	ADMITTING-PROV-NPI-NUM
2022-06-24	AFFILIATED-PROGRAM-ID

2022-06-24	AFFILIATED-PROGRAM-TYPE
2022-06-24	BILLING-PROV-NPI-NUM
2022-06-24	BILLING-PROV-NPI-NUM
2022-06-24	BILLING-PROV-NPI-NUM
2022-06-24	BILLING-PROV-NPI-NUM
2022-06-24	CIP071
2022-06-24	CIP071/ PROCEDURE-CODE-MOD-1
2022-06-24	CIP075
2022-06-24	CIP075/ PROCEDURE-CODE-MOD-2
2022-06-24	CIP079
2022-06-24	CIP079/ PROCEDURE-CODE-MOD-3
2022-06-24	CIP083

2022-06-24	CIP083/ PROCEDURE-CODE-MOD-4
2022-06-24	CIP087
2022-06-24	CIP087/ PROCEDURE-CODE-MOD-5
2022-06-24	CIP091
2022-06-24	CIP091/ PROCEDURE-CODE-MOD-6
2022-06-24	CIP107
2022-06-24	CIP107/ ALLOWED-CHARGE-SRC
2022-06-24	CIP115
2022-06-24	CIP115/ TOT-COPAY-AMT
2022-06-24	CIP131
2022-06-24	CIP131/ NATIONAL-HEALTH-CARE-ENTITY-ID
2022-06-24	CIP191
2022-06-24	CIP191/ REFERRING-PROV-TAXONOMY
2022-06-24	CIP192
2022-06-24	CIP192/ REFERRING-PROV-TYPE
2022-06-24	CIP193
2022-06-24	CIP193/ REFERRING-PROV-SPECIALTY
2022-06-24	CIP195
2022-06-24	CIP195/ DRG-REL-WEIGHT
2022-06-24	CIP201
2022-06-24	CIP201/ BMI
2022-06-24	CIP206
2022-06-24	CIP206/ TOT-BENEFICIARY-COINSURANCE-PAID-AMOUNT
2022-06-24	CIP208

2022-06-24	CIP208/ TOT-BENEFICIARY-COPAYMENT-PAID-AMOUNT
2022-06-24	CIP210
2022-06-24	CIP210/ TOT-BENEFICIARY-DEDUCTIBLE-PAID-AMOUNT
2022-06-24	CIP213
2022-06-24	CIP214
2022-06-24	CIP224
2022-06-24	CIP224/ UNDER-DIRECTION-OF-PROV-NPI
2022-06-24	CIP225
2022-06-24	CIP225/ UNDER-DIRECTION-OF-PROV-TAXONOMY
2022-06-24	CIP226
2022-06-24	CIP226/ UNDER-SUPERVISION-OF-PROV-NPI
2022-06-24	CIP227
2022-06-24	CIP227/ UNDER-SUPERVISION-OF-PROV-TAXONOMY
2022-06-24	CIP249
2022-06-24	CIP249/ REVENUE-CENTER-QUANTITY-ACTUAL
2022-06-24	CIP250
2022-06-24	CIP250/ REVENUE-CENTER-QUANTITY-ALLOWED
2022-06-24	CIP253

2022-06-24	CIP253/ TPL-AMT
2022-06-24	CIP262
2022-06-24	CIP262/ SERVICING-PROV-TAXONOMY
2022-06-24	CIP270/ XIX-MBESCBES-CATEGORY-OF-SERVICE
2022-06-24	CIP278/ NDC-QUANTITY
2022-06-24	CIP290
2022-06-24	CIP290/ BEGINNING-DATE-OF-SERVICE

2022-06-24	CIP291
2022-06-24	CIP291/ ENDING-DATE-OF-SERVICE
2022-06-24	CIP292
2022-06-24	CIP292/ TOT-BENEFICIARY-COPAYMENT-LIABLE-AMOUNT
2022-06-24	CIP293
2022-06-24	CIP293/ TOT-BENEFICIARY-COINSURANCE-LIABLE-AMOUNT

2022-06-24	CIP294
2022-06-24	CIP294/ TOT-BENEFICIARY-DEDUCTIBLE-LIABLE-AMOUNT
2022-06-24	CIP295
2022-06-24	CIP295/ COMBINED-BENE-COST-SHARING-PAID-AMOUNT
2022-06-24	CIP296
2022-06-24	CIP296/ IHS-SERVICE-IND
2022-06-24	CLAIM-STATUS-CATEGORY
2022-06-24	CLT066
2022-06-24	CLT066/ TOT-COPAY-AMT
2022-06-24	CLT081
2022-06-24	CLT081/ NATIONAL-HEALTH-CARE-ENTITY-ID
2022-06-24	CLT137

2022-06-24	CLT137/ REFERRING-PROV-TAXONOMY
2022-06-24	CLT138
2022-06-24	CLT138/ REFERRING-PROV-TYPE
2022-06-24	CLT139
2022-06-24	CLT139/ REFERRING-PROV-SPECIALTY
2022-06-24	CLT143
2022-06-24	CLT143/ BMI
2022-06-24	CLT153
2022-06-24	CLT153/ TOT-BENEFICIARY-COINSURANCE-PAID-AMOUNT
2022-06-24	CLT155
2022-06-24	CLT155/ TOT-BENEFICIARY-COPAYMENT-PAID-AMOUNT
2022-06-24	CLT157
2022-06-24	CLT157/ TOT-BENEFICIARY-DEDUCTIBLE-PAID-AMOUNT
2022-06-24	CLT160
2022-06-24	CLT161
2022-06-24	CLT169
2022-06-24	CLT169/ UNDER-DIRECTION-OF-PROV-NPI
2022-06-24	CLT170
2022-06-24	CLT170/ UNDER-DIRECTION-OF-PROV-TAXONOMY

2022-06-24	CLT171
2022-06-24	CLT171/ UNDER-SUPERVISION-OF-PROV-NPI
2022-06-24	CLT172
2022-06-24	CLT172/ UNDER-SUPERVISION-OF-PROV-TAXONOMY
2022-06-24	CLT202
2022-06-24	CLT202/ REVENUE-CENTER-QUANTITY-ACTUAL
2022-06-24	CLT203
2022-06-24	CLT203/ REVENUE-CENTER-QUANTITY-ALLOWED
2022-06-24	CLT214
2022-06-24	CLT214/ SERVICING-PROV-TAXONOMY
2022-06-24	CLT224/ XIX-MBESCBES-CATEGORY-OF-SERVICE
2022-06-24	CLT230/ NDC-QUANTITY
2022-06-24	CLT239
2022-06-24	CLT239/ TOT-BENEFICIARY-COPAYMENT-LIABLE-AMOUNT

2022-06-24	CLT240
2022-06-24	CLT240/ TOT-BENEFICIARY-COINSURANCE-LIABLE-AMOUNT
2022-06-24	CLT241
2022-06-24	CLT241/ TOT-BENEFICIARY-DEDUCTIBLE-LIABLE-AMOUNT
2022-06-24	CLT242
2022-06-24	CLT242/ COMBINED-BENE-COST-SHARING-PAID-AMOUNT
2022-06-24	CLT243
2022-06-24	CLT243/ IHS-SERVICE-IND

2022-06-24	COMPOUND-DRUG-IND
2022-06-24	COT051
2022-06-24	COT051/ TOT-COPAY-AMT
2022-06-24	COT067
2022-06-24	COT067/ NATIONAL-HEALTH-CARE-ENTITY-ID
2022-06-24	COT119
2022-06-24	COT119/ REFERRING-PROV-TAXONOMY
2022-06-24	COT120
2022-06-24	COT120/ REFERRING-PROV-TYPE
2022-06-24	COT121
2022-06-24	COT121/ REFERRING-PROV-SPECIALTY
2022-06-24	COT125
2022-06-24	COT125/ BMI
2022-06-24	COT130
2022-06-24	COT130/ TOT-BENEFICIARY-COINSURANCE-PAID-AMOUNT
2022-06-24	COT132
2022-06-24	COT132/ TOT-BENEFICIARY-COPAYMENT-PAID-AMOUNT
2022-06-24	COT134
2022-06-24	COT134/ TOT-BENEFICIARY-DEDUCTIBLE-PAID-AMOUNT

2022-06-24	COT137
2022-06-24	COT138
2022-06-24	COT144
2022-06-24	COT144/ DATE-CAPITATED-AMOUNT-REQUESTED
2022-06-24	COT145
2022-06-24	COT145/ CAPITATED-PAYMENT-AMT-REQUESTED
2022-06-24	COT148
2022-06-24	COT148/ UNDER-DIRECTION-OF-PROV-NPI
2022-06-24	COT149
2022-06-24	COT149/ UNDER-DIRECTION-OF-PROV-TAXONOMY
2022-06-24	COT151
2022-06-24	COT151/ UNDER-SUPERVISION-OF-PROV-TAXONOMY
2022-06-24	COT176
2022-06-24	COT176/ BENEFICIARY-COPAYMENT-PAID-AMOUNT
2022-06-24	COT183
2022-06-24	COT183

2022-06-24	COT183
2022-06-24	COT184
2022-06-24	COT184
2022-06-24	COT184
2022-06-24	COT211/ XIX-MBESCBES-CATEGORY-OF-SERVICE
2022-06-24	COT220
2022-06-24	COT220/ HCPCS-RATE
2022-06-24	COT225/ NDC-QUANTITY
2022-06-24	COT228

2022-06-24	COT228/ ORDERING-PROV-NUM
2022-06-24	COT229
2022-06-24	COT229/ ORDERING-PROV-NPI-NUM
2022-06-24	COT230
2022-06-24	COT230/ TOT-BENEFICIARY-COPAYMENT-LIABLE-AMOUNT
2022-06-24	COT231
2022-06-24	COT231/ TOT-BENEFICIARY-COINSURANCE-LIABLE-AMOUNT
2022-06-24	COT232

2022-06-24	COT232/ TOT-BENEFICIARY-DEDUCTIBLE-LIABLE-AMOUNT
2022-06-24	COT233
2022-06-24	COT233/ COMBINED-BENE-COST-SHARING-PAID-AMOUNT
2022-06-24	COT234
2022-06-24	COT234/ IHS-SERVICE-IND
2022-06-24	COVERAGE-TYPE
2022-06-24	CRX042
2022-06-24	CRX042/ TOT-COPAY-AMT
2022-06-24	CRX057
2022-06-24	CRX057/ NATIONAL-HEALTH-CARE-ENTITY-ID
2022-06-24	CRX076
2022-06-24	CRX076/ PRESCRIBING-PROV-TAXONOMY
2022-06-24	CRX077
2022-06-24	CRX077/ PRESCRIBING-PROV-TYPE
2022-06-24	CRX078
2022-06-24	CRX078/ PRESCRIBING-PROV-SPECIALTY

2022-06-24	CRX087
2022-06-24	CRX087/ TOT-BENEFICIARY-COINSURANCE-PAID-AMOUNT
2022-06-24	CRX089
2022-06-24	CRX089/ TOT-BENEFICIARY-COPAYMENT-PAID-AMOUNT
2022-06-24	CRX092
2022-06-24	CRX092/ TOT-BENEFICIARY-DEDUCTIBLE-PAID-AMOUNT
2022-06-24	CRX095
2022-06-24	CRX096
2022-06-24	CRX103
2022-06-24	CRX103/ DISPENSING-PRESCRIPTION-DRUG-PROV-TAXONOMY
2022-06-24	CRX123
2022-06-24	CRX123/ BENEFICIARY-COPAYMENT-PAID-AMOUNT
2022-06-24	CRX131

2022-06-24	CRX131
2022-06-24	CRX131
2022-06-24	CRX131
2022-06-24	CRX132
2022-06-24	CRX132
2022-06-24	CRX132
2022-06-24	CRX141
2022-06-24	CRX141/ DISPENSE-FEE-SUBMITTED
2022-06-24	CRX150/ XIX-MBESCBES-CATEGORY-OF-SERVICE
2022-06-24	CRX162
2022-06-24	CRX162/ PRESCRIPTION-ORIGIN-CODE
2022-06-24	CRX163

2022-06-24	CRX163/ TOT-BENEFICIARY-COPAYMENT-LIABLE-AMOUNT
2022-06-24	CRX164
2022-06-24	CRX164/ TOT-BENEFICIARY-COINSURANCE-LIABLE-AMOUNT
2022-06-24	CRX165
2022-06-24	CRX165/ TOT-BENEFICIARY-DEDUCTIBLE-LIABLE-AMOUNT
2022-06-24	CRX166
2022-06-24	CRX166/ COMBINED-BENE-COST-SHARING-PAID-AMOUNT

2022-06-24	CRX167
2022-06-24	CRX167/ INGREDIENT-COST-SUBMITTED
2022-06-24	CRX168
2022-06-24	CRX168/ INGREDIENT-COST-PAID-AMT
2022-06-24	CRX169
2022-06-24	CRX169/ DISPENSE-FEE-PAID-AMT
2022-06-24	CRX170
2022-06-24	CRX170/ PROFESSIONAL-SERVICE-FEE-SUBMITTED
2022-06-24	CRX171

2022-06-24	CRX171/ PROFESSIONAL-SERVICE-FEE-PAID-AMT
2022-06-24	CRX172
2022-06-24	CRX172/ IHS-SERVICE-IND
2022-06-24	DATE-OF-BIRTH
2022-06-24	DATE-OF-BIRTH
2022-06-24	DESTINATION-STATE
2022-06-24	DESTINATION-ZIP-CODE
2022-06-24	DIAGNOSIS-RELATED-GROUP-IND

2022-06-24	DISABILITY-TYPE-CODE
2022-06-24	DISPENSE-FEE
2022-06-24	DISPENSING-PRESCRIPTION-DRUG-PROV-NPI
2022-06-24	DRG-DESCRIPTION
2022-06-24	DRG-OUTLIER-AMT
2022-06-24	DRG-REL-WEIGHT

2022-06-24	DRUG-UTILIZATION-CODE
2022-06-24	ELG-IDENTIFIER-ISSUING-ENTITY-ID
2022-06-24	ELG045
2022-06-24	ELG045/ ENGL-PROF-CODE
2022-06-24	ELG065
2022-06-24	ELG095
2022-06-24	ELG108
2022-06-24	ELG119
2022-06-24	ELG194
2022-06-24	ELG194/ NATIONAL-HEALTH-CARE-ENTITY-ID
2022-06-24	ELG195
2022-06-24	ELG195/ NATIONAL-HEALTH-CARE-ENTITY-ID-TYPE
2022-06-24	ELG215
2022-06-24	ELG215/AMERICAN-INDIAN-ALASKA-NATIVE-INDICATOR

2022-06-24	ELG269
2022-06-24	ELG269/ ELIGIBLE-FEDERAL-POVERTY-LEVEL-PERCENTAGE
2022-06-24	ELG270
2022-06-24	ELG270/ LOCKED-IN-SRVCS
2022-06-24	ELG271
2022-06-24	ELG271/ ETHNICITY-OTHER
2022-06-24	HEALTH-HOME-CHRONIC-CONDITION-OTHER-EXPLANATION
2022-06-24	HEALTH-HOME-ENTITY-EFF-DATE
2022-06-24	HEALTH-HOME-ENTITY-EFF-DATE

2022-06-24	HEALTH-HOME-PROVIDER-NPI
2022-06-24	IMMIGRATION-STATUS-FIVE-YEAR-BAR-END-DATE
2022-06-24	IP-LT-QUANTITY-OF-SERVICE-ALLOWED
2022-06-24	LEVEL-OF-CARE-STATUS
2022-06-24	LICENSE-OR-ACCREDITATION-NUMBER
2022-06-24	LICENSE-TYPE

2022-06-24	LOCKIN-PROV-NUM
2022-06-24	LOCKIN-PROV-TYPE
2022-06-24	LTSS-LEVEL-CARE
2022-06-24	LTSS-PROV-NUM
2022-06-24	MARITAL-STATUS-OTHER-EXPLANATION
2022-06-24	MCR091/ RECORD-ID, MCR092/ SUBMITTING-STATE, MCR093/ RECORD-NUMBER, MCR094/ STATE-PLAN-ID-NUM, MCR095/ NATIONAL-HEALTH-CARE-ENTITY-ID, MCR096/ NATIONAL-HEALTH-CARE-ENTITY-ID-TYPE, MCR097/ NATIONAL-HEALTH-CARE-ENTITY-NAME, MCR098/ NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-EFF-DATE, MCR099/ NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-END-DATE, MCR0100/ STATE-NOTATION, MCR0101/ FILLER

2022-06-24	MCR102/ RECORD-ID, MCR103/ SUBMITTING-STATE, MCR104/ RECORD-NUMBER, MCR105/ STATE-PLAN-ID-NUM, MCR106/ CHPID, MCR107/ SHPID, MCR108/ CHPID-SHPID-RELATIONSHIP-EFF-DATE, MCR109/ CHPID-SHPID-RELATIONSHIP-END-DATE, MCR110/ STATE-NOTATION, MCR111/ FILLER
2022-06-24	MEDICARE-COINS-AMT
2022-06-24	MEDICARE-DEDUCTIBLE-AMT
2022-06-24	MFP-QUALIFIED-RESIDENCE

2022-06-24	MFP-REASON-PARTICIPATION-ENDED
2022-06-24	N/A
2022-06-24	NON-COV-DAYS
2022-06-24	NON-COV-DAYS
2022-06-24	OPERATING-PROV-NPI-NUM
2022-06-24	ORIGINATION-ADDR-LN2
2022-06-24	ORIGINATION-STATE
2022-06-24	OUTLIER-CODE

2022-06-24	POLICY-OWNER-FIRST-NAME
2022-06-24	POLICY-OWNER-LAST-NAME
2022-06-24	PRESCRIBING-PROV-NPI-NUM
2022-06-24	PRIMARY-LANGUAGE-ENGL-PROF-CODE
2022-06-24	PROCEDURE-CODE-1
2022-06-24	PROV-IDENTIFIER
2022-06-24	PROV-IDENTIFIER-ISSUING-ENTITY-ID
2022-06-24	PROV-LOCATION-ID

2022-06-24	PROV-LOCATION-ID
2022-06-24	PROV-LOCATION-ID
2022-06-24	PROV-LOCATION-ID
2022-06-24	PRV046
2022-06-24	PRV081/ PROV-IDENTIFIER
2022-06-24	PRV110/ SUBMITTING-STATE-PROV-ID-OF-AFFILIATED-ENTITY
2022-06-24	REASON-FOR-CHANGE
2022-06-24	REFERRING-PROV-NPI-NUM

2022-06-24	SERVICING-PROV-NPI-NUM
2022-06-24	SSI-IND
2022-06-24	SSI-STATE-SUPPLEMENT-STATUS-CODE
2022-06-24	SSI-STATUS
2022-06-24	STATE-SPEC-ELIG-GROUP
2022-06-24	TEACHING-IND
2022-06-24	TOT-COPAY-AMT

2022-06-24	TPL-ENTITY-ADDR-TYPE
2022-06-24	TPL092
2022-06-24	TPL092/ NATIONAL-HEALTH-CARE-ENTITY-ID-TYPE
2022-06-24	TPL093
2022-06-24	TPL093/ NATIONAL-HEALTH-CARE-ENTITY-ID
2022-06-24	TPL094
2022-06-24	TPL094/ NATIONAL-HEALTH-CARE-ENTITY-NAME
2022-06-24	TYPE-OF-OTHER-THIRD-PARTY-LIABILITY
2022-07-15	CIP100
2022-07-15	CIP104
2022-07-15	CIP112

2022-07-15	CIP113
2022-07-15	CIP114
2022-07-15	CIP251
2022-07-15	CIP252

2022-07-15	CIP254
2022-07-15	CLT052
2022-07-15	CLT056
2022-07-15	CLT063
2022-07-15	CLT064

2022-07-15	CLT065
2022-07-15	CLT204
2022-07-15	CLT205
2022-07-15	CLT208

2022-07-15	COT033
2022-07-15	COT034
2022-07-15	COT037
2022-07-15	COT041

2022-07-15	COT048
2022-07-15	COT049
2022-07-15	COT050
2022-07-15	COT066

2022-07-15	COT112
2022-07-15	COT113
2022-07-15	COT166
2022-07-15	COT167
2022-07-15	COT174

2022-07-15	COT175
2022-07-15	COT178
2022-07-15	COT186
2022-07-15	CRX029
2022-07-15	CRX032

2022-07-15	CRX039
2022-07-15	CRX040
2022-07-15	CRX041
2022-07-15	CRX121

2022-07-15	CRX122
2022-07-15	CRX125
2022-08-05	CIP194
2022-08-05	CIP202
2022-08-05	CLT144
2022-08-05	COT126

2022-08-05	CRX081
2022-08-26	CIP132

2022-08-26	CLT082

2022-08-26	COT068

2022-08-26	CRX058
2022-08-26	ELG252

2022-10-07	CIP293, CLT240, COT231, CRX164
2022-10-07	CIP294, CLT241, COT232, CRX165
2022-10-07	ELG040
2022-10-07	PRV024

2022-10-28	CIP099, CLT051, COT036, CRX028
2022-10-28	ELG095
2022-11-18	ELG097
2022-11-18	ELG270
2022-11-18	MCR020

2022-12-30	IHS-SERVICE-IND (CIP296, CLT243, COT234, CRX172)
2023-01-05	CIP.002.099
2023-01-05	CLT.002.051
2023-01-05	COT.002.036
2023-01-05	CRX.002.028
2023-01-09	ELG.005.095
2023-01-26	PRV.006.088

2023-02-16	CIP.003.296
2023-02-16	CIP.003.296
2023-02-16	CLT.003.243
2023-02-16	CLT.003.243
2023-02-16	COT.003.234
2023-02-16	COT.003.234
2023-02-16	CRX.003.172
2023-02-16	CRX.003.172
2023-02-23	CIP.002.099
2023-02-23	CIP.002.099
2023-03-10	ELG034
2023-03-10	ELG074

2023-03-10	ELG095
2023-03-24	CRX - CLAIM PRESCRIPTION
2023-03-24	CRX - CLAIM PRESCRIPTION
2023-05-10	ELG.003.038
2023-05-10	ELG.003.038
2023-05-31	CIP.002.126
2023-05-31	CIP.002.126
2023-05-31	CIP.003.257
2023-05-31	CLT.002.076
2023-05-31	CLT.002.076
2023-05-31	CLT.002.076
2023-05-31	CLT.003.211
2023-05-31	COT.002.062
2023-05-31	COT.002.062
2023-05-31	COT.002.228

2023-05-31	COT.002.229
2023-05-31	COT.003.186
2023-05-31	CRX.002.053
2023-05-31	CRX.002.053
2023-05-31	ELG.005.085

2023-05-31	ELG.005.085
2023-06-01	CIP.002.126
2023-06-01	CIP.002.127
2023-06-01	CLT.002.076
2023-06-01	CLT.002.077
2023-06-01	COT.002.062
2023-06-01	COT.002.063
2023-06-01	COT.002.229
2023-06-01	CRX.002.053
2023-06-01	CRX.002.054

2023-06-01	CRX.003.134
2023-06-02	CIP.002.126
2023-06-02	CIP.002.127
2023-06-02	CIP.003.257
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2023-06-02	CLT.002.076
2023-06-02	CLT.002.076
2023-06-02	CLT.002.077
2023-06-02	CLT.003.211
2023-06-02	COT.002.062
2023-06-02	COT.002.063
2023-06-02	COT.003.186

2023-06-02	CRX.002.053
2023-06-02	CRX.002.053
2023-06-02	CRX.002.054
2023-06-02	CRX.003.134
2023-06-14	CIP.002.132

2023-06-14	CLT.002.082

2023-06-14	COT.002.068

2023-06-14	CRX.002.058
2023-06-14	PRV.009.120

2023-06-21	ELG.003.034
2023-06-23	PRV120
2023-07-12	CIP.002.194
2023-07-12	CIP.002.194
2023-07-12	CIP.002.194
2023-07-12	CIP.002.202
2023-07-12	CIP.002.202

2023-07-12	CLT.002.144
2023-07-12	CLT.002.144
2023-07-12	COT.002.126
2023-07-12	COT.002.126
2023-07-12	CRX.002.081
2023-07-12	CRX.002.081
2023-07-12	ELG.003.040

2023-07-12	ELG.005.097
2023-07-12	ELG.005.097

2023-07-12	ELG.009.270
2023-07-13	CIP.002.022
2023-07-13	CIP.003.234
2023-07-13	CLT.002.022
2023-07-13	CLT.003.187
2023-07-13	COT.002.022
2023-07-13	COT.003.157
2023-07-13	CRX.002.022
2023-07-13	CRX.003.111

2023-07-13	ELG.002.019
2023-07-13	ELG.003.033
2023-07-13	ELG.004.064
2023-07-13	ELG.005.082
2023-07-13	ELG.006.106
2023-07-13	ELG.007.117
2023-07-13	ELG.008.129
2023-07-13	ELG.010.149
2023-07-13	ELG.011.162
2023-07-13	ELG.012.171
2023-07-13	ELG.013.181
2023-07-13	ELG.014.191
2023-07-13	ELG.015.203
2023-07-13	ELG.016.212

2023-07-13	ELG.017.223
2023-07-13	ELG.018.232
2023-07-13	ELG.020.241
2023-07-13	ELG.021.251
2023-07-13	ELG.022.260
2023-07-13	TPL.002.019
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2023-07-14	CIP194
2023-07-14	CIP202
2023-07-14	CIP234
2023-07-14	CIP234

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2023-07-14	CLT144
2023-07-14	CLT187
2023-07-14	CLT187
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2023-07-14	COT022
2023-07-14	COT126
2023-07-14	COT157
2023-07-14	COT157
2023-07-14	CRX022
2023-07-14	CRX022
2023-07-14	CRX081
2023-07-14	CRX111

2023-07-14	CRX111
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2023-07-14	ELG.003.269
2023-07-14	ELG.009.139
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2023-07-14	ELG019
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2023-07-14	ELG038
2023-07-14	ELG040
2023-07-14	ELG064
2023-07-14	ELG064
2023-07-14	ELG082
2023-07-14	ELG082
2023-07-14	ELG097
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2023-07-14	ELG129
2023-07-14	ELG139
2023-07-14	ELG139
2023-07-14	ELG149

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2023-07-14	ELG162
2023-07-14	ELG171
2023-07-14	ELG171
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2023-07-14	ELG191
2023-07-14	ELG191
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2023-07-14	ELG212
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2023-07-14	ELG223
2023-07-14	ELG232
2023-07-14	ELG232
2023-07-14	ELG241
2023-07-14	ELG241
2023-07-14	ELG251
2023-07-14	ELG251

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2023-07-14	ELG260
2023-07-14	ELG269
2023-07-14	ELG270
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2023-07-14	TPL066
2023-07-14	TPL066
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2023-08-01	CIP.002.139
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2023-08-01	CLT.002.075
2023-08-01	CLT.002.078
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2023-08-01	CLT.002.091
2023-08-01	CLT.002.151
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2023-08-01	COT.002.061

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2023-08-01	COT.002.072
2023-08-01	COT.002.073
2023-08-01	COT.002.128
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2023-08-01	CRX.002.061
2023-08-01	CRX.002.082
2023-08-01	CRX.002.160
2023-08-01	ELG.003.049
2023-08-01	ELG.005.086
2023-08-01	ELG.016.215
2023-08-01	ELG.018.233
2023-08-07	CIP.002.026

2023-08-07	CIP.002.212
2023-08-07	CIP.003.239
2023-08-07	CLT.002.025
2023-08-07	CLT.002.159
2023-08-07	CLT.003.192
2023-08-07	COT.002.025
2023-08-07	COT.002.136
2023-08-07	COT.003.162
2023-08-07	CRX.002.025
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2023-08-07	CRX.003.116
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2023-08-09	CIP.002.104

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2023-08-09	CIP.002.112
2023-08-09	CIP.002.113
2023-08-09	CIP.002.113
2023-08-09	CIP.002.114

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2023-08-09	CIP.003.251
2023-08-09	CIP.003.252
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2023-08-09	CIP.003.254
2023-08-09	CLT.002.052
2023-08-09	CLT.002.052
2023-08-09	CLT.002.056

2023-08-09	CLT.002.056
2023-08-09	CLT.002.063
2023-08-09	CLT.002.063
2023-08-09	CLT.002.064
2023-08-09	CLT.002.064
2023-08-09	CLT.002.065
2023-08-09	CLT.002.065
2023-08-09	CLT.003.204

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2023-08-09	CLT.003.205
2023-08-09	CLT.003.208
2023-08-09	CLT.003.208
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2023-08-09	COT.002.037
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2023-08-09	COT.002.041
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2023-08-09	COT.002.048
2023-08-09	COT.002.048
2023-08-09	COT.002.049
2023-08-09	COT.002.049

2023-08-09	COT.002.050
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2023-08-09	COT.002.112
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2023-08-09	COT.002.113
2023-08-09	COT.002.113
2023-08-09	COT.003.166
2023-08-09	COT.003.166
2023-08-09	COT.003.166

2023-08-09	COT.003.167
2023-08-09	COT.003.167
2023-08-09	COT.003.174
2023-08-09	COT.003.174
2023-08-09	COT.003.175
2023-08-09	COT.003.175
2023-08-09	COT.003.178
2023-08-09	COT.003.178
2023-08-09	CRX.002.029
2023-08-09	CRX.002.029
2023-08-09	CRX.002.032

2023-08-09	CRX.002.032
2023-08-09	CRX.002.039
2023-08-09	CRX.002.039
2023-08-09	CRX.002.040
2023-08-09	CRX.002.040
2023-08-09	CRX.002.041
2023-08-09	CRX.002.041
2023-08-09	CRX.003.121

2023-08-09	CRX.003.121
2023-08-09	CRX.003.122
2023-08-09	CRX.003.122
2023-08-09	CRX.003.125
2023-08-09	CRX.003.125
2023-08-09	ELG.004.074
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2023-08-10	COT.002.232
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2023-08-10	CRX.002.164
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2023-08-10	CRX.002.165
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2023-08-14	CIP.002.162
2023-08-14	CIP.002.163
2023-08-14	CIP.002.164
2023-08-14	CIP.002.165
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2023-08-14	CLT.002.114

2023-08-14	CLT.002.115
2023-08-14	CLT.002.116
2023-08-14	CLT.002.117
2023-08-14	CLT.002.118
2023-08-14	CLT.002.119
2023-08-14	CLT.002.120
2023-08-14	CLT.002.121
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2023-08-14	COT.002.098
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2023-08-14	COT.002.101

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2023-08-14	COT.003.179
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2023-08-14	COT.003.204
2023-08-14	COT.003.205
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2023-08-14	CRX.001.009
2023-08-14	CRX.001.010
2023-08-14	CRX.002.018

2023-08-14	CRX.002.060
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2023-08-14	ELG.004.067
2023-08-14	ELG.004.068
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2023-08-14	ELG.006.105
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2023-08-14	ELG.008.128
2023-08-14	ELG.009.138
2023-08-14	ELG.010.148
2023-08-14	ELG.011.161
2023-08-14	ELG.012.170
2023-08-14	ELG.013.180
2023-08-14	ELG.014.190
2023-08-14	ELG.015.202
2023-08-14	ELG.016.211
2023-08-14	ELG.017.222
2023-08-14	ELG.018.231
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2023-08-14	ELG.022.259

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2023-08-14	MCR.003.043
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2023-08-14	MCR.007.084
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2023-08-14	PRV.001.009

2023-08-14	PRV.001.010
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2023-08-14	PRV.003.048
2023-08-14	PRV.003.049
2023-08-14	PRV.004.062
2023-08-14	PRV.005.074
2023-08-14	PRV.006.086
2023-08-14	PRV.007.096
2023-08-14	PRV.008.108
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2023-08-15	CIP.002.178
2023-08-15	CIP.002.184
2023-08-15	CIP.003.245
2023-08-15	CIP.003.251
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2023-08-15	CLT.002.174
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2023-08-15	COT.003.175

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2023-08-15	TPL.005.065
2023-08-15	TPL.006.074

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2023-08-16	CIP.003.269
2023-08-16	CIP.003.269

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2023-08-21	COT.003.214
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2023-08-21	CRX.002.106

2023-08-21	CRX.003.153
2023-08-21	ELG.001.014
2023-08-21	ELG.002.028
2023-08-21	ELG.003.059
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2023-08-21	ELG.005.101
2023-08-21	ELG.006.112
2023-08-21	ELG.007.124
2023-08-21	ELG.008.134
2023-08-21	ELG.009.144
2023-08-21	ELG.010.157
2023-08-21	ELG.011.166
2023-08-21	ELG.012.176
2023-08-21	ELG.013.186
2023-08-21	ELG.014.198
2023-08-21	ELG.015.207
2023-08-21	ELG.016.218
2023-08-21	ELG.017.227
2023-08-21	ELG.018.236
2023-08-21	ELG.020.245
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2023-09-28	STATE-NOTATION/COT.004.285

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2023-09-28	PROVIDER-CLAIM-FORM-OTHER-TEXT/CRX.002.175
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2023-09-28	TOT-SDP-PAID-AMT/CRX.002.178

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2023-09-28	LINE-ADJUSTMENT-IND/CRX.003.116
2023-09-28	PRESCRIPTION-QUANTITY-ALLOWED/CRX.003.131

2023-09-28	PRESCRIPTION-QUANTITY-ACTUAL/CRX.003.132
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2023-09-28	ADJUDICATION-DATE/CRX.004.202
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2023-09-28	MSIS-IDENTIFICATION-NUM/ELG.003.033
2023-09-28	PREFERRED-LANGUAGE-CODE/ELG.003.046
2023-09-28	APPLICATION-SIGNATURE-DATE/ELG.003.273

2023-09-28	MSIS-IDENTIFICATION-NUM/ELG.004.064
2023-09-28	MSIS-IDENTIFICATION-NUM/ELG.005.082
2023-09-28	MEDICAID-BASIS-OF-ELIGIBILITY/ELG.005.084

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2023-09-28	UNIQUE-TRANSACTION-ID/FTX.009.323
2023-09-28	ADJUSTMENT-IND/FTX.009.324
2023-09-28	PAYMENT-OR-RECOUPMENT-DATE/FTX.009.325
2023-09-28	PAYMENT-OR-RECOUPMENT-AMOUNT/FTX.009.326

2023-09-28	CHECK-EFF-DATE/FTX.009.327
2023-09-28	CHECK-NUM/FTX.009.328
2023-09-28	PAYER-ID/FTX.009.329
2023-09-28	PAYER-ID-TYPE/FTX.009.330
2023-09-28	PAYER-ID-TYPE-OTHER-TEXT/FTX.009.331

2023-09-28	PAYEE-ID/FTX.009.332
2023-09-28	PAYEE-ID-TYPE /FTX.009.333
2023-09-28	PAYEE-ID-TYPE-OTHER-TEXT/FTX.009.334
2023-09-28	PAYEE-MCR-PLAN-TYPE/FTX.009.335

2023-09-28	PAYEE-MCR-PLAN-TYPE-OTHER-TEXT/FTX.009.336
2023-09-28	PAYEE-TAX-ID/FTX.009.337
2023-09-28	PAYEE-TAX-ID-TYPE/FTX.009.338
2023-09-28	PAYEE-TAX-ID-TYPE-OTHER-TEXT/FTX.009.339
2023-09-28	WRAP-PERIOD-START-DATE/FTX.009.340

2023-09-28	WRAP-PERIOD-END-DATE/FTX.009.341
2023-09-28	CATEGORY-FOR-FEDERAL-REIMBURSEMENT/ FTX.009.342
2023-09-28	MBESCBES-CATEGORY-OF-SERVICE/FTX.009.343
2023-09-28	MBESCBES-FORM/FTX.009.344

2023-09-28	MBESCBES-FORM-GROUP/FTX.009.345
2023-09-28	WAIVER-ID/FTX.009.346
2023-09-28	WAIVER-TYPE/FTX.009.347
2023-09-28	FUNDING-CODE/FTX.009.348
2023-09-28	FUNDING-SOURCE-NONFEDERAL-SHARE/ FTX.009.349

2023-09-28	SOURCE-LOCATION/FTX.009.350
2023-09-28	SPA-NUMBER/FTX.009.351
2023-09-28	EXPENDITURE-AUTHORITY-TYPE/FTX.009.352
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2023-09-28	RECORD-NUMBER/FTX.095.359
2023-09-28	ICN-ORIG/FTX.095.360

2023-09-28	ICN-ADJ/FTX.095.361
2023-09-28	UNIQUE-TRANSACTION-ID/FTX.095.362
2023-09-28	ADJUSTMENT-IND/FTX.095.363
2023-09-28	PAYMENT-OR-RECOUPMENT-DATE/FTX.095.364
2023-09-28	PAYMENT-OR-RECOUPMENT-AMOUNT/FTX.095.365

2023-09-28	CHECK-EFF-DATE/FTX.095.366
2023-09-28	CHECK-NUM/FTX.095.367
2023-09-28	PAYER-ID/FTX.095.368
2023-09-28	PAYER-ID-TYPE/FTX.095.369
2023-09-28	PAYER-ID-TYPE-OTHER-TEXT/FTX.095.370

2023-09-28	PAYER-MCR-PLAN-TYPE/FTX.095.371
2023-09-28	PAYER-MCR-PLAN-TYPE-OTHER-TEXT/FTX.095.372
2023-09-28	PAYEE-ID/FTX.095.373
2023-09-28	PAYEE-ID-TYPE /FTX.095.374

2023-09-28	PAYEE-ID-TYPE-OTHER-TEXT/FTX.095.375
2023-09-28	PAYEE-MCR-PLAN-TYPE/FTX.095.376
2023-09-28	PAYEE-MCR-PLAN-TYPE-OTHER-TEXT/FTX.095.377
2023-09-28	PAYEE-TAX-ID/FTX.095.378
2023-09-28	PAYEE-TAX-ID-TYPE/FTX.095.379

2023-09-28	PAYEE-TAX-ID-TYPE-OTHER-TEXT/FTX.095.380
2023-09-28	CONTRACT-ID/FTX.095.381
2023-09-28	INSURANCE-CARRIER-ID-NUM/FTX.095.382
2023-09-28	MSIS-IDENTIFICATION-NUM/FTX.095.383
2023-09-28	PAYMENT-PERIOD-BEGIN-DATE/FTX.095.384

2023-09-28	PAYMENT-PERIOD-END-DATE/FTX.095.385
2023-09-28	PAYMENT-PERIOD-TYPE/FTX.095.386
2023-09-28	PAYMENT-PERIOD-TYPE-OTHER-TEXT/FTX.095.387
2023-09-28	TRANSACTION-TYPE/FTX.095.388
2023-09-28	TRANSACTION-TYPE-OTHER-TEXT/FTX.095.389
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2023-09-28	MBESCBES-CATEGORY-OF-SERVICE/FTX.095.391
2023-09-28	MBESCBES-FORM/FTX.095.392
2023-09-28	MBESCBES-FORM-GROUP/FTX.095.393
2023-09-28	WAIVER-ID/FTX.095.394

2023-09-28	WAIVER-TYPE/FTX.095.395
2023-09-28	FUNDING-CODE/FTX.095.396
2023-09-28	FUNDING-SOURCE-NONFEDERAL-SHARE/ FTX.095.397
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2023-09-28	SOURCE-LOCATION/FTX.095.399

2023-09-28	SPA-NUMBER/FTX.095.400
2023-09-28	PAYMENT-CAT-XREF/FTX.095.401
2023-09-28	EXPENDITURE-AUTHORITY-TYPE/FTX.095.402
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2023-09-28	STATE-NOTATION /FTX.095.405
2023-09-28	FILE-SUBMISSION-METHOD/MCR.001.113
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2023-09-28	SUBMITTING-STATE/MCR.010.115
2023-09-28	RECORD-NUMBER/MCR.010.116
2023-09-28	STATE-PLAN-ID-NUM/MCR.010.117

2023-09-28	MANAGED-CARE-PLAN-ID-TYPE/MCR.010.118
2023-09-28	MANAGED-CARE-PLAN-ID/MCR.010.119
2023-09-28	MANAGED-CARE-ID-EFF-DATE/MCR.010.120
2023-09-28	MANAGED-CARE-ID-END-DATE/MCR.010.121
2023-09-28	STATE-NOTATION/MCR.010.122

2023-09-28	FILE-SUBMISSION-METHOD/PRV.001.139
2023-09-28	ATYPICAL-PROV-IND/PRV.002.140
2023-09-28	FILE-SUBMISSION-METHOD/TPL.001.095
2023-09-28	MSIS-IDENTIFICATION-NUM/TPL.002.019

2023-09-28	MSIS-IDENTIFICATION-NUM/TPL.003.032
2023-09-28	MSIS-IDENTIFICATION-NUM/TPL.005.066
2024-04-12	DATA-DICTIONARY-VERSION/CIP.001.002

2024-04-12	FILE-NAME/CIP.001.006
2024-04-12	ICN-ADJ/CIP.002.020
2024-04-12	MSIS-IDENTIFICATION-NUM/CIP.002.022

2024-04-12	CROSSOVER-INDICATOR/CIP.002.023
2024-04-12	ADJUSTMENT-IND/CIP.002.026
2024-04-12	PROCEDURE-CODE-1/CIP.002.070

2024-04-12	PROCEDURE-CODE-2/CIP.002.074
2024-04-12	PROCEDURE-CODE-3/CIP.002.078

2024-04-12	PROCEDURE-CODE-4/CIP.002.082
2024-04-12	PROCEDURE-CODE-5/CIP.002.086

2024-04-12	PROCEDURE-CODE-6/CIP.002.090
2024-04-12	TYPE-OF-CLAIM/CIP.002.100

2024-04-12	SOURCE-LOCATION/CIP.002.104
2024-04-12	TOT-MEDICAID-PAID-AMT/CIP.002.114

2024-04-12	FUNDING-CODE/CIP.002.126
2024-04-12	FUNDING-SOURCE-NONFEDERAL-SHARE/ CIP.002.127
2024-04-12	MEDICAID-COV-INPATIENT-DAYS/CIP.002.136
2024-04-12	CLAIM-LINE-COUNT/CIP.002.137

2024-04-12	HEALTH-HOME-PROV-IND/CIP.002.176
2024-04-12	WAIVER-ID/CIP.002.178

2024-04-12	BILLING-PROV-NUM/CIP.002.179
2024-04-12	BILLING-PROV-NPI-NUM/CIP.002.180
2024-04-12	ADMITTING-PROV-NPI-NUM/CIP.002.184
2024-04-12	REFERRING-PROV-NPI-NUM/CIP.002.190

2024-04-12	SPLIT-CLAIM-IND/CIP.002.203
2024-04-12	HEALTH-HOME-PROVIDER-NPI/CIP.002.221
2024-04-12	BILLING-PROV-ADDR-LN-1/CIP.002.298
2024-04-12	BILLING-PROV-ADDR-LN-2/CIP.002.299
2024-04-12	BILLING-PROV-CITY/CIP.002.300
2024-04-12	BILLING-PROV-STATE/CIP.002.301

2024-04-12	BILLING-PROV-ZIP-CODE/CIP.002.302
2024-04-12	SERVICE-FACILITY-LOCATION-ORG-NPI/CIP.002.303
2024-04-12	SERVICE-FACILITY-LOCATION-ADDR-LN-1/ CIP.002.304
2024-04-12	SERVICE-FACILITY-LOCATION-ADDR-LN-2/ CIP.002.305
2024-04-12	SERVICE-FACILITY-LOCATION-CITY/CIP.002.306

2024-04-12	SERVICE-FACILITY-LOCATION-STATE/CIP.002.307
2024-04-12	SERVICE-FACILITY-LOCATION-ZIP-CODE/ CIP.002.308
2024-04-12	MSIS-IDENTIFICATION-NUM/CIP.003.234
2024-04-12	ICN-ADJ/CIP.003.236

2024-04-12	MEDICAID-PAID-AMT/CIP.003.254
2024-04-12	TYPE-OF-SERVICE/CIP.003.257
2024-04-12	SERVICING-PROV-NPI-NUM/CIP.003.261

2024-04-12	OPERATING-PROV-NPI-NUM/CIP.003.265
2024-04-12	IHS-SERVICE-IND/CIP.003.296
2024-04-12	MBESCBES-CATEGORY-OF-SERVICE/CIP.003.315

2024-04-12	MBESCBES-FORM/CIP.003.316
2024-04-12	REFERRING-PROV-NPI-NUM/CIP.003.319
2024-04-12	MBESCBES-FORM-GROUP/CIP.003.340
2024-04-12	RECORD-ID/CIP.004.322

2024-04-12	SUBMITTING-STATE/CIP.004.323
2024-04-12	ICN-ADJ/CIP.004.326
2024-04-12	ADJUSTMENT-IND/CIP.004.327
2024-04-12	DIAGNOSIS-SEQUENCE-NUMBER/CIP.004.330
2024-04-12	FILE-NAME/CLT.001.006

2024-04-12	ICN-ADJ/CLT.002.020
2024-04-12	MSIS-IDENTIFICATION-NUM/CLT.002.022
2024-04-12	CROSSOVER-INDICATOR/CLT.002.023

2024-04-12	ADJUSTMENT-IND/CLT.002.025
2024-04-12	TYPE-OF-CLAIM/CLT.002.052

2024-04-12	TOT-MEDICAID-PAID-AMT/CLT.002.065
2024-04-12	FUNDING-CODE/CLT.002.076
2024-04-12	MEDICAID-COV-INPATIENT-DAYS/CLT.002.086

2024-04-12	CLAIM-LINE-COUNT/CLT.002.087
2024-04-12	HEALTH-HOME-PROV-IND/CLT.002.127
2024-04-12	WAIVER-ID/CLT.002.129

2024-04-12	BILLING-PROV-NPI-NUM/CLT.002.131
2024-04-12	REFERRING-PROV-NPI-NUM/CLT.002.136
2024-04-12	SPLIT-CLAIM-IND/CLT.002.150
2024-04-12	HEALTH-HOME-PROVIDER-NPI/CLT.002.167
2024-04-12	ADMITTING-PROV-NPI-NUM/CLT.002.174

2024-04-12	BILLING-PROV-ADDR-LN-1/CLT.002.244
2024-04-12	BILLING-PROV-ADDR-LN-2/CLT.002.245
2024-04-12	BILLING-PROV-CITY/CLT.002.246
2024-04-12	BILLING-PROV-STATE/CLT.002.247
2024-04-12	BILLING-PROV-ZIP-CODE/CLT.002.248
2024-04-12	SERVICE-FACILITY-LOCATION-ORG-NPI/CLT.002.249

2024-04-12	SERVICE-FACILITY-LOCATION-ADDR-LN-1/ CLT.002.250
2024-04-12	SERVICE-FACILITY-LOCATION-ADDR-LN-2/ CLT.002.251
2024-04-12	SERVICE-FACILITY-LOCATION-CITY/CLT.002.252
2024-04-12	SERVICE-FACILITY-LOCATION-STATE/CLT.002.253
2024-04-12	SERVICE-FACILITY-LOCATION-ZIP-CODE/ CLT.002.254

2024-04-12	MSIS-IDENTIFICATION-NUM/CLT.003.187
2024-04-12	ICN-ADJ/CLT.003.189
2024-04-12	MEDICAID-PAID-AMT/CLT.003.208

2024-04-12	SERVICING-PROV-NPI-NUM/CLT.003.213
2024-04-12	CATEGORY-FOR-FEDERAL-REIMBURSEMENT/ CLT.003.219
2024-04-12	ADJUDICATION-DATE/CLT.003.233

2024-04-12	IHS-SERVICE-IND/CLT.003.243
2024-04-12	MBESCBES-CATEGORY-OF-SERVICE/CLT.003.261

2024-04-12	MBESCBES-FORM/CLT.003.262
2024-04-12	REFERRING-PROV-NPI-NUM/CLT.003.265
2024-04-12	MBESCBES-FORM-GROUP/CLT.003.282
2024-04-12	RECORD-ID/CLT.004.268

2024-04-12	ICN-ADJ/CLT.004.272
2024-04-12	ADJUSTMENT-IND/CLT.004.273
2024-04-12	DIAGNOSIS-SEQUENCE-NUMBER/CLT.004.276
2024-04-12	ICN-ADJ/COT.002.020

2024-04-12	MSIS-IDENTIFICATION-NUM/COT.002.022
2024-04-12	CROSSOVER-INDICATOR/COT.002.023
2024-04-12	ADJUSTMENT-IND/COT.002.025

2024-04-12	TYPE-OF-CLAIM/COT.002.037
2024-04-12	SOURCE-LOCATION/COT.002.041

2024-04-12	TOT-BILLED-AMT/COT.002.048
2024-04-12	TOT-MEDICAID-PAID-AMT/COT.002.050

2024-04-12	OTHER-INSURANCE-IND/COT.002.057
2024-04-12	FUNDING-CODE/COT.002.062
2024-04-12	FUNDING-SOURCE-NONFEDERAL-SHARE/ COT.002.063

2024-04-12	PLAN-ID-NUMBER/COT.002.066
2024-04-12	CLAIM-LINE-COUNT/COT.002.070

2024-04-12	HEALTH-HOME-PROV-IND/COT.002.109
2024-04-12	WAIVER-ID/COT.002.111

2024-04-12	BILLING-PROV-NUM/COT.002.112
2024-04-12	BILLING-PROV-NPI-NUM/COT.002.113
2024-04-12	BILLING-PROV-TAXONOMY/COT.002.114

2024-04-12	REFERRING-PROV-NPI-NUM/COT.002.118
2024-04-12	HEALTH-HOME-PROVIDER-NPI/COT.002.146
2024-04-12	BILLING-PROV-ADDR-LN-1/COT.002.236
2024-04-12	BILLING-PROV-ADDR-LN-2/COT.002.237
2024-04-12	BILLING-PROV-CITY/COT.002.238
2024-04-12	BILLING-PROV-STATE/COT.002.239

2024-04-12	BILLING-PROV-ZIP-CODE/COT.002.240
2024-04-12	SERVICE-FACILITY-LOCATION-ORG-NPI/ COT.002.241
2024-04-12	SERVICE-FACILITY-LOCATION-ADDR-LN-1/ COT.002.242
2024-04-12	SERVICE-FACILITY-LOCATION-ADDR-LN-2/ COT.002.243
2024-04-12	SERVICE-FACILITY-LOCATION-CITY/COT.002.244

2024-04-12	SERVICE-FACILITY-LOCATION-STATE/COT.002.245
2024-04-12	SERVICE-FACILITY-LOCATION-ZIP-CODE/ COT.002.246
2024-04-12	REFERRING-PROV-NUM-2/COT.002.250
2024-04-12	REFERRING-PROV-NPI-NUM-2/COT.002.251

2024-04-12	MSIS-IDENTIFICATION-NUM/COT.003.157
2024-04-12	ICN-ADJ/COT.003.159
2024-04-12	PROCEDURE-CODE/COT.003.169

2024-04-12	PROCEDURE-CODE-MOD-1/COT.003.172
2024-04-12	MEDICAID-PAID-AMT/COT.003.178
2024-04-12	TYPE-OF-SERVICE/COT.003.186

2024-04-12	SERVICING-PROV-NPI-NUM/COT.003.190
2024-04-12	ORIGINATION-ZIP-CODE/COT.003.203
2024-04-12	DESTINATION-ZIP-CODE/COT.003.208
2024-04-12	CATEGORY-FOR-FEDERAL-REIMBURSEMENT/ COT.003.210

2024-04-12	PROCEDURE-CODE-MOD-3/COT.003.218
2024-04-12	PROCEDURE-CODE-MOD-4/COT.003.219
2024-04-12	PROCEDURE-CODE-MOD-2/COT.003.227
2024-04-12	IHS-SERVICE-IND/COT.003.234

2024-04-12	MBESCBES-CATEGORY-OF-SERVICE/COT.003.256
2024-04-12	MBESCBES-FORM/COT.003.257

2024-04-12	SERVICE-FACILITY-LOCATION-ORG-NPI/ COT.003.258
2024-04-12	SERVICE-FACILITY-LOCATION-ADDR-LN-1/ COT.003.259
2024-04-12	SERVICE-FACILITY-LOCATION-ADDR-LN-2/ COT.003.260
2024-04-12	SERVICE-FACILITY-LOCATION-CITY/COT.003.261
2024-04-12	SERVICE-FACILITY-LOCATION-STATE/COT.003.262

2024-04-12	SERVICE-FACILITY-LOCATION-ZIP-CODE/ COT.003.263
2024-04-12	REFERRING-PROV-NUM/COT.003.266
2024-04-12	REFERRING-PROV-NPI-NUM/COT.003.267
2024-04-12	REFERRING-PROV-NUM-2/COT.003.268

2024-04-12	REFERRING-PROV-NPI-NUM-2/COT.003.269
2024-04-12	ORDERING-PROV-NPI-NUM/COT.003.271
2024-04-12	MBESCBES-FORM-GROUP/COT.003.290
2024-04-12	RECORD-ID/COT.004.274

2024-04-12	ICN-ADJ/COT.004.278
2024-04-12	ADJUSTMENT-IND/COT.004.279
2024-04-12	DIAGNOSIS-SEQUENCE-NUMBER/COT.004.282
2024-04-12	DATA-DICTIONARY-VERSION/CRX.001.002
2024-04-12	FILE-NAME/CRX.001.006

2024-04-12	ICN-ADJ/CRX.002.020
2024-04-12	MSIS-IDENTIFICATION-NUM/CRX.002.022
2024-04-12	CROSSOVER-INDICATOR/CRX.002.023

2024-04-12	ADJUSTMENT-IND/CRX.002.025
2024-04-12	TYPE-OF-CLAIM/CRX.002.029
2024-04-12	SOURCE-LOCATION/CRX.002.032

2024-04-12	TOT-MEDICAID-PAID-AMT/CRX.002.041
2024-04-12	OTHER-INSURANCE-IND/CRX.002.048
2024-04-12	FUNDING-CODE/CRX.002.053

2024-04-12	FUNDING-SOURCE-NONFEDERAL-SHARE/ CRX.002.054
2024-04-12	CLAIM-LINE-COUNT/CRX.002.060
2024-04-12	HEALTH-HOME-PROV-IND/CRX.002.067

2024-04-12	WAIVER-ID/CRX.002.069
2024-04-12	BILLING-PROV-NUM/CRX.002.070

2024-04-12	BILLING-PROV-NPI-NUM/CRX.002.071
2024-04-12	PRESCRIBING-PROV-NPI-NUM/CRX.002.075
2024-04-12	DISPENSING-PRESCRIPTION-DRUG-PROV-NPI/ CRX.002.102
2024-04-12	HEALTH-HOME-PROVIDER-NPI/CRX.002.104

2024-04-12	PRESCRIPTION-ORIGIN-CODE/CRX.002.162
2024-04-12	MSIS-IDENTIFICATION-NUM/CRX.003.111
2024-04-12	ICN-ADJ/CRX.003.113

2024-04-12	MEDICAID-PAID-AMT/CRX.003.125
2024-04-12	PRESCRIPTION-QUANTITY-ACTUAL/CRX.003.132
2024-04-12	UNIT-OF-MEASURE/CRX.003.133
2024-04-12	TYPE-OF-SERVICE/CRX.003.134

2024-04-12	CATEGORY-FOR-FEDERAL-REIMBURSEMENT/ CRX.003.149
2024-04-12	IHS-SERVICE-IND/CRX.003.172

2024-04-12	MBESCBES-CATEGORY-OF-SERVICE/CRX.003.180
2024-04-12	MBESCBES-FORM/CRX.003.181

2024-04-12	PROCEDURE-CODE-MOD-1/CRX.003.183
2024-04-12	PROCEDURE-CODE-MOD-2/CRX.003.184
2024-04-12	PROCEDURE-CODE-MOD-3/CRX.003.185
2024-04-12	PROCEDURE-CODE-MOD-4/CRX.003.186
2024-04-12	PROCEDURE-CODE-MOD-5/CRX.003.187

2024-04-12	PROCEDURE-CODE-MOD-6/CRX.003.188
2024-04-12	PROCEDURE-CODE-MOD-7/CRX.003.189
2024-04-12	PROCEDURE-CODE-MOD-8/CRX.003.190
2024-04-12	PROCEDURE-CODE-MOD-9/CRX.003.191
2024-04-12	PROCEDURE-CODE-MOD-10/CRX.003.192

2024-04-12	MBESCBES-FORM-GROUP/CRX.003.209
2024-04-12	RECORD-ID/CRX.004.196
2024-04-12	ICN-ADJ/CRX.004.200
2024-04-12	ADJUSTMENT-IND/CRX.004.201

2024-04-12	DIAGNOSIS-SEQUENCE-NUMBER/CRX.004.204
2024-04-12	DATA-DICTIONARY-VERSION/ELG.001.002
2024-04-12	SUBMISSION-TRANSACTION-TYPE/ELG.001.003
2024-04-12	FILE-NAME/ELG.001.006
2024-04-12	MSIS-IDENTIFICATION-NUM/ELG.002.019

2024-04-12	MSIS-IDENTIFICATION-NUM/ELG.003.033
2024-04-12	VETERAN-IND/ELG.003.039
2024-04-12	CITIZENSHIP-IND/ELG.003.040

2024-04-12	IMMIGRATION-STATUS-FIVE-YEAR-BAR-END-DATE/ ELG.003.044
2024-04-12	ELIGIBLE-FEDERAL-POVERTY-LEVEL-PERCENTAGE/ ELG.003.269
2024-04-12	APPLICATION-SIGNATURE-DATE/ELG.003.273

2024-04-12	MSIS-IDENTIFICATION-NUM/ELG.004.064
2024-04-12	ELIGIBLE-ZIP-CODE/ELG.004.071
2024-04-12	MSIS-IDENTIFICATION-NUM/ELG.005.082
2024-04-12	SSDI-IND/ELG.005.089

2024-04-12	SSI-IND/ELG.005.090
2024-04-12	CONCEPTION-TO-BIRTH-IND/ELG.005.094
2024-04-12	ELIGIBILITY-REDETERMINTATION-DATE/ ELG.005.274
2024-04-12	CONTINUOUS-ELIGIBILITY-CODE/ELG.005.277

2024-04-12	ELIGIBILITY-TERMINATION-REASON-OTHER-TYPE-TEXT/ELG.005.281
2024-04-12	MSIS-IDENTIFICATION-NUM/ELG.006.106
2024-04-12	MSIS-IDENTIFICATION-NUM/ELG.007.117

2024-04-12	MSIS-IDENTIFICATION-NUM/ELG.008.129
2024-04-12	MSIS-IDENTIFICATION-NUM/ELG.009.139
2024-04-12	LOCKED-IN-SRVCS/ELG.009.270

2024-04-12	MSIS-IDENTIFICATION-NUM/ELG.010.149
2024-04-12	MSIS-IDENTIFICATION-NUM/ELG.011.162
2024-04-12	MSIS-IDENTIFICATION-NUM/ELG.012.171

2024-04-12	WAIVER-ID/ELG.012.172
2024-04-12	MSIS-IDENTIFICATION-NUM/ELG.013.181

2024-04-12	MSIS-IDENTIFICATION-NUM/ELG.014.191
2024-04-12	MANAGED-CARE-PLAN-ID/ELG.014.192

2024-04-12	MANAGED-CARE-PLAN-TYPE/ELG.014.193
2024-04-12	MSIS-IDENTIFICATION-NUM/ELG.015.203

2024-04-12	MSIS-IDENTIFICATION-NUM/ELG.016.212
2024-04-12	MSIS-IDENTIFICATION-NUM/ELG.017.223
2024-04-12	MSIS-IDENTIFICATION-NUM/ELG.018.232

2024-04-12	MSIS-IDENTIFICATION-NUM/ELG.020.241
2024-04-12	MSIS-IDENTIFICATION-NUM/ELG.021.251
2024-04-12	MSIS-IDENTIFICATION-NUM/ELG.022.260

2024-04-12	RECORD-ID/ELG.023.282
2024-04-12	SUBMITTING-STATE/ELG.023.283
2024-04-12	RECORD-NUMBER/ELG.023.284
2024-04-12	MSIS-IDENTIFICATION-NUM/ELG.023.285

2024-04-12	SEX-ASSIGNED-AT-BIRTH/ELG.023.286
2024-04-12	SEX-ASSIGNED-AT-BIRTH-OTHER-TEXT/ ELG.023.287
2024-04-12	GENDER-IDENTITY/ELG.023.288
2024-04-12	GENDER-IDENTITY-OTHER-TEXT/ELG.023.289

2024-04-12	SEXUAL-ORIENTATION/ELG.023.290
2024-04-12	SEXUAL-ORIENTATION-OTHER-TEXT/ELG.023.291
2024-04-12	SOGI-EFF-DATE/ELG.023.292
2024-04-12	SOGI-END-DATE/ELG.023.293
2024-04-12	STATE-NOTATION/ELG.023.294

2024-04-12	DATA-DICTIONARY-VERSION/FTX.001.002
2024-04-12	FILE-NAME/FTX.001.006
2024-04-12	ICN-ORIG/FTX.002.020
2024-04-12	ICN-ADJ/FTX.002.021
2024-04-12	UNIQUE-TRANSACTION-ID/FTX.002.022

2024-04-12	ADJUSTMENT-IND/FTX.002.023
2024-04-12	CHECK-EFF-DATE/FTX.002.026
2024-04-12	PAYER-ID/FTX.002.028
2024-04-12	PAYER-ID-TYPE/FTX.002.029

2024-04-12	PAYEE-ID/FTX.002.033
2024-04-12	PAYEE-ID-TYPE /FTX.002.034

2024-04-12	PAYEE-TAX-ID/FTX.002.038
2024-04-12	PAYEE-TAX-ID-TYPE/FTX.002.039
2024-04-12	PAYEE-TAX-ID-TYPE-OTHER-TEXT/FTX.002.040

2024-04-12	MSIS-IDENTIFICATION-NUM/FTX.002.042
2024-04-12	CATEGORY-FOR-FEDERAL-REIMBURSEMENT/ FTX.002.045

2024-04-12	MBESCBES-CATEGORY-OF-SERVICE/FTX.002.046
2024-04-12	MBESCBES-FORM/FTX.002.047

2024-04-12	MBESCBES-FORM-GROUP/FTX.002.048
2024-04-12	WAIVER-ID/FTX.002.049
2024-04-12	FUNDING-CODE/FTX.002.051

2024-04-12	SPA-NUMBER/FTX.002.055
2024-04-12	RECORD-ID/FTX.003.064
2024-04-12	ICN-ORIG/FTX.003.067
2024-04-12	ICN-ADJ/FTX.003.068

2024-04-12	UNIQUE-TRANSACTION-ID/FTX.003.069
2024-04-12	ADJUSTMENT-IND/FTX.003.070
2024-04-12	PAYER-ID/FTX.003.075
2024-04-12	PAYER-ID-TYPE/FTX.003.076

2024-04-12	PAYEE-ID/FTX.003.078
2024-04-12	PAYEE-ID-TYPE /FTX.003.079

2024-04-12	PAYEE-TAX-ID/FTX.003.081
2024-04-12	INSURANCE-CARRIER-ID-NUM/FTX.003.084
2024-04-12	INSURANCE-PLAN-ID/FTX.003.085

2024-04-12	MSIS-IDENTIFICATION-NUM/FTX.003.086
2024-04-12	MEMBER-ID/FTX.003.087

2024-04-12	MBESCBES-CATEGORY-OF-SERVICE/FTX.003.091
2024-04-12	MBESCBES-FORM/FTX.003.092

2024-04-12	WAIVER-ID/FTX.003.094
2024-04-12	SPA-NUMBER/FTX.003.099
2024-04-12	RECORD-ID/FTX.004.105

2024-04-12	ICN-ORIG/FTX.004.108
2024-04-12	ICN-ADJ/FTX.004.109
2024-04-12	UNIQUE-TRANSACTION-ID/FTX.004.110
2024-04-12	ADJUSTMENT-IND/FTX.004.111

2024-04-12	PAYER-ID/FTX.004.116
2024-04-12	PAYER-ID-TYPE/FTX.004.117
2024-04-12	PAYEE-ID/FTX.004.119

2024-04-12	PAYEE-ID-TYPE /FTX.004.120
2024-04-12	PAYEE-TAX-ID/FTX.004.122
2024-04-12	PAYEE-TAX-ID-TYPE/FTX.004.123

2024-04-12	PAYEE-TAX-ID-TYPE-OTHER-TEXT/FTX.004.124
2024-04-12	INSURANCE-CARRIER-ID-NUM/FTX.004.125
2024-04-12	INSURANCE-PLAN-ID/FTX.004.126

2024-04-12	MSIS-IDENTIFICATION-NUM/FTX.004.127
2024-04-12	SSN/FTX.004.128
2024-04-12	MEMBER-ID/FTX.004.129

2024-04-12	POLICY-OWNER-CODE/FTX.004.131
2024-04-12	MBESCBES-CATEGORY-OF-SERVICE/FTX.004.135

2024-04-12	MBESCBES-FORM/FTX.004.136
2024-04-12	WAIVER-ID/FTX.004.138
2024-04-12	RECORD-ID/FTX.005.149

2024-04-12	ICN-ORIG/FTX.005.152
2024-04-12	ICN-ADJ/FTX.005.153
2024-04-12	UNIQUE-TRANSACTION-ID/FTX.005.154
2024-04-12	ADJUSTMENT-IND/FTX.005.155

2024-04-12	PAYER-ID/FTX.005.160
2024-04-12	PAYER-ID-TYPE/FTX.005.161
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2024-04-12	PAYEE-ID-TYPE /FTX.005.164
2024-04-12	PAYEE-TAX-ID/FTX.005.168
2024-04-12	PAYEE-TAX-ID-TYPE-OTHER-TEXT/FTX.005.170
2024-04-12	INSURANCE-PLAN-ID/FTX.005.172

2024-04-12	MSIS-IDENTIFICATION-NUM/FTX.005.173
2024-04-12	MBESCBES-CATEGORY-OF-SERVICE/FTX.005.177

2024-04-12	MBESCBES-FORM/FTX.005.178
2024-04-12	WAIVER-ID/FTX.005.180
2024-04-12	SPA-NUMBER/FTX.005.186

2024-04-12	RECORD-ID/FTX.006.192
2024-04-12	ICN-ORIG/FTX.006.195
2024-04-12	ICN-ADJ/FTX.006.196
2024-04-12	UNIQUE-TRANSACTION-ID/FTX.006.197
2024-04-12	ADJUSTMENT-IND/FTX.006.198

2024-04-12	PAYER-ID/FTX.006.203
2024-04-12	PAYER-ID-TYPE/FTX.006.204
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2024-04-12	PAYEE-ID-TYPE /FTX.006.207
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2024-04-12	MSIS-IDENTIFICATION-NUM/FTX.006.215
2024-04-12	MBESCBES-CATEGORY-OF-SERVICE/FTX.006.219

2024-04-12	MBESCBES-FORM/FTX.006.220
2024-04-12	WAIVER-ID/FTX.006.222
2024-04-12	SPA-NUMBER/FTX.006.228

2024-04-12	RECORD-ID/FTX.007.236
2024-04-12	ICN-ORIG/FTX.007.239
2024-04-12	ICN-ADJ/FTX.007.240
2024-04-12	UNIQUE-TRANSACTION-ID/FTX.007.241
2024-04-12	ADJUSTMENT-IND/FTX.007.242

2024-04-12	PAYER-ID/FTX.007.247
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2024-04-12	RECORD-ID/FTX.008.279
2024-04-12	ICN-ORIG/FTX.008.282

2024-04-12	ICN-ADJ/FTX.008.283
2024-04-12	UNIQUE-TRANSACTION-ID/FTX.008.284
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2024-04-12	ADJUSTMENT-IND/FTX.008.285
2024-04-12	CHECK-EFF-DATE/FTX.008.288

2024-04-12	PAYER-ID/FTX.008.290
2024-04-12	PAYER-ID-TYPE/FTX.008.291
2024-04-12	PAYEE-ID/FTX.008.293

2024-04-12	PAYEE-ID-TYPE /FTX.008.294
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2024-04-12	PAYEE-TAX-ID-TYPE-OTHER-TEXT/FTX.008.300

2024-04-12	MBESCBES-CATEGORY-OF-SERVICE/FTX.008.304
2024-04-12	MBESCBES-FORM/FTX.008.305

2024-04-12	WAIVER-ID/FTX.008.307
2024-04-12	SPA-NUMBER/FTX.008.312
2024-04-12	RECORD-ID/FTX.009.318

2024-04-12	ICN-ORIG/FTX.009.321
2024-04-12	ICN-ADJ/FTX.009.322
2024-04-12	UNIQUE-TRANSACTION-ID/FTX.009.323
2024-04-12	ADJUSTMENT-IND/FTX.009.324
2024-04-12	PAYER-ID/FTX.009.329

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2024-04-12	PAYEE-ID-TYPE /FTX.009.333
2024-04-12	PAYEE-TAX-ID/FTX.009.337

2024-04-12	MBESCBES-CATEGORY-OF-SERVICE/FTX.009.343
2024-04-12	MBESCBES-FORM/FTX.009.344

2024-04-12	WAIVER-ID/FTX.009.346
2024-04-12	RECORD-ID/FTX.095.357
2024-04-12	ICN-ORIG/FTX.095.360

2024-04-12	ICN-ADJ/FTX.095.361
2024-04-12	UNIQUE-TRANSACTION-ID/FTX.095.362
2024-04-12	ADJUSTMENT-IND/FTX.095.363
2024-04-12	PAYER-ID/FTX.095.368

2024-04-12	PAYER-ID-TYPE/FTX.095.369
2024-04-12	PAYEE-ID/FTX.095.373

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2024-04-12	PAYEE-TAX-ID/FTX.095.378
2024-04-12	INSURANCE-CARRIER-ID-NUM/FTX.095.382

2024-04-12	MSIS-IDENTIFICATION-NUM/FTX.095.383
2024-04-12	PAYMENT-PERIOD-TYPE/FTX.095.386

2024-04-12	MBESCBES-CATEGORY-OF-SERVICE/FTX.095.391
2024-04-12	MBESCBES-FORM/FTX.095.392

2024-04-12	WAIVER-ID/FTX.095.394
2024-04-12	SPA-NUMBER/FTX.095.400
2024-04-12	DATA-DICTIONARY-VERSION/MCR.001.002
2024-04-12	FILE-NAME/MCR.001.006

2024-04-12	DATE-FILE-CREATED/MCR.001.008
2024-04-12	MANAGED-CARE-CONTRACT-EFF-DATE/ MCR.002.020

2024-04-12	MANAGED-CARE-PLAN-TYPE/MCR.002.024
2024-04-12	PERCENT-BUSINESS/MCR.002.028

2024-04-12	MANAGED-CARE-SERVICE-AREA/MCR.002.029
2024-04-12	MANAGED-CARE-ZIP-CODE/MCR.003.047
2024-04-12	MANAGED-CARE-FAX-NUMBER/MCR.003.051

2024-04-12	MANAGED-CARE-SERVICE-AREA-NAME/ MCR.004.058
2024-04-12	OPERATING-AUTHORITY/MCR.005.067

2024-04-12	RECORD-ID/MCR.010.114
2024-04-12	MANAGED-CARE-PLAN-ID/MCR.010.119
2024-04-12	DATA-DICTIONARY-VERSION/PRV.001.002
2024-04-12	FILE-NAME/PRV.001.006

2024-04-12	FACILITY-GROUP-INDIVIDUAL-CODE/PRV.002.026
2024-04-12	ADDR-ZIP-CODE/PRV.003.052
2024-04-12	ADDR-BORDER-STATE-IND/PRV.003.056

2024-04-12	LICENSE-ISSUING-ENTITY-ID/PRV.004.068
2024-04-12	PROV-CLASSIFICATION-TYPE/PRV.006.088

2024-04-12	BED-COUNT/PRV.010.135
2024-04-12	DATA-DICTIONARY-VERSION/TPL.001.002
2024-04-12	FILE-NAME/TPL.001.006
2024-04-12	DATE-FILE-CREATED/TPL.001.008

2024-04-12	MSIS-IDENTIFICATION-NUM/TPL.002.019
2024-04-12	TPL-HEALTH-INSURANCE-COVERAGE-IND/ TPL.002.020
2024-04-12	MSIS-IDENTIFICATION-NUM/TPL.003.032

2024-04-12	MSIS-IDENTIFICATION-NUM/TPL.005.066
2024-04-12	INSURANCE-CARRIER-ZIP-CODE/TPL.006.082
2024-06-03	DATA-DICTIONARY-VERSION/CIP.001.002
2024-06-03	DATA-MAPPING-DOCUMENT-VERSION/CIP.001.005
2024-06-03	FUNDING-CODE/CIP.002.126

2024-06-03	MEDICAID-COV-INPATIENT-DAYS/CIP.002.136
2024-06-03	MEDICARE-HIC-NUM/CIP.002.196
2024-06-03	LINE-NUM-ORIG/CIP.003.237

2024-06-03	REVENUE-CENTER-QUANTITY-ACTUAL/CIP.003.249
2024-06-03	REVENUE-CENTER-QUANTITY-ALLOWED/ CIP.003.250
2024-06-03	TYPE-OF-SERVICE/CIP.003.257
2024-06-03	NDC-QUANTITY/CIP.003.278

2024-06-03	DATA-DICTIONARY-VERSION/CLT.001.002
2024-06-03	DATA-MAPPING-DOCUMENT-VERSION/CLT.001.005
2024-06-03	FUNDING-CODE/CLT.002.076
2024-06-03	MEDICARE-HIC-NUM/CLT.002.140

2024-06-03	LINE-NUM-ORIG/CLT.003.190
2024-06-03	REVENUE-CENTER-QUANTITY-ACTUAL/CLT.003.202
2024-06-03	REVENUE-CENTER-QUANTITY-ALLOWED/ CLT.003.203
2024-06-03	TYPE-OF-SERVICE/CLT.003.211

2024-06-03	NDC-QUANTITY/CLT.003.230
2024-06-03	DATA-DICTIONARY-VERSION/COT.001.002
2024-06-03	DATA-MAPPING-DOCUMENT-VERSION/COT.001.005
2024-06-03	FUNDING-CODE/COT.002.062
2024-06-03	BILLING-PROV-TAXONOMY/COT.002.114

2024-06-03	MEDICARE-HIC-NUM/COT.002.122
2024-06-03	LINE-NUM-ORIG/COT.003.160
2024-06-03	SERVICE-QUANTITY-ACTUAL/COT.003.183

2024-06-03	SERVICE-QUANTITY-ALLOWED/COT.003.184
2024-06-03	TYPE-OF-SERVICE/COT.003.186

2024-06-03	HCBS-TAXONOMY/COT.003.188
2024-06-03	NDC-QUANTITY/COT.003.225
2024-06-03	DATA-DICTIONARY-VERSION/CRX.001.002

2024-06-03	DATA-MAPPING-DOCUMENT-VERSION/CRX.001.005
2024-06-03	FUNDING-CODE/CRX.002.053
2024-06-03	MEDICARE-HIC-NUM/CRX.002.079
2024-06-03	LINE-NUM-ORIG/CRX.003.114

2024-06-03	PRESCRIPTION-QUANTITY-ALLOWED/CRX.003.131
2024-06-03	PRESCRIPTION-QUANTITY-ACTUAL/CRX.003.132
2024-06-03	TYPE-OF-SERVICE/CRX.003.134

2024-06-03	HCBS-TAXONOMY/CRX.003.136

2024-06-03	DRUG-UTILIZATION-CODE/CRX.003.143
2024-06-03	DATA-DICTIONARY-VERSION/ELG.001.002
2024-06-03	DATA-MAPPING-DOCUMENT-VERSION/ELG.001.005

2024-06-03	MEDICARE-HIC-NUM/ELG.003.050
2024-06-03	ELIGIBLE-ADDR-LN1/ELG.004.066
2024-06-03	ELIGIBLE-ADDR-END-DATE/ELG.004.076

2024-06-03	DUAL-ELIGIBLE-CODE/ELG.005.085

2024-06-03	RESTRICTED-BENEFITS-CODE/ELG.005.097
2024-06-03	ELIGIBILITY-DETERMINANT-END-DATE/ELG.005.100
2024-06-03	ELIGIBILITY-REDETERMINATION-DATE/ELG.005.274

2024-06-03	ELIGIBILITY-TERMINATION-REASON-OTHER-TYPE-TEXT/ELG.005.281
2024-06-03	HEALTH-HOME-SPA-PARTICIPATION-END-DATE/ELG.006.110
2024-06-03	HEALTH-HOME-SPA-PROVIDER-END-DATE/ELG.007.122
2024-06-03	STATE-NOTATION/ELG.007.124
2024-06-03	HEALTH-HOME-CHRONIC-CONDITION-END-DATE/ELG.008.133

2024-06-03	LOCKIN-END-DATE/ELG.009.143
2024-06-03	STATE-NOTATION/ELG.009.144
2024-06-03	MFP-ENROLLMENT-END-DATE/ELG.010.156
2024-06-03	STATE-PLAN-OPTION-TYPE/ELG.011.163
2024-06-03	LTSS-ELIGIBILITY-END-DATE/ELG.013.185

2024-06-03	MANAGED-CARE-PLAN-TYPE/ELG.014.193
2024-06-03	MANAGED-CARE-PLAN-ENROLLMENT-END-DATE/ ELG.014.197
2024-06-03	ETHNICITY-DECLARATION-END-DATE/ELG.015.206
2024-06-03	DISABILITY-TYPE-END-DATE/ELG.017.226

2024-06-03	1115A-END-DATE/ELG.018.235
2024-06-03	HCBS-CHRONIC-CONDITION-NON-HEALTH-HOME-END-DATE/ELG.020.244
2024-06-03	ENROLLMENT-END-DATE/ELG.021.254
2024-06-03	ELG-IDENTIFIER-EFF-DATE/ELG.022.263
2024-06-03	DATA-DICTIONARY-VERSION/FTX.001.002

2024-06-03	DATA-MAPPING-DOCUMENT-VERSION/FTX.001.005
2024-06-03	ADJUSTMENT-IND/FTX.002.023
2024-06-03	PAYER-MCR-PLAN-TYPE-OTHER-TEXT/FTX.002.032
2024-06-03	CAPITATION-PERIOD-START-DATE/FTX.002.043
2024-06-03	FUNDING-CODE/FTX.002.051

2024-06-03	FUNDING-SOURCE-NONFEDERAL-SHARE/ FTX.002.052
2024-06-03	ADJUSTMENT-IND/FTX.003.070
2024-06-03	FUNDING-CODE/FTX.003.096
2024-06-03	ADJUSTMENT-IND/FTX.004.111
2024-06-03	FUNDING-CODE/FTX.004.140
2024-06-03	ADJUSTMENT-IND/FTX.005.155

2024-06-03	COVERAGE-PERIOD-START-DATE/FTX.005.174
2024-06-03	FUNDING-CODE/FTX.005.182
2024-06-03	ADJUSTMENT-IND/FTX.006.198
2024-06-03	FUNDING-CODE/FTX.006.224
2024-06-03	ADJUSTMENT-IND/FTX.007.242
2024-06-03	PAYMENT-PERIOD-START-DATE/FTX.007.259

2024-06-03	FUNDING-CODE/FTX.007.269
2024-06-03	ADJUSTMENT-IND/FTX.008.285
2024-06-03	COST-SETTLEMENT-PERIOD-START-DATE/ FTX.008.301
2024-06-03	FUNDING-CODE/FTX.008.309
2024-06-03	ADJUSTMENT-IND/FTX.009.324
2024-06-03	WRAP-PERIOD-START-DATE/FTX.009.340

2024-06-03	FUNDING-CODE/FTX.009.348
2024-06-03	ADJUSTMENT-IND/FTX.095.363
2024-06-03	FUNDING-CODE/FTX.095.396
2024-06-03	DATA-DICTIONARY-VERSION/MCR.001.002
2024-06-03	DATA-MAPPING-DOCUMENT-VERSION/MCR.001.005

2024-06-03	CORE-BASED-STATISTICAL-AREA-CODE/ MCR.002.027
2024-06-03	MANAGED-CARE-MAIN-REC-END-DATE/ MCR.002.031
2024-06-03	MANAGED-CARE-LOCATION-AND-CONTACT-INFO-END-DATE/MCR.003.040

2024-06-03	MANAGED-CARE-SERVICE-AREA-END-DATE/ MCR.004.060
2024-06-03	MANAGED-CARE-OP-AUTHORITY-END-DATE/ MCR.005.070
2024-06-03	MANAGED-CARE-PLAN-POP-END-DATE/ MCR.006.079
2024-06-03	DATE-ACCREDITATION-END/MCR.007.088
2024-06-03	MANAGED-CARE-PLAN-OTHER-ID-TYPE/ MCR.010.118

2024-06-03	MANAGED-CARE-PLAN-OTHER-ID/MCR.010.119
2024-06-03	MANAGED-CARE-ID-END-DATE/MCR.010.121
2024-06-03	DATA-DICTIONARY-VERSION/PRV.001.002
2024-06-03	DATA-MAPPING-DOCUMENT-VERSION/PRV.001.005
2024-06-03	PROV-LOCATION-AND-CONTACT-INFO-EFF-DATE/ PRV.003.044

2024-06-03	PROV-LOCATION-AND-CONTACT-INFO-END-DATE/ PRV.003.045
2024-06-03	ADDR-LN1/PRV.003.047
2024-06-03	BED-TYPE-END-DATE/PRV.010.131
2024-06-03	DATA-DICTIONARY-VERSION/TPL.001.002
2024-06-03	DATA-MAPPING-DOCUMENT-VERSION/TPL.001.005

2024-06-03	ELIG-PRSN-MAIN-END-DATE/TPL.002.026
2024-06-03	INSURANCE-COVERAGE-END-DATE/TPL.003.049
2024-06-03	INSURANCE-CATEGORIES-END-DATE/TPL.004.060

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Field(s)	Action
Data Dictionary	UPDATE
Data Dictionary	UPDATE
Data Dictionary	UPDATE
Data Dictionary	ADD
Data Dictionary	UPDATE
Data Dictionary	UPDATE
Data Dictionary	UPDATE
Data Dictionary	UPDATE
Data Dictionary	UPDATE

Data Dictionary	UPDATE
Data Dictionary	UPDATE

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Data Dictionary	UPDATE
Data Dictionary	UPDATE
Data Dictionary	ADD

Data Dictionary	ADD
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Coding requirement	UPDATE
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Definition	UPDATE
All Data Element Attributes	DELETE
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All Data Element Attributes	DELETE
Entire New Data Element	ADD
Entire New Data Element	ADD

Definition; Coding Requirement	UPDATE
Definition; Coding Requirement	UPDATE
Coding Requirement	UPDATE

Definition; Coding Requirement	UPDATE
All Data Element Attributes	DELETE
All Data Element Attributes	DELETE

Coding Requirement	UPDATE
Definition; Coding Requirement	UPDATE

Definition; Coding Requirement	UPDATE
Definition; Coding Requirement	UPDATE
Entire New Data Element	ADD
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Definition; Coding Requirement	UPDATE
Coding Requirement	UPDATE
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Size; Coding Requirement	UPDATE
All Data Element Attributes	DELETE
All Data Element Attributes	DELETE
Definition; Coding Requirement	UPDATE

All Data Element Attributes	DELETE
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Coding Requirement	UPDATE
Entire New Data Element	ADD

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Definition	UPDATE

Definition; Coding Requirement	UPDATE
Definition; Coding Requirement	UPDATE
Entire New Data Element	ADD

Definition	UPDATE
Definition; Coding Requirement	UPDATE
All Data Element Attributes	DELETE

Definition; Coding Requirement	UPDATE
All Data Element Attributes	DELETE
Entire New Data Element	ADD

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Definition	UPDATE

Definition	UPDATE
Definition	UPDATE
Coding requirement	UPDATE

Definition	UPDATE
Coding Requirement	UPDATE
Definition, Coding Requirement	UPDATE

Coding Requirement	UPDATE
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Coding requirement; Definition	UPDATE
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Data Element Name; Data Element Name Text; Coding Requirement	UPDATE
Data Element Name; Data Element Name Text; Coding Requirement	UPDATE
Data Element Name; Data Element Name Text	UPDATE
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Data Element Name; Data Element Name Text; Coding Requirement	UPDATE
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Data Element Name; Data Element Name Text; Coding Requirement	UPDATE
Data Element Name; Data Element Name Text; Coding Requirement	UPDATE
Data Element Name; Data Element Name Text	UPDATE

Data Element Name; Data Element Name Text; VVL	UPDATE
Coding Requirement; VVL	UPDATE
Definition	UPDATE
Coding Requirement	UPDATE

Coding Requirement	UPDATE
VVL; coding requirement	UPDATE
Coding Requirement	UPDATE

Coding Requirement	UPDATE
Coding Requirement	UPDATE
Coding Requirement; Description; Valid Value Code Set	UPDATE

Coding Requirement; definition	UPDATE
Coding Requirement	UPDATE
All Data Element Attributes	ADD
VVL; coding requirement	UPDATE

VVL; coding requirement	UPDATE
Coding Requirement	UPDATE
Coding Requirement	UPDATE
Coding Requirement	UPDATE
Definition	UPDATE

Coding Requirement	UPDATE
Definition	UPDATE
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Coding Requirement	UPDATE
Coding requirement	UPDATE

Coding Requirement; definition	UPDATE
Coding requirement	UPDATE
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Data Element Name; Data Element Name Text; Coding Requirement	UPDATE
Data Element Name; Data Element Name Text; Coding Requirement	UPDATE
Data Element Name; Data Element Name Text	UPDATE
Data Element Name; Coding Requirement; VVL	UPDATE
Data Element Name; Coding Requirement; VVL	UPDATE
Coding Requirement	UPDATE

Data Element Name; Data Element Name Text; Coding Requirement	UPDATE
Data Element Name; Data Element Name Text; Coding Requirement	UPDATE
Data Element Name; Data Element Name Text	UPDATE
Coding Requirement; VVL	UPDATE
Coding Requirement; VVL	UPDATE

Definition	UPDATE
Coding Requirement	UPDATE
Coding Requirement; Definition	UPDATE

Coding Requirement	UPDATE
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Coding Requirement	UPDATE

Coding Requirement	UPDATE
Coding Requirement; Description; Valid Value Code Set	UPDATE

Coding Requirement; Definition	UPDATE
Data Element Name; Data Element Name Text; Coding Requirement	UPDATE
All Data Element Attributes	ADD
Coding Requirement; VVL	UPDATE

Coding Requirement	UPDATE
Coding Requirement	UPDATE
Coding Requirement; Necessity	UPDATE
Coding Requirement	UPDATE

Definition	UPDATE
Coding Requirement	UPDATE
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Coding Requirement; Definition	UPDATE
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Coding Requirement; Definition	UPDATE
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Data Element Name; Data Element Name Text	UPDATE

Data Element Name; Data Element Name Text; VVL	UPDATE
Data Element Name; Data Element Name Text; VVL	UPDATE
Coding Requirement; Definition	UPDATE
Data Element Name; Data Element Name Text; Coding Requirement	UPDATE

Definition	UPDATE
Coding Requirement	UPDATE
VVL; Coding Requirement	UPDATE

VVL	UPDATE
Coding Requirement	UPDATE
Coding Requirement; VVL	UPDATE

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Coding Requirement; Description; VVL	UPDATE
Coding Requirement; Definition	UPDATE

Coding Requirement	UPDATE
Data Element Name; Data Element Name Text; Coding Requirement	UPDATE
Data Element Name; Data Element Name Text; Coding Requirement	UPDATE
Data Element Name; Data Element Name Text	UPDATE
Data Element Name; Data Element Name Text; VVL	UPDATE

Data Element Name; Data Element Name Text; VVL	UPDATE
Data Element Name; Data Element Name Text; Definition	UPDATE
Data Element Name; Data Element Name Text; Coding Requirement	UPDATE
Data Element Name; Data Element Name Text; Definition	UPDATE

Coding Requirement	UPDATE
Coding Requirement; Definition	UPDATE
All Data Element Attributes	ADD
Coding Requirement; VVL	UPDATE

Coding Requirement	UPDATE
Coding Requirement	UPDATE
Coding Requirement	UPDATE
VVL	UPDATE
VVL; Definition	UPDATE

Coding Requirement	UPDATE
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Definition	UPDATE
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Coding Requirement	UPDATE
Coding Requirement	UPDATE
Coding Requirement; Necessity	UPDATE
VVL	UPDATE

Coding Requirement	UPDATE
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Coding Requirement; Definition; VVL	UPDATE
Coding Requirement; Definition	UPDATE

Data Element name; Data Element Name Text; VVL; Coding Requirement	UPDATE
Data Element name; Data Element Name Text; VVL; Coding Requirement	UPDATE
Data Element name; Data Element Name Text; VVL; Coding Requirement	UPDATE
Data Element name; Data Element Name Text; VVL; Coding Requirement	UPDATE
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Data Element name; Data Element Name Text; VVL; Coding Requirement	UPDATE
Data Element name; Data Element Name Text; VVL; Coding Requirement	UPDATE
Data Element name; Data Element Name Text; VVL; Coding Requirement	UPDATE

All Data Element Attributes	ADD
Coding Requirement; VVL	UPDATE
Coding Requirement	UPDATE
Coding Requirement	UPDATE

Coding Requirement	UPDATE
VVL	UPDATE
VVL	UPDATE
Definition	UPDATE
Definition	UPDATE

Definition, Coding Requirement	UPDATE
Coding Requirement	UPDATE
Coding Requirement	UPDATE

Coding Requirement	UPDATE
Coding requirement	UPDATE
Coding Requirement	UPDATE

Definition	UPDATE
Coding Requirement; VVL	UPDATE
Definition	UPDATE
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Coding Requirement	UPDATE
Definition	UPDATE
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Definition	UPDATE
Definition	UPDATE
Coding Requirement; VVL	UPDATE

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Coding Requirement	UPDATE
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Coding Requirement; VVL	UPDATE
Definition	UPDATE
Coding Requirement; Necessity	UPDATE
Coding Requirement	UPDATE
All Data Element Attributes	DELETE

Coding Requirement	UPDATE
Coding Requirement	UPDATE
Coding Requirement; Definition	UPDATE
Coding Requirement	UPDATE

Coding Requirement; Definition	UPDATE
Coding Requirement	UPDATE

0	UPDATE
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0	UPDATE

Definition, Coding Requirement	UPDATE
Coding Requirement; Necessity	UPDATE

Coding Requirement; Definition, VVL	UPDATE
Coding Requirement; Definitions	UPDATE

Coding Requirement	UPDATE
Coding Requirement	UPDATE
Coding Requirement	UPDATE

Definition	UPDATE
Coding Requirement; VVL	UPDATE
Coding Requirement; Necessity	UPDATE
Coding Requirement	UPDATE

All Data Element Attributes	DELETE
Coding Requirement	UPDATE
Coding Requirement; Definition	UPDATE
Coding Requirement	UPDATE

Coding Requirement; Definition	UPDATE
Coding Requirement	UPDATE

Coding Requirement; Definition	UPDATE
Data Element Name Text	UPDATE
Data Element Name Text	UPDATE

Definition, Coding Requirement	UPDATE
Data Element Name Text	UPDATE

Coding Requirement; Definition; VVL	UPDATE
Coding Requirement; Definition	UPDATE

Coding Requirement	UPDATE
Definition	UPDATE
Coding Requirement	UPDATE

Coding Requirement; Necessity	UPDATE
Coding Requirement	UPDATE
All Data Element Attributes	DELETE
Coding Requirement	UPDATE

Coding Requirement; Definition	UPDATE
Coding Requirement	UPDATE
Coding Requirement; Definition	UPDATE

Coding Requirement	UPDATE
Coding Requirement; Definition	UPDATE
Coding Requirement	UPDATE

Coding Requirement	UPDATE
Data Element Name Text	UPDATE
Data Element Name	UPDATE

Definition, Coding Requirement	UPDATE
Coding Requirement; Definition	UPDATE
Data Element Name Text	UPDATE

VVL	UPDATE
Coding Requirement; Definition; VVL	UPDATE

Coding Requirement; Definition	UPDATE
Coding Requirement	UPDATE
Coding Requirement	UPDATE

Coding Requirement; Necessity	UPDATE
Coding Requirement	UPDATE
All Data Element Attributes	DELETE
Coding Requirement	UPDATE

Coding Requirement; Definition	UPDATE
Coding Requirement	UPDATE
Definition	UPDATE

Coding Requirement	UPDATE
Coding Requirement	UPDATE
Coding Requirement	UPDATE
Data Element Name Text	UPDATE

Definition, Coding Requirement	UPDATE
Coding Requirement; Description; Valid Value Code Set	UPDATE

Coding Requirement; Definition	UPDATE
Coding Requirement	UPDATE
Definition	UPDATE

Coding Requirement	UPDATE
Coding Requirement; Necessity	UPDATE
Coding Requirement	UPDATE
All Data Element Attributes	DELETE
Coding Requirement	UPDATE

Coding Requirement; Definition	UPDATE
Coding Requirement	UPDATE
Coding Requirement	UPDATE

Coding Requirement	UPDATE
Coding Requirement; Definition	UPDATE

Definition, Coding Requirement	UPDATE
Coding Requirement; Definition; VVL	UPDATE

Coding Requirement; Definition	UPDATE
Coding Requirement	UPDATE
Definition	UPDATE

Coding Requirement; VVL	UPDATE
Coding Requirement; Necessity	UPDATE
Coding Requirement	UPDATE
All Data Element Attributes	DELETE
Coding Requirement	UPDATE

Coding Requirement; Definition	UPDATE
Coding Requirement	UPDATE
Coding Requirement	UPDATE

Coding Requirement	UPDATE
Coding Requirement	UPDATE
Coding Requirement; Data Element Name Text; Definition	UPDATE
Coding Requirement; Necessity; VVL	UPDATE

Coding Requirement; Definition; VVL	UPDATE
Coding Requirement; Definition	UPDATE

Coding Requirement	UPDATE
Coding Requirement	UPDATE
Coding Requirement; Necessity	UPDATE

Coding Requirement	UPDATE
All Data Element Attributes	DELETE
All Data Element Attributes	DELETE
Coding Requirement	UPDATE
Coding Requirement	UPDATE

Coding Requirement; Definition	UPDATE
Coding Requirement	UPDATE
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Coding Requirement	UPDATE
Coding Requirement; Definition	UPDATE
Coding Requirement	UPDATE

Coding Requirement; Definition; VVL	UPDATE
Coding Requirement; Definition	UPDATE

Coding Requirement	UPDATE
Definition	UPDATE
Coding Requirement	UPDATE

Coding Requirement; Necessity	UPDATE
Coding Requirement	UPDATE
All Data Element Attributes	DELETE
Coding Requirement	UPDATE
Coding Requirement; Definition	UPDATE

Coding Requirement	UPDATE
Coding Requirement	UPDATE

Coding Requirement	UPDATE
Coding Requirement; Definition	UPDATE

Coding Requirement; Definition; VVL	UPDATE
Coding Requirement; Definition	UPDATE

Coding Requirement	UPDATE
Coding Requirement	UPDATE
Coding Requirement; Necessity	UPDATE

Coding Requirement	UPDATE
All Data Element Attributes	DELETE
Coding Requirement	UPDATE
Coding Requirement; Definition	UPDATE

Coding Requirement	UPDATE
Coding Requirement	UPDATE

Coding Requirement	UPDATE
Coding Requirement; Definition	UPDATE
Coding Requirement	UPDATE

Definition, Coding Requirement	UPDATE
Coding Requirement; Necessity	UPDATE

Coding Requirement; Definition; VVL	UPDATE
Coding Requirement; Definition	UPDATE

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Coding Requirement	UPDATE
Coding Requirement	UPDATE

Definition	UPDATE
Definition	UPDATE

Coding Requirement; VVL	UPDATE
Coding Requirement	UPDATE
Coding Requirement	UPDATE
Definition	UPDATE

Coding Requirement	UPDATE
Coding Requirement; VVL	UPDATE
Coding Requirement	UPDATE

Coding Requirement	UPDATE
Definition	UPDATE

Definition	UPDATE
Coding Requirement	UPDATE
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Coding Requirement	UPDATE

Definition	UPDATE
Coding Requirement	UPDATE
Definition	UPDATE

Definition	UPDATE
Coding Requirement; Necessity; VVL	UPDATE
Definition	UPDATE
Definition	UPDATE
Coding Requirement(s)	UPDATE

Coding Requirement(s)	UPDATE
Definition	UPDATE
Coding Requirement(s)	UPDATE

Definition	UPDATE
Definition	UPDATE
Valid Value List; Coding Requirement(s)	UPDATE
Definition	UPDATE

Definition	UPDATE
Definition	UPDATE
Coding Requirement(s)	UPDATE
Definition	UPDATE

Coding Requirement(s)	UPDATE
Definition	UPDATE
Definition	UPDATE
Valid Value List; Coding Requirement(s)	UPDATE

Definition	UPDATE
Definition	UPDATE
Definition	UPDATE
Coding Requirement(s)	UPDATE
Coding Requirement(s)	UPDATE

Definition	UPDATE
Coding Requirement(s)	UPDATE
Definition; Coding Requirement(s)	UPDATE

Definition	UPDATE
Valid Value List; Coding Requirement(s)	UPDATE

Definition	UPDATE
Definition	UPDATE
Definition	UPDATE

Definition	UPDATE
Coding Requirement(s)	UPDATE
Definition	UPDATE
Coding Requirement(s)	UPDATE

Definition	UPDATE
Definition	UPDATE
Valid Value List; Coding Requirement(s)	UPDATE

Definition	UPDATE

Definition	UPDATE
Definition	UPDATE
Definition	UPDATE

Definition	UPDATE
Coding Requirement(s)	UPDATE
Coding Requirement(s)	UPDATE

Coding Requirement(s)	UPDATE

Coding Requirement(s)	UPDATE
Coding Requirement(s)	UPDATE
Data Element Name	UPDATE

Coding Requirement(s)	UPDATE
Coding Requirement(s)	UPDATE
Coding Requirement(s)	UPDATE
Necessity	UPDATE
Coding Requirement(s)	UPDATE

Coding Requirement(s)	UPDATE
Necessity	UPDATE
Coding Requirement(s)	UPDATE
Coding Requirement(s)	UPDATE
Coding Requirement(s)	UPDATE

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Coding Requirement(s)	UPDATE
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Coding Requirement(s)	UPDATE

Coding Requirement(s)	UPDATE
Coding Requirement(s)	UPDATE
Coding Requirement(s)	UPDATE
Coding Requirement(s)	UPDATE
Definition	UPDATE

Definition	UPDATE
Necessity; Coding Requirement(s)	UPDATE
Coding Requirement(s)	UPDATE
Coding Requirement(s)	UPDATE
Coding Requirement(s)	UPDATE

Necessity; Coding Requirement(s)	UPDATE
Necessity; Coding Requirement(s)	UPDATE
Coding Requirement(s)	UPDATE
Necessity; Coding Requirement(s)	UPDATE
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Necessity; Coding Requirement(s)	UPDATE

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Necessity; Coding Requirement(s)	UPDATE
Coding Requirement(s)	UPDATE
Necessity; Coding Requirement(s)	UPDATE
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Coding Requirement(s)	UPDATE
Necessity; Coding Requirement(s)	UPDATE
Coding Requirement(s)	Update
Coding Requirement(s)	UPDATE
Necessity; Coding Requirement(s)	UPDATE
Coding Requirement(s)	UPDATE

Coding Requirement(s)	UPDATE
Necessity; Coding Requirement(s)	UPDATE
Coding Requirement(s)	UPDATE
Definition	UPDATE
Definition	UPDATE

Definition	UPDATE
Coding Requirement(s)	UPDATE
Coding Requirement(s)	UPDATE

Coding Requirement(s)	UPDATE
Coding Requirement(s)	UPDATE
Coding Requirement(s)	UPDATE
Coding Requirement(s)	UPDATE
Data Element Name; Data Element Name Text; Valid Value List; Coding Requirement(s)	UPDATE

Data Element Name; Data Element Name Text;	UPDATE
Coding Requirement(s)	UPDATE
Definition	UPDATE
Definition	UPDATE
Data Element Name Text	UPDATE

Data Element Name Text; Coding Requirement(s)	UPDATE
Coding Requirement(s)	UPDATE
Coding Requirement(s)	UPDATE
Definition	UPDATE
Definition	UPDATE

Coding Requirement(s)	UPDATE
Coding Requirement(s)	UPDATE
Coding Requirement(s)	UPDATE

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Before
CHIP-CODE (ELG054) v2.3 Definition:A code used to distinguish among Medicaid, Medicaid Expansion, and Separate CHIP populations
When Type of Claim not in ('Z','3','C','W","2","B","V"," 4","D","X") then value may match (PRV.002.019) Submitting State Provider IDorWhen Type of Claim not in ('Z','3','C','W","2","B","V"," 4","D","X") then value may match (PRV.005.081) Provider Identi where the Provider Identifier Type = '1'
Value must be reported in Provider Identifier (PRV.005.080) with an associated Provider Identifier Type (PRV.005.081) equal to '1'
N/A
"If associated Type of Claim value is 2, 4, 5, B, D, or E, then value should not be populated
“If associated Type of Claim value is 2, 4, 5, B, D, or E, then value should not be populated
"If associated Crossover Indicator value is '0' (not a crossover claim), then value should no populated."AND"(Medicare Enrolled) if associated Dual Eligible Code (ELG.005.085) value i ["01", "02", "03", "04", "05", "06", "08", "09", or "10"], then value is mandatory and must b provided"
|Definition||The amount paid by Medicaid/CHIP agency or the managed care plan on this cl or adjustment at the claim detail level. For claims where Medicaid payment is only availab the header level, report the entire payment amount on the T-MSIS record corresponding to line item with the highest charge or the 1st detail. Zero fill Medicaid Amount Paid on all oth MSIS records created from the original claim.|
|DE NO| DATA ELEMENT NAME| DEFINITION| NECESSITY |CODING REQUIREMENT||CIP103 | CLAIM-STATUS-CATEGORY| Not Applicable |Not Applicable |(Denied Claim) if associated Ty Claim equals Z or associated Claim Status is in [26, 87, 542, 858, 654], then value must b "F2"||CLT055 |CLAIM-STATUS-CATEGORY| Not Applicable |Not Applicable |(Denied Claim) if associated Type of Claim equals Z or associated Claim Status is in [26, 87, 542, 858, 654 then value must be "F2"||COT040 |CLAIM-STATUS-CATEGORY| Not Applicable |Not Applicab (Denied Claim) if associated Type of Claim equals Z or associated Claim Status is in [26, 8 542, 858, 654], then value must be "F2"||CRX031 |CLAIM-STATUS-CATEGORY| Not Applica Not Applicable |(Denied Claim) if associated Type of Claim equals Z or associated Claim St is in [26, 87, 542, 858, 654], then value must be "F2"|

|DE NO| DATA ELEMENT NAME| DEFINITION| NECESSITY |CODING REQUIREMENT||ELG213|R
Not Applicable |Not Applicable |A code indicating the individual's race either in accordance
requirements of Section 4302 of the Affordable Care Act classifications Race Code clarifica
If state has beneficiaries coded in their database as "Asian" with no additional detail, then
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 "N
Hawaiian," "Other Pacific Islander," "Unspecified" or "Unknown."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 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
an individual who explicitly did not provide information or refused to answer a question|

|DE No|Data Element Name|Definition||CIP098|ADJUDICATION-DATE|The date on which the
payment status of the claim was finally adjudicated by the state.||CLT050|ADJUDICATION-D
The date on which the payment status of the claim was finally adjudicated by the state.||
COT035|ADJUDICATION-DATE|The date on which the payment status of the claim was final
adjudicated by the state.||CRX027|ADJUDICATION-DATE|The date on which the payment st
of the claim was finally adjudicated by the state.||CIP286|ADJUDICATION-DATE|The date on
which the payment status of the claim was finally adjudicated by the state.||CLT233|
ADJUDICATION-DATE|The date on which the payment status of the claim was finally adjudi
by the state.||COT221|ADJUDICATION-DATE|The date on which the payment status of the c
was finally adjudicated by the state.||CRX157|ADJUDICATION-DATE|The date on which the
payment status of the claim was finally adjudicated by the state.|

|DE NO| DATA ELEMENT NAME| DEFINITION| NECESSITY |CODING REQUIREMENT||COT112| BILLING-PROV-NUM| Not Applicable |Not Applicable |Value must be reported in Provider Identifier (PRV.005.080) with an associated Provider Identifier Type (PRV.005.081) equal to

|DE NO| DATA ELEMENT NAME| DEFINITION| NECESSITY |CODING REQUIREMENT||COT112| BILLING-PROV-NUM| Not Applicable |Not Applicable |Not Applicable|

|DE NO| DATA ELEMENT NAME| DEFINITION| NECESSITY |CODING REQUIREMENT||COT112| BILLING-PROV-NUM| Not Applicable |Not Applicable |When Type of Service (COT..003.186) ['119', ‘120', '122'] value must match Plan ID Number (COT.002.066)|

|DE NO|DEFINITION||ELG046|A code indicating the language the individual speaks other th English at home.|

|DE NO| DATA ELEMENT NAME |DEFINITION||CIP025|1115A-DEMONSTRATION-IND|Indicates the claim or encounter was covered under the authority of an 1115(A) demonstration. 111 is a Center for Medicare and Medicaid Innovation demonstration.|

|DE NO| DATA ELEMENT NAME |DEFINITION||CLT024|1115A-DEMONSTRATION-IND|Indicates the claim or encounter was covered under the authority of an 1115(A) demonstration. 111 is a Center for Medicare and Medicaid Innovation demonstration.|

|DE NO| DATA ELEMENT NAME |DEFINITION||COT024|1115A-DEMONSTRATION-IND|Indicate that the claim or encounter was covered under the authority of an 1115(A) demonstration. 1115(A) is a Center for Medicare and Medicaid Innovation demonstration.|

|DE NO| DATA ELEMENT NAME |DEFINITION||CRX024|1115A-DEMONSTRATION-IND|Indicate that the claim or encounter was covered under the authority of an 1115(A) demonstration. 1115(A) is a Center for Medicare and Medicaid Innovation demonstration.|

N/A

N/A

|DE NO| DATA ELEMENT NAME |DEFINITION||ELG233|1115A-DEMONSTRATION-IND|Indicate
that the claim or encounter was covered under the authority of an 1115(A) demonstration.
1115(A) is a Center for Medicare and Medicaid Innovation demonstration.|

|FILE SEGMENT NAME WITH RECORD ID COMPUTING||ELIGIBLE-IDENTIFIER-ELG00022|

|DE NO| DATA ELEMENT NAME |DEFINITION||ELG095|ELIGIBILITY-CHANGE-REASON|The rea
for a change in an individual's eligibility status. Report this reason when there is a change
the individual's eligibility status.|

|DE NO| DATA ELEMENT NAME| DEFINITION| NECESSITY |CODING REQUIREMENT||COT191|
SERVICING-PROV-TAXONOMY|[No longer essential - Both data element and associated
requirement(s); preserved for file submission integrity. See Data Dictionary v2.3 for specifi
definition and coding requirement description(s).]| Conditional| Not Applicable|

|DE NO| DATA ELEMENT NAME| DEFINITION| NECESSITY ||ELG224|DISABILITY-TYPE-CODE|[N
longer essential - Both data element and associated requirement(s); preserved for file
submission integrity. See Data Dictionary v2.3 for specific definition and coding requireme
description(s).]|Conditional|

DE NO| DATA ELEMENT NAME| DEFINITION|CIP228 | MEDICARE-PAID-AMT |The amount paid
Medicare on this claim or adjustment.|

DE NO| DATA ELEMENT NAME| DEFINITION|CLT179 | MEDICARE-PAID-AMT |The amount pai
Medicare on this claim or adjustment.|

DE NO| DATA ELEMENT NAME| DEFINITION|COT182 | MEDICARE-PAID-AMT |The amount pa
Medicare on this claim or adjustment.|

DE NO| DATA ELEMENT NAME| DEFINITION|CRX129 | MEDICARE-PAID-AMT |The amount pa
Medicare on this claim or adjustment.|

DE NO| DATA ELEMENT NAME| NECESSITY|CODING REQUIREMENT|ELG073|ELIGIBLE-PHON
NUM|Optional||

DE NO| DATA ELEMENT NAME|NECESSITY|CIP184|ADMITTING-PROV-NPI-NUM||CLT006|FILE-
NAME||CRX006|FILE-NAME||ELG006|FILE-NAME||MCR006|FILE-NAME||PRV006|FILE-NAME||
TPL006|FILE-NAME||CIP127|FUNDING-SOURCE-NONFEDERAL-SHARE||CLT077|FUNDING-
SOURCE-NONFEDERAL-SHARE||COT063|FUNDING-SOURCE-NONFEDERAL-SHARE||CRX054|
FUNDING-SOURCE-NONFEDERAL-SHARE||ELG111|HEALTH-HOME-ENTITY-EFF-DATE||TPL044
POLICY-OWNER-FIRST-NAME||TPL045|POLICY-OWNER-LAST-NAME||CIP093|PROCEDURE-CO
DATE-6||CIP088|PROCEDURE-CODE-FLAG-5||PRV043|PROV-LOCATION-ID||PRV064|PROV-
LOCATION-ID||PRV076|PROV-LOCATION-ID||PRV129|PROV-LOCATION-ID||COT191|SERVICIN
PROV-TAXONOMY||

DE NO| DATA ELEMENT NAME|DEFINITION|CIP202|REMITTANCE-NUM|The Remittance Advic
Number is a sequential number that identifies the current Remittance Advice (RA) produce
a provider. The number is incremented by one each time a new RA is generated. The first
(5) positions are Julian date following a YYDDD format. The RA is the detailed explanation
reason for the payment amount. The RA number is not the check number.|CLT144|
REMITTANCE-NUM|The Remittance Advice Number is a sequential number that identifies t
current Remittance Advice (RA) produced for a provider. The number is incremented by on
each time a new RA is generated. The first five (5) positions are Julian date following a YYD
format. The RA is the detailed explanation of the reason for the payment amount. The RA
number is not the check number.|COT126|REMITTANCE-NUM|The Remittance Advice Numb
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 fiv
positions are Julian date following a YYDDD format. The RA is the detailed explanation of th
reason for the payment amount. The RA number is not the check number.|CRX081|
REMITTANCE-NUM|The Remittance Advice Number is a sequential number that identifies t
current Remittance Advice (RA) produced for a provider. The number is incremented by on
each time a new RA is generated. The first five (5) positions are Julian date following a YYD
format. The RA is the detailed explanation of the reason for the payment amount. The RA
number is not the check number.|

N/A
DE NO| DATA ELEMENT NAME|DEFINITION|CRX143|DRUG-UTILIZATION-CODE|A code indica the conflict, intervention and outcome of a prescription presented for fulfillment. The T-MS Drug Utilization Code data element is composite field comprised of three distinct NCPDP da elements: "Reason for Service Code" (439-E4); "Professional Service Code" (44-E5); and "R 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 r in different coverage, pricing, patient financial responsibility, drug utilization review outcor or if the information affects payment for, or documentation of, professional pharmacy serv The NCPDP "Results of Service Code" (bytes 1 & 2 of the T-MSIS Drug Utilization Code) exp whether the pharmacist filled the prescription, filled part of the prescription, etc. The NCPD "Professional Service Code" (bytes 3 & 4 of the T-MSIS Drug Utilization Code) describes wh the pharmacist did for the patient. The NCPDP "Result of Service Code" (bytes 5 & 6 of the MSIS Drug Utilization Code) describes the action the pharmacist took in response to a conf or the result of a pharmacist's professional service.Because the T-MSIS Drug Utilization Co data element is a composite field, it is necessary for the state to populate all six bytes if ar the three NCPDP fields has a value. In such situations, use 'spaces' as placeholders for not applicable codes.|
N/A
DE NO| DATA ELEMENT NAME|CODING REQUIREMENT|ELG087|ELIGIBILITY-GROUP|Benefici reported with ELIGIBILITY-GROUP="72", "73", "74", "75" are expected to be covered by an alternative benefit plan and should be reported with RESTRICTED-BENEFITS-CODE=7 and STATE-PLAN-OPTION-TYPE="06".
DE NO| DATA ELEMENT NAME|CODING REQUIREMENT|ELG097|RESTRICTED-BENEFITS-COD
DE NO| DATA ELEMENT NAME|CODING REQUIREMENT|ELG163|STATE-PLAN-OPTION-TYPE| Beneficiaries reported with ELIGIBILITY-GROUP="72", "73", "74", "75" are expected to be covered by an alternative benefit plan and should be reported with RESTRICTED-BENEFITS CODE=7 and STATE-PLAN-OPTION-TYPE="06”.|

DE No|Data Element Name|Definition| CODING REQUIREMENT|CIP025|1115A-DEMONSTRAT IND|Indicates that the claim or encounter was covered under the authority of an 1115(A) demonstration. 1115(A) is a Center for Medicare and Medicaid Innovation demonstration|1 Value must be in 1115A Demonstration Indicator List (VVL)2.(FD1) when value equals '0', i invalid or not populated, the associated 1115A Demonstration Indicator (ELG.018.223) mu equal '0', is invalid or not populated3. Value must be 1 character4. Conditional
DE No|Data Element Name|Definition| CODING REQUIREMENT|COT024|1115A-DEMONSTRATION-IND|Indicates that the claim or encounter was covered under the author an 1115(A) demonstration. 1115(A) is a Center for Medicare and Medicaid Innovation demonstration|1. Value must be in 1115A Demonstration Indicator List (VVL)2.(FD1) when value equals '0', is invalid or not populated, the associated 1115A Demonstration Indicator (ELG.018.223) must equal '0', is invalid or not populated3. Value must be 1 character4. Conditional
DE No|Data Element Name|Definition| CODING REQUIREMENT|CRX024|1115A-DEMONSTRATION-IND|Indicates that the claim or encounter was covered under the author an 1115(A) demonstration. 1115(A) is a Center for Medicare and Medicaid Innovation demonstration|1. Value must be in 1115A Demonstration Indicator List (VVL)2.(FD1) when value equals '0', is invalid or not populated, the associated 1115A Demonstration Indicator (ELG.018.223) must equal '0', is invalid or not populated3. Value must be 1 character4. Conditional
DE No|Data Element Name|Definition| CODING REQUIREMENT|CLT024|1115A-DEMONSTRATION-IND|Indicates that the claim or encounter was covered under the author an 1115(A) demonstration. 1115(A) is a Center for Medicare and Medicaid Innovation demonstration|1. Value must be in 1115A Demonstration Indicator List (VVL)2.(FD1) when value equals '0', is invalid or not populated, the associated 1115A Demonstration Indicator (ELG.018.223) must equal '0', is invalid or not populated3. Value must be 1 character4. Conditional
DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|CLT045|ADMISSION-HOU The time of admission to a psychiatric or long-term care facility.|1.(LV) value must be in Ho List (VVL)2.(S) value must be 2 characters3.(N) conditional|
|DE NO|DATA ELEMENT NAME| DEFINITION||CIP030|ADMITTING-DIAGNOSIS-CODE|ICD-9 or 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".|

|DE NO|DATA ELEMENT NAME| DEFINITION||CLT027|ADMITTING-DIAGNOSIS-CODE|ICD-9 or 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".|

|DE No|Data Element Name|Definition|CLT027|ADMITTING-DIAGNOSIS-CODE|ICD-9 or ICD-1 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".1.(GS) value must satisfy the requirements of Diagnosi Code (CE)|

|DE No|Data Element Name|Definition||CLT174|ADMITTING-PROV-NPI-NUM|A National Provi Identifier (NPI) is a unique 10-digit identification number issued to health care providers in 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, intelliger free numeric identifier (10-digit number).|

|DE No|Data Element Name|Definition||CIP184|ADMITTING-PROV-NPI-NUM|A National Provi Identifier (NPI) is a unique 10-digit identification number issued to health care providers in 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, intelliger free numeric identifier (10-digit number).|

|DE No|Data Element Name|Definition||PRV120|AFFILIATED-PROGRAM-IDA data element to identify the Medicaid/CHIP programs, waivers and demonstrations in which the provider participates.(health plan federalassigned) if associated Affiliated Program Type (DE) value then value must be the federal-assigned plan ID of the health plan in which a provideris enrolled to provide services.(health plan state assigned) if associated Affiliated Program Ty (DE) value is 2, then value must be the state-assignedplan 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 valuemust be the core Federal Waiver ID in which a provider is allowed to deliver services to eligible beneficiaries.(health home entity) if associated AffiliatedProgram 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 ProgramType (DE) value is 5, then value must b identifier for something other than a health plan, waiver, or health home entity.

|DE No|Data Element Name|Definition||PRV119|AFFILIATED-PROGRAM-TYPE| A code to iden
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
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 Ty
(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 AffiliatedProgra
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 ProgramType (DE) value is 5, then value must
identifier for something other than a health plan, waiver, or health home entity.|

|DE No|Data Element Name|Definition||CIP180|BILLING-PROV-NPI-NUM|A National Provider
Identifier (NPI) is a unique 10-digit identification number issued to health care providers in
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, intelliger
free numeric identifier (10-digit number).|

|DE No|Data Element Name|Definition||CLT131|BILLING-PROV-NPI-NUM|A National Provider
Identifier (NPI) is a unique 10-digit identification number issued to health care providers in
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, intelliger
free numeric identifier (10-digit number).|

|DE No|Data Element Name|Definition||COT113|BILLING-PROV-NPI-NUM|A National Provide
Identifier (NPI) is a unique 10-digit identification number issued to health care providers in
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, intelliger
free numeric identifier (10-digit number).|

|DE No|Data Element Name|Definition||CRX071|BILLING-PROV-NPI-NUM|A National Provide
Identifier (NPI) is a unique 10-digit identification number issued to health care providers in
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, intelliger
free numeric identifier (10-digit number).|

|DE NO| DATA ELEMENT NAMECIP071|PROCEDURE-CODE-MOD-1

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCIP071|PROCEDURE-CODE-M
1|X(2)|CLAIMIP|CLAIM-HEADER-RECORD-IP-CIP00002

|DE NO| DATA ELEMENT NAMECIP075|PROCEDURE-CODE-MOD-2

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCIP075|PROCEDURE-CODE-M
2|X(2)|CLAIMIP|CLAIM-HEADER-RECORD-IP-CIP00002

|DE NO| DATA ELEMENT NAMECIP079|PROCEDURE-CODE-MOD-3

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCIP079|PROCEDURE-CODE-M
3|X(2)|CLAIMIP|CLAIM-HEADER-RECORD-IP-CIP00002

|DE NO| DATA ELEMENT NAMECIP083|PROCEDURE-CODE-MOD-4

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCIP083|PROCEDURE-CODE-M 4|X(2)|CLAIMIP|CLAIM-HEADER-RECORD-IP-CIP00002
|DE NO| DATA ELEMENT NAMECIP087|PROCEDURE-CODE-MOD-5
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCIP087|PROCEDURE-CODE-M 5|X(2)|CLAIMIP|CLAIM-HEADER-RECORD-IP-CIP00002
|DE NO| DATA ELEMENT NAMECIP091|PROCEDURE-CODE-MOD-6
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCIP091|PROCEDURE-CODE-M 6|X(2)|CLAIMIP|CLAIM-HEADER-RECORD-IP-CIP00002
|DE NO| DATA ELEMENT NAMECIP107|ALLOWED-CHARGE-SRC
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCIP107|ALLOWED-CHARGE-S X(1)|CLAIMIP|CLAIM-LINE-RECORD-IP-CIP00003
|DE NO| DATA ELEMENT NAMECIP115|TOT-COPAY-AMT
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCIP115|TOT-COPAY-AMT| S9(11)V99|CLAIMIP|CLAIM-HEADER-RECORD-IP-CIP00002
|DE NO| DATA ELEMENT NAMECIP131|NATIONAL-HEALTH-CARE-ENTITY-ID
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCIP131|NATIONAL-HEALTH-C ENTITY-ID|X(10)|CLAIMIP|CLAIM-HEADER-RECORD-IP-CIP00002
|DE NO| DATA ELEMENT NAMECIP191|REFERRING-PROV-TAXONOMY
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCIP191|REFERRING-PROV-TAXONOMY|X(12)|CLAIMIP|CLAIM-HEADER-RECORD-IP-CIP00002
|DE NO| DATA ELEMENT NAMECIP192|REFERRING-PROV-TYPE
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCIP192|REFERRING-PROV-TYI X(2)|CLAIMIP|CLAIM-HEADER-RECORD-IP-CIP00002
|DE NO| DATA ELEMENT NAMECIP193|REFERRING-PROV-SPECIALTY
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCIP193|REFERRING-PROV-SPECIALTY|X(2)|CLAIMIP|CLAIM-HEADER-RECORD-IP-CIP00002
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE SEGMENT (with RECORD-ID)CIP195|DRG-REL-WEI X(8)|CLAIM-HEADER-RECORD-IP-CIP00002
DE_NO|DATA_ELEMENT_NAME|SIZE|CIP195|DRG-REL-WEIGHT|X(8)|
|DE NO| DATA ELEMENT NAMECIP201|BMI
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCIP201|BMI|S9(5)V9|CLAIMIP CLAIM-HEADER-RECORD-IP-CIP00002
|DE NO| DATA ELEMENT NAME|DEFINITIONCIP206|BENEFICIARY-COINSURANCE-AMOUNT|Th amount of money the beneficiary paid towards coinsurance.
DE No|Data Element NameCIP206|BENEFICIARY-COINSURANCE-AMOUNT
|DE NO| DATA ELEMENT NAME|DEFINITIONCIP208|BENEFICIARY-COPAYMENT-AMOUNT|The amount of money the beneficiary paid towards a co-payment.

DE No|Data Element NameCIP208|BENEFICIARY-COPAYMENT-AMOUNT
|DE NO| DATA ELEMENT NAME|DEFINITIONCIP210|BENEFICIARY-DEDUCTIBLE-AMOUNT|The amount of money the beneficiary paid towards an annual deductible.
DE No|Data Element NameCIP210|BENEFICIARY-DEDUCTIBLE-AMOUNT
|DE NO| DATA ELEMENT NAME|DEFINITIONCIP213|COPAY-WAIVED-IND|An indicator signifyi that the copay was waived by the provider.
DE No|Data Element Name|Definition| CODING REQUIREMENT|CIP214|HEALTH-HOME-ENTI NAME||1.Value must 50 characters or less2.Value must not contain a pipe or asterisk symbols3.Conditional
|DE NO| DATA ELEMENT NAMECIP224|UNDER-DIRECTION-OF-PROV-NPI
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCIP224|UNDER-DIRECTION-O PROV-NPI|X(10)|CLAIMIP|CLAIM-HEADER-RECORD-IP-CIP00002
|DE NO| DATA ELEMENT NAMECIP225|UNDER-DIRECTION-OF-PROV-TAXONOMY
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCIP225|UNDER-DIRECTION-O PROV-TAXONOMY|X(12)|CLAIMIP|CLAIM-HEADER-RECORD-IP-CIP00002
|DE NO| DATA ELEMENT NAMECIP226|UNDER-SUPERVISION-OF-PROV-NPI
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCIP226|UNDER-SUPERVISION PROV-NPI|X(10)|CLAIMIP|CLAIM-HEADER-RECORD-IP-CIP00002
|DE NO| DATA ELEMENT NAMECIP227|UNDER-SUPERVISION-OF-PROV-TAXONOMY
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCIP227|UNDER-SUPERVISION PROV-TAXONOMY|X(12)|CLAIMIP|CLAIM-HEADER-RECORD-IP-CIP00002
|DE NO| DATA ELEMENT NAME|CODING REQUIREMENTCIP249|IP-LT-QUANTITY-OF-SERVICE ACTUAL|For use with CLAIMIP and CLAIMLT claims. For CLAIMOT and CLAIMRX claims/enco records, use the OT-RX-CLAIM-QUANTITY-ACTUAL field
DE No|Data Element NameCIP249|IP-LT-QUANTITY-OF-SERVICE-ACTUAL
|DE NO| DATA ELEMENT NAME|CODING REQUIREMENTCIP250|IP-LT-QUANTITY-OF-SERVICE ALLOWED|
DE No|Data Element NameCIP250|IP-LT-QUANTITY-OF-SERVICE-ALLOWED
|DE NO| DATA ELEMENT NAMECIP253|TPL-AMT

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCIP253|TPL-AMT|S9(11)V99
|DE NO| DATA ELEMENT NAMECIP262|SERVICING-PROV-TAXONOMY
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCIP262|SERVICING-PROV-TAXONOMY|X(12)|CLAIMIP|CLAIM-LINE-RECORD-IP-CIP00003
SIZEX(4)
SIZES9(6)V999
N/A
N/A

N/A
N/A
N/A
N/A
N/A
N/A
N/A

N/A
N/A
N/A
N/A
N/A
N/A
|DE No|Data Element Name|Coding Requirement||CIP103,CLT.055,COT.040,CRX.031|CLAIM STATUS-CATEGORY|(Denied Claim) if associated Type of Claim equals Z or associated Clai Status is in [26, 87, 542, 858, 654], then value must be "F2"
|DE NO| DATA ELEMENT NAMECLT066|TOT-COPAY-AMT
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCLT066|TOT-COPAY-AMT| S9(11)V99|CLAIMLT|CLAIM-HEADER-RECORD-LT-CLT00002
|DE NO| DATA ELEMENT NAMECLT081|NATIONAL-HEALTH-CARE-ENTITY-ID
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCLT081|NATIONAL-HEALTH-C ENTITY-ID|X(10)|CLAIMLT|CLAIM-HEADER-RECORD-LT-CLT00002
|DE NO| DATA ELEMENT NAMECLT137|REFERRING-PROV-TAXONOMY

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCLT137|REFERRING-PROV-TAXONOMY|X(12)|CLAIMLT|CLAIM-HEADER-RECORD-LT-CLT00002
|DE NO| DATA ELEMENT NAMECLT138|REFERRING-PROV-TYPE
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCLT138|REFERRING-PROV-TY X(2)|CLAIMLT|CLAIM-HEADER-RECORD-LT-CLT00002
|DE NO| DATA ELEMENT NAMECLT139|REFERRING-PROV-SPECIALTY
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCLT139|REFERRING-PROV-SPECIALTY|X(2)|CLAIMLT|CLAIM-HEADER-RECORD-LT-CLT00002
|DE NO| DATA ELEMENT NAMECLT143|BMI
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCLT143|BMI|S9(5)V9|CLAIML CLAIM-HEADER-RECORD-LT-CLT00002
|DE NO| DATA ELEMENT NAME|DEFINITIONCLT153|BENEFICIARY-COINSURANCE-AMOUNT|T amount of money the beneficiary paid towards coinsurance.
DE No|Data Element NameCLT153|BENEFICIARY-COINSURANCE-AMOUNT
|DE NO| DATA ELEMENT NAME|DEFINITIONCLT155|BENEFICIARY-COPAYMENT-AMOUNT|The amount of money the beneficiary paid towards a co-payment.
DE No|Data Element NameCLT155|BENEFICIARY-COPAYMENT-AMOUNT
|DE NO| DATA ELEMENT NAME|DEFINITIONCLT157|BENEFICIARY-DEDUCTIBLE-AMOUNT|The amount of money the beneficiary paid towards an annual deductible.
DE No|Data Element NameCLT157|BENEFICIARY-DEDUCTIBLE-AMOUNT
|DE NO| DATA ELEMENT NAME|DEFINITIONCLT160|COPAY-WAIVED-IND|An indicator signify that the copay was waived by the provider.
DE No|Data Element Name|Definition| CODING REQUIREMENT|CLT.161|HEALTH-HOME-ENT NAME||1.(GS) value must satisfy the requirements of Health Home Entity Name (CE)
|DE NO| DATA ELEMENT NAMECLT169|UNDER-DIRECTION-OF-PROV-NPI
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCLT169|UNDER-DIRECTION-C PROV-NPI|X(12)|CLAIMLT|CLAIM-HEADER-RECORD-LT-CLT00002
|DE NO| DATA ELEMENT NAMECLT170|UNDER-SUPERVISION-OF-PROV-NPI
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCLT170|UNDER-DIRECTION-C PROV-TAXONOMY|X(12)|CLAIMLT|CLAIM-HEADER-RECORD-LT-CLT00002

|DE NO| DATA ELEMENT NAMECLT171|UNDER-SUPERVISION-OF-PROV-NPI

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCLT171|UNDER-SUPERVISION-PROV-NPI|X(12)|CLAIMLT|CLAIM-HEADER-RECORD-LT-CLT00002

|DE NO| DATA ELEMENT NAMECLT172|UNDER-SUPERVISION-OF-PROV-TAXONOMY

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCLT172|UNDER-SUPERVISION-PROV-TAXONOMY|X(12)|CLAIMLT|CLAIM-HEADER-RECORD-LT-CLT00002

|DE NO| DATA ELEMENT NAME|CODING REQUIREMENTCLT202|IP-LT-QUANTITY-OF-SERVICE-ACTUAL|For use with CLAIMIP and CLAIMLT claims. For CLAIMOT and CLAIMRX claims/enco records, use the OT-RX-CLAIM-QUANTITY-ACTUAL field

DE No|Data Element NameCLT202|IP-LT-QUANTITY-OF-SERVICE-ACTUAL

|DE NO| DATA ELEMENT NAME|CODING REQUIREMENTCLT203|IP-LT-QUANTITY-OF-SERVICE-ALLOWED|For use with CLAIMIP and CLAIMLT claims. For CLAIMOT and CLAIMRX claims/encounter records, use the OT-RX-CLAIM-QUANTITY-ACTUAL field

DE No|Data Element NameCLT203|IP-LT-QUANTITY-OF-SERVICE-ALLOWED

|DE NO| DATA ELEMENT NAMECLT214|SERVICING-PROV-TAXONOMY

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCLT214|SERVICING-PROV-TAXONOMY|X(12)|CLAIMLT|CLAIM-LINE-RECORD-LT-CLT00003

SIZEX(4)

SIZES9(6)V999

N/A

N/A

N/A
N/A
N/A
N/A
N/A
N/A
N/A
N/A

DE NO|DATA ELEMENT NAME|DEFINITION|CODING REQUIREMENT|CRX086|COMPOUND-DRU IND|Indicator to specify if the drug is compound or not. see Compound Drug Indicator List (VVL.038)|1.(LV) value must be in Compound Drug Indicator List (VVL)2.(S) value must be character3.(N) conditional
|DE NO| DATA ELEMENT NAMECOT051|TOT-COPAY-AMT
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCOT051|TOT-COPAY-AMT| S9(11)V99|CLAIMOT|CLAIM-HEADER-RECORD-OT-COT00002
|DE NO| DATA ELEMENT NAMECOT067|NATIONAL-HEALTH-CARE-ENTITY-ID
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCOT067|NATIONAL-HEALTH-C ENTITY-ID|X(10)|CLAIMOT|CLAIM-HEADER-RECORD-OT-COT00002
|DE NO| DATA ELEMENT NAMECOT119|REFERRING-PROV-TAXONOMY
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCOT119|REFERRING-PROV-TAXONOMY|X(12)|CLAIMOT|CLAIM-HEADER-RECORD-OT-COT00002
|DE NO| DATA ELEMENT NAMECOT120|REFERRING-PROV-TYPE
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCOT120|REFERRING-PROV-TY X(2)|CLAIMOT|CLAIM-HEADER-RECORD-OT-COT00002
|DE NO| DATA ELEMENT NAMECOT121|REFERRING-PROV-SPECIALTY
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCOT121|REFERRING-PROV-SPECIALTY|X(2)|CLAIMOT|CLAIM-HEADER-RECORD-OT-COT00002
|DE NO| DATA ELEMENT NAMECOT125|BMI
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCOT125|BMI|S9(5)V9|CLAIMC CLAIM-HEADER-RECORD-OT-COT00002
|DE NO| DATA ELEMENT NAME|DEFINITIONCOT130|BENEFICIARY-COINSURANCE-AMOUNT|T amount of money the beneficiary paid towards coinsurance.
DE No|Data Element NameCOT130|BENEFICIARY-COINSURANCE-AMOUNT
|DE NO| DATA ELEMENT NAME|DEFINITIONCOT132|BENEFICIARY-COPAYMENT-AMOUNT|The amount of money the beneficiary paid towards a co-payment.
DE No|Data Element NameCOT132|BENEFICIARY-COPAYMENT-AMOUNT
|DE NO| DATA ELEMENT NAME|DEFINITIONCOT134|BENEFICIARY-DEDUCTIBLE-AMOUNT|The amount of money the beneficiary paid towards an annual deductible.
DE No|Data Element NameCOT134|BENEFICIARY-DEDUCTIBLE-AMOUNT

|DE NO| DATA ELEMENT NAME|DEFINITIONCOT137|COPAY-WAIVED-IND|An indicator signify that the copay was waived by the provider.

DE No|Data Element Name|Definition| CODING REQUIREMENT|COT138|HEALTH-HOME-ENT NAME||1.Value must 50 characters or less2.Value must not contain a pipe or asterisk symbols3.Conditional

|DE NO| DATA ELEMENT NAMECOT144|DATE-CAPITATED-AMOUNT-REQUESTED

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCOT144|DATE-CAPITATED-AMOUNT-REQUESTED|9(8)|CLAIMOT|CLAIM-HEADER-RECORD-OT-COT00002

|DE NO| DATA ELEMENT NAMECOT145|CAPITATED-PAYMENT-AMT-REQUESTED

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCOT145|CAPITATED-PAYMENT AMT-REQUESTED|S9(11)V99|CLAIMOT|CLAIM-HEADER-RECORD-OT-COT00002

|DE NO| DATA ELEMENT NAMECOT148|UNDER-DIRECTION-OF-PROV-NPI

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCOT148|UNDER-DIRECTION-O PROV-NPI|X(10)|CLAIMOT|CLAIM-HEADER-RECORD-OT-COT00002

|DE NO| DATA ELEMENT NAMECOT149|UNDER-DIRECTION-OF-PROV-TAXONOMY

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENT COT149|UNDER-DIRECTION-PROV-TAXONOMY|X(12)|CLAIMOT|CLAIM-HEADER-RECORD-OT-COT00002

|DE NO| DATA ELEMENT NAMECOT151|UNDER-SUPERVISION-OF-PROV-TAXONOMY

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCOT151|UNDER-SUPERVISIO PROV-TAXONOMY|X(12)|CLAIMOT|CLAIM-HEADER-RECORD-OT-COT00002

|DE NO| DATA ELEMENT NAME|NECESSITY|DEFINITIONCOT176|COPAY-AMT |Conditional|The copayment amount paid by an enrollee for the service, which does not include the amount by the insurance company.

DE No|Data Element NameCOT176|COPAY-AMT

SIZES9(6)V999

DE No|Data Element NameCOT183|OT-RX-CLAIM-QUANTITY-ACTUAL

|DE NO| DATA ELEMENT NAME|DEFINITION|CODING REQUIREMENTCOT183|OT-RX-CLAIM-QUANTITY-ACTUAL|The quantity of a drug, service, or product that is rendered/dispensed f prescription, specific date of service, or billing time span.|For use with CLAIMOT and CLAIM claims. For CLAIMIP and CLAIMOT claims/encounter records, use the IP-LT-QUANTITY-OF-SERVICE field. The value in OT-RX-CLAIM-QUANTITY-ACTUAL must correspond with the valu UNIT-OF-MEASURE.This field is only applicable when the service being billed can be quanti in discrete units, e.g., a number of visits or the number of units of a prescription/refill that filled. For prescriptions/refills, use the Medicaid Drug Rebate definition of a unit, which is th smallest unit by which the drug is normally measured; e.g. tablet, capsule, milliliter, etc. F drugs not identifiable or dispensed by a normal unit, e.g. powder filled vials, use 1 as the number of units

SIZES9(6)V999

DE No|Data Element NameCOT184|OT-RX-CLAIM-QUANTITY-ACTUAL

|DE NO| DATA ELEMENT NAME|DEFINITION|CODING REQUIREMENTCOT184|OT-RX-CLAIM-QUANTITY-ALLOWED|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 t quantity allowed.|For use with CLAIMOT and CLAIMRX claims. For CLAIMIP and CLAIMOT claims/encounter records, use the IP-LT-QUANTITY-OF-SERVICE field. NOTE: One prescriptio 100 250 milligram tablets results in OT-RX-CLAIM-QUANTITY-ALLOWED =100.This field is o applicable when the service being billed can be quantified in discrete units, e.g., a number visits or the number of units of a prescription/refill that were filled. For prescriptions/refills, the Medicaid Drug Rebate definition of a unit, which is the smallest unit by which the drug normally measured; e.g. tablet, capsule, milliliter, etc. For drugs not identifiable or dispens by a normal unit, e.g. powder filled vials, use 1 as the number of units.The value in OT-RX-CLAIM-QUANTITY-ALLOWED must correspond with the value in UNIT-OF-MEASURE.

SIZEX(4)

|DE NO| DATA ELEMENT NAMECOT220|HCPCS-RATE

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCOT220|HCPCS-RATE|X(14)|CLAIMOT|CLAIM-LINE-RECORD-OT-COT00003

SIZES9(6)V999

N/A

N/A
N/A
N/A
N/A
N/A
N/A
N/A
N/A

N/A
N/A
N/A
N/A
N/A
|DE NO| DATA ELEMENT NAME DEFINITION||TPL058|COVERAGE-TYPE|This code identifies th relationship of the policy holder to the Medicaid/CHIP beneficiary.see Policy Owner Code Li (VVL.099)|
|DE NO| DATA ELEMENT NAMECRX042|TOT-COPAY-AMT
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCRX042|TOT-COPAY-AMT| S9(11)V99|CLAIMRX|CLAIM-HEADER-RECORD-RX-CRX00002
|DE NO| DATA ELEMENT NAMECRX057|NATIONAL-HEALTH-CARE-ENTITY-ID
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCRX057|NATIONAL-HEALTH-C ENTITY-ID|X(10)|CLAIMRX|CLAIM-HEADER-RECORD-RX-CRX00002
|DE NO| DATA ELEMENT NAMECRX076|PRESCRIBING-PROV-TAXONOMY
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCRX076|PRESCRIBING-PROV- TAXONOMY|X(12)|CLAIMRX|CLAIM-HEADER-RECORD-RX-CRX00002
|DE NO| DATA ELEMENT NAMECRX077|PRESCRIBING-PROV-TYPE
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCRX077|PRESCRIBING-PROV- TYPE|X(2)|CLAIMRX|CLAIM-HEADER-RECORD-RX-CRX00002
|DE NO| DATA ELEMENT NAMECRX078|PRESCRIBING-PROV-SPECIALTY
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCRX078|PRESCRIBING-PROV- SPECIALTY|X(2)|CLAIMRX|CLAIM-HEADER-RECORD-RX-CRX00002

|DE NO| DATA ELEMENT NAME|DEFINITIONCRX087|BENEFICIARY-COINSURANCE-AMOUNT|T
amount of money the beneficiary paid towards coinsurance.

DE No|Data Element NameCRX087|BENEFICIARY-COINSURANCE-AMOUNT

|DE NO| DATA ELEMENT NAME|DEFINITIONCRX089|BENEFICIARY-COPAYMENT-AMOUNT|The
amount of money the beneficiary paid towards a co-payment.

DE No|Data Element NameCRX089|BENEFICIARY-COPAYMENT-AMOUNT

|DE NO| DATA ELEMENT NAME|DEFINITIONCRX092|BENEFICIARY-DEDUCTIBLE-AMOUNT|The
amount of money the beneficiary paid towards an annual deductible.

DE No|Data Element NameCRX092|BENEFICIARY-DEDUCTIBLE-AMOUNT

|DE NO| DATA ELEMENT NAME|DEFINITIONCRX095|COPAY-WAIVED-IND|An indicator signify
that the copay was waived by the provider.

DE No|Data Element Name|Definition| CODING REQUIREMENT|CRX.096|HEALTH-HOME-ENT
NAME||1.(GS) value must satisfy the requirements of Health Home Entity Name (CE)

|DE NO| DATA ELEMENT NAMECRX103|DISPENSING-PRESCRIPTION-DRUG-PROV-TAXONOMY

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCRX103|DISPENSING-
PRESCRIPTION-DRUG-PROV-TAXONOMY|X(12)|CLAIMOT|CLAIM-HEADER-RECORD-RX-CRX00

|DE NO| DATA ELEMENT NAME|NECESSITY|DEFINITIONCRX123|COPAY-AMT |Conditional|The
copayment amount paid by an enrollee for the service, which does not include the amount
by the insurance company.

DE No|Data Element NameCRX123|COPAY-AMT

SIZES9(6)V999

DE No|Data Element NameCRX131|OT-RX-CLAIM-QUANITY-ALLOWED
|DE NO| DATA ELEMENT NAME|NECESSITY|DEFINITION |CODING REQUIREMENTCRX131|OT-CLAIM-QUANITY-ALLOWED||The maximum allowable quantity of a drug or service that may 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 t quantity allowed.|NOTE: One prescription for 100 250 milligram tablets results in OT-RX-CL QUANTITY-ALLOWED =100.
|DE NO| DATA ELEMENT NAME|CODING REQUIREMENTCRX131|OT-RX-CLAIM-QUANITY-ALLOWED|The value in OT-RX-CLAIM-QUANTITY-ALLOWED must correspond with the value UNIT-OF-MEASURE.
SIZES9(6)V999
DE No|Data Element NameCRX132|OT-RX-CLAIM-QUANTITY-ACTUAL
|DE NO| DATA ELEMENT NAME|NECESSITY|DEFINITION |CODING REQUIREMENTCRX132|OT-CLAIM-QUANTITY-ACTUAL||The quantity of a drug, service, or product that is rendered/dispensed for a prescription, specific date of service, or billing time span.|The va OT-RX-CLAIM-QUANTITY-ACTUAL must correspond with the value in UNIT-OF-MEASURE.
|DE NO| DATA ELEMENT NAME|NECESSITY|DEFINITIONCRX141|DISPENSE-FEE||The charge t cover the cost of dispensing the prescription. Dispensing costs include overhead, supplies, labor, etc. to fill the prescription.
DE No|Data Element NameCRX141|DISPENSE-FEE
SIZEX(4)
N/A
N/A
N/A

N/A
N/A
N/A
N/A
N/A
N/A
N/A

N/A
N/A
N/A
N/A
N/A
N/A
N/A
N/A
N/A

N/A
N/A
N/A
DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|PRV034|DATE-OF-BIRTH individual's date of birth.|1.Value must be 8 characters in the form "CCYYMMDD"2. The dat must be a valid calendar date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. (FD1) value must be less than or equal to associated End of Time Period (PRV.001.010)4. (FD1) value must be less than or equal to associated Date File Created (PRV.001.008)5. (N) conditional6. (FDN) the difference between current value and Start of Period (PRV.001.009) must be between 18 and 85 years|
DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|CLT126|DATE-OF-BIRTH| individual's date of birth.|1.Value must be 8 characters in the form "CCYYMMDD"2. The dat must be a valid calendar date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3.(N) mandatory4.(FD) value must equal Date of Birth (ELG.002.024) when Conceptio Birth Indicator (ELG.005.094) does not equal '1' and Eligibility Group (ELG.005.087)does no equal '64'|
DE No|Data Element Name|Definition| CODING REQUIREMENT|COT207|DESTINATION-STAT The ANSI state numeric code for the U.S. state, Territory, or the District of Columbia code d destination state in which a patient is transported either from home or a long term care fa to a health care provider for healthcare services or vice versa.|1.(GS) value must satisfy th requirements of Address State (CE)2.(FD1) (transportation claim) value is mandatory and n be provided for all transportation claims3.(N) conditional|
|DE NO| DATA ELEMENT NAME| DEFINITION||COT208|DESTINATION-ZIP-CODE|Description: U ZIP Code component of an address associated with a given entity (e.g. person, organizatio agency, etc.)|
|DE No|Data Element Name|Definition||CIP069|DIAGNOSIS-RELATED-GROUP-IND|An indicat identifying the grouping algorithm used to assign Diagnosis Related Group (DRG) values.|

DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|ELG224 |DISABILITY-TYP CODE |Obsolete |1.(LV) value must be in Disability Type Code List (VVL)2.(S) value must be characters3.(N) conditional
DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|CRX141|DISPENSE-FEE|T 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 t provider towards the professional dispensing fee.If the provider does not break out the professional dispensingfee 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 professionaldispens fee amount paid, or the amount billed or paid towards ingredient costs.|1.(S) value may in up to 6 digits to the left of the decimal point, and 3 digits to the right e.g. 123456.7892.(N) mandatory
|DE No|Data Element Name|Definition||CRX102|DISPENSING-PRESCRIPTION-DRUG-PROV-N National Provider Identifier (NPI) is a unique 10-digit identification number issued to health providers in the United States by CMS. Healthcare providers acquire their unique 10-digit N to identify themselves in a standard way throughout their industry. The NPI is a 10-position intelligence-free numeric identifier (10-digit number).|
|DE No|Data Element Name|Definition||CIP029|DRG-DESCRIPTION|Description of the associ state-specific DRG code. If using standard MS-DRG classification system, a DRG Descriptio not required.|
|DE No|Data Element Name|Definition| CODING REQUIREMENTCIP194 |DRG-OUTLIER-AMT|T 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 "diagn related group" discharge with extra dollars for patient stays that substantially exceed the typical requirements for patient stays in the same DRG category. |1.(GS) value must satisf requirements of US Dollar Amount (DT)2.(N) conditional3.(FD1) value must not be populate when Outlier Code (CIP.002.197) is '01' ,'02' or '10'
|DE No|Data Element Name|Definition||CIP195|DRG Relative Weight |The relative weight fo 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 annuallyin 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.|

DE No|Data Element Name|CODING REQUIREMENT|CRX143|DRUG-UTILIZATION-CODE|1.(S
value must be 6 characters or less2.(S) characters 1 and 2 (2-character string) may be in D
Utilization Result of Service Code List (VVL), or spaces in cases where code is unused or no
available3.(S) characters 3 and 4 (2-character string) may be in Drug Utilization Profession
Service Code List (VVL), or spaces in cases where code is unused or not available4.(S)
characters 5 and 6 (2-character string) may be in Drug Utilization Reason For Service Code
(VVL), or not populated in cases where code is unused or not available5.(N) mandatory|

DE No|Data Element Name|Definition| CODING REQUIREMENT|ELG262|ELG-IDENTIFIER-ISSUING-ENTITY-ID|This data element is reserved for future use.|1.(S) value must be 18 characters or less2.(N) optional|

|DE NO| DATA ELEMENT NAMEELG045|PRIMARY-LANGUAGE-ENGL-PROF-CODE

DE No|Data Element NameELG045|PRIMARY-LANGUAGE-ENGL-PROF-CODE

DE NO| DATA ELEMENT NAME COMPUTING|ELG065|ADDR-TYPE

DE No|Segment Name|DE Name|DefinitionELG095|ELIGIBILITY-DETERMINANTS-ELG00005|
ELIGIBILITY-CHANGE-REASON|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.

DE No|Data Element Name|Definition| CODING REQUIREMENT|ELG108|HEALTH-HOME-ENT
NAME|A field to identify the health home SPA in which an individual is enrolled. Because ar
identification numbering schema has not been established, the entities' names are being u
instead.|1.(S) value must 100 characters or less2.(IV) value must not contain a pipe symbo
(N) mandatory|

DE No|Data Element Name|Definition| CODING REQUIREMENT|ELG119|HEALTH-HOME-ENT
NAME| A field to identify the health home SPA in which an individual is enrolled. Because a
identification numbering schema has not been established, the entities' names are being u
instead.|1.(S) value must 100 characters or less2.(IV) value must not contain a pipe symbo
(N) mandatory

|DE NO| DATA ELEMENT NAMEELG194|NATIONAL-HEALTH-CARE-ENTITY-ID

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTELG194|NATIONAL-HEALTH-C
ENTITY-ID|X(10)|ELIGIBLE|MANAGED-CARE-PARTICIPATION-ELG00014

|DE NO| DATA ELEMENT NAMEELG195|NATIONAL-HEALTH-CARE-ENTITY-ID-TYPE

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTELG195|NATIONAL-HEALTH-C
ENTITY-ID-TYPE|X(1)|ELIGIBLE|MANAGED-CARE-PARTICIPATION-ELG00014

|DE NO| DATA ELEMENT NAMEELG215|CERTIFIED-AMERICAN-INDIAN-ALASKAN-NATIVE-INDICATOR

DE No|Data Element NameELG215|CERTIFIED-AMERICAN-INDIAN-ALASKAN-NATIVE-INDICA

N/A
N/A
N/A
N/A
N/A
N/A
|DE No|Data Element Name|Definition||ELG131|HEALTH-HOME-CHRONIC-CONDITION-OTHE EXPLANATION|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.|
DE No|Data Element Name|Definition|CODING REQUIREMENT|ELG111|HEALTH-HOME-ENTI EFF-DATE|The date on which the health home entity was approved by CMS to participate i Health Home Program.|1.(GS) value must satisfy the requirements of Date (DT)
DE No|Data Element Name|Definition| CODING REQUIREMENT|ELG123|HEALTH-HOME-ENT EFF-DATE|The date on which the health home entity was approved by CMS to participate i Health Home Program.|1.Value must be 8 characters in the form "CCYYMMDD"2.(LV) the d must be a valid calendar date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)2.(N) mandatory

|DE No|Data Element Name|Definition||CIP221|HEALTH-HOME-PROVIDER-NPI|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 N to identify themselves in a standard way throughout their industry. The NPI is a 10-position intelligence-free numeric identifier (10-digit number).||CLT167|HEALTH-HOME-PROVIDER-N National Provider Identifier (NPI) is a unique 10-digit identification number issued to health providers in the United States by CMS. Healthcare providers acquire their unique 10-digit N to identify themselves in a standard way throughout their industry. The NPI is a 10-position intelligence-free numeric identifier (10-digit number).||COT146|HEALTH-HOME-PROVIDER-N National Provider Identifier (NPI) is a unique 10-digit identification number issued to health providers in the United States by CMS. Healthcare providers acquire their unique 10-digit N to identify themselves in a standard way throughout their industry. The NPI is a 10-position intelligence-free numeric identifier (10-digit number).||CRX104|HEALTH-HOME-PROVIDER-N National Provider Identifier (NPI) is a unique 10-digit identification number issued to health providers in the United States by CMS. Healthcare providers acquire their unique 10-digit N to identify themselves in a standard way throughout their industry. The NPI is a 10-position intelligence-free numeric identifier (10-digit number).|

DE No|Data Element Name|Definition| CODING REQUIREMENT|ELG044|IMMIGRATION-STAT FIVE-YEAR-BAR-END-DATE||1.(GS) value must satisfy the requirements of End Date (CE)2.((U.S. Citizen) if associated Citizenship Indicator (ELG.003.040) value is '1', then value shou not be populated3.(FD1) (Non U.S. Citizen) if associated Citizenship Indicator (ELG.003.040 value is '0', then value should be populated4.(N) conditional5.(FD1) (U.S. Citizen) value sh not be populated when Immigration Status (ELG.003.042) equals '8'

|DE No|Data Element Name|Definition|CIP250|IP-LT-QUANTITY-OF-SERVICE-ALLOWED|On fa claim entries, this field is to capture maximum allowable quantity by revenue code catego e.g., number of days in a particular type of accommodation, pints of blood, etc. However, w HCPCS codes are required for services, the units are equal to the number of times the procedure/servicebeing reported was performed.|

DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|ELG088|LEVEL-OF-CARE STATUS||1. Value must be in Level of Care Status List (VVL)2. Value must be 3 characters3 Conditional

|DE No|Data Element Name|Definition||PRV069|LICENSE-OR-ACCREDITATION-NUMBER|A da element to capture the license or accreditation number issued to the provider by the licens entity or accreditation body identified in the LICENSE-ISSUING-ENTITY-ID data element.|

|DE No|Data Element Name|Definition||PRV067|LICENSE-TYPE|A code to identify the kind o license or accreditation number that is captured in the LICENSE-OR-ACCREDITATION-NUME data element.|

DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|ELG140|LOCKIN-PROV-N
The State-specific Medicaid Provider Identifier is a state-assigned unique identifier that sta
should report with all individual providers,practice groups, facilities, and other entities. Thi
should be the identifier that is used in the state's Medicaid Management Information Syste
1.Value must be 30 characters or less2.Value must be reported in Provider Identifier
(PRV.005.080) with an associated Provider Identifier Type (PRV.005.081) equal to '1'3.(N)
mandatory4.(DI) value must match Provider Identifier (PRV.005.081)

DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|ELG141|LOCKIN-PROV-T
1.(LV) value must be in Lockin Provider Type List (VVL)2.Value must be 2
characters3.Mandatory

DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|ELG182|LTSS-LEVEL-CAR
(LV) value must be in LTSS Level Care List (VVL)|

DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|ELG183|LTSS-PROV-NUM
unique identification number assigned by the state to the long term care facility furnishing
healthcare services to the individual.|1.Value must be 30 characters or less2. Value must b
reported in Provider Identifier (PRV.005.080) with an associated Provider Identifier Type
(PRV.005.081) equal to '1'3.(N) mandatory4.(DI) value must match Provider Identifier
(PRV.005.081)|

DE No|Data Element Name|Definition| CODING REQUIREMENT|ELG035|MARITAL-STATUS-
OTHER-EXPLANATION||1.(FD1) if associated Marital Status (ELG.003.035) equals '14' (Othe
then value is mandatory and must be provided2.(S) value must be 50 characters or less3.(
conditional

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTMCR091|RECORD-ID|X(8)|
MNGDCARE|NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-MCR00008MCR092|SUBMITTING-STA
X(2)|MNGDCARE|NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-MCR00008MCR093|RECORD-
NUMBER|9(11)|MNGDCARE|NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-MCR00008MCR094|
STATE-PLAN-ID-NUM|X(12)|MNGDCARE|NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-
MCR00008MCR095|NATIONAL-HEALTH-CARE-ENTITY-ID|X(10)|MNGDCARE|NATIONAL-HEAL
CARE-ENTITY-ID-INFO-MCR00008MCR096|NATIONAL-HEALTH-CARE-ENTITY-ID-TYPE|X(1)|
MNGDCARE|NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-MCR00008MCR097|NATIONAL-HEALT
CARE-ENTITY-NAME|X(50)|MNGDCARE|NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-
MCR00008MCR098|NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-EFF-DATE|9(8)|MNGDCARE|
NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-MCR00008MCR099|NATIONAL-HEALTH-CARE-ENT
ID-INFO-END-DATE|9(8)|MNGDCARE|NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-
MCR00008MCR0100|STATE-NOTATION|X(500)|MNGDCARE |NATIONAL-HEALTH-CARE-ENTIT
INFO-MCR00008MCR0101|FILLER|X(390)|MNGDCARE|NATIONAL-HEALTH-CARE-ENTITY-ID-I
MCR00008

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTMCR102|RECORD-ID|X(8)|
MNGDCARE|CHPID-SHPID-RELATIONSHIPS-MCR00009MCR103|SUBMITTING-STATE|X(2)|
MNGDCARE|CHPID-SHPID-RELATIONSHIPS-MCR00009MCR104|RECORD-NUMBER|9(11)|
MNGDCARE|CHPID-SHPID-RELATIONSHIPS-MCR00009MCR105|STATE-PLAN-ID-NUM|X(12)|
MNGDCARE|CHPID-SHPID-RELATIONSHIPS-MCR00009MCR106|CHPID|X(8)|MNGDCARE|CHP
SHPID-RELATIONSHIPS-MCR00009MCR107|SHPID|X(10)|MNGDCARE |CHPID-SHPID-
RELATIONSHIPS-MCR00009MCR108|CHPID-SHPID-RELATIONSHIP-EFF-DATE|9(8)|MNGDCAR
CHPID-SHPID-RELATIONSHIPS-MCR00009MCR109|CHPID-SHPID-RELATIONSHIP-END-DATE|9
MNGDCARE |CHPID-SHPID-RELATIONSHIPS-MCR00009MCR110|STATE-NOTATION|X(500)|
MNGDCARE |CHPID-SHPID-RELATIONSHIPS-MCR00009MCR111|FILLER|X(431)|MNGDCARE|
CHPID-SHPID-RELATIONSHIPS-MCR00009

DE NO|DATA ELEMENT NAME|DEFINITION|CODING REQUIREMENT|CRX128|MEDICARE-COIN
AMT|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 Amount (DT)|1.Value must be between -99999999999.99 99999999999.992.Value must be expressed as a number with 2-digit precision (e.g. 100.5 (payments can't be separated) value 99998 is an exception to the US Dollar Amount requirements4.(N) conditional

DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|CRX127|MEDICARE-DEDUCTIBLE-AMT| The amount paid by Medicaid/CHIP on this claim at the claim line level toward the beneficiary's Medicare deductible. If the Medicare deductibleamount can be identified separately from Medicare coinsurance payments, code that amount in this field. Medicare coinsurance anddeductible paymentscannot be separated, fill this field with the combined payment amount and MEDICARE-COINSURANCE-PAYMENT is not required.|1.(GS value must satisfy the requirements of US Dollar Amount (DT)2.(N) conditionalThe amount by Medicaid/CHIP on this claim at the claim line level toward the beneficiary's Medicare deductible. If the Medicare deductible amount can beidentified separately from Medicare coinsurance payments, code that amount in this field. If the Medicare coinsurance and deductible payments cannot be separated, fill this fieldwith thecombined payment amount MEDICARE-COINSURANCE-PAYMENT is not required. see US Dollar Amount (TMSIS.DT.000.

DE No|Data Element Name|Definition| CODING REQUIREMENT|ELG152|MFP-QUALIFIED-RESIDENCE|A code describing type of qualified institution at the time of transition to the community for an eligible MFP Demonstration participant.|

DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|ELG153|MFP-REASON-PARTICIPATION-ENDED| A code describing why an individual's participation in Money Follow the Person demonstration ended.|1. (LV) value must be in MFP Reason Participation Ended (VVL)2.(S) value must be 2 characters3.(N) conditional4.(FD1) value must not be populated when Enrollment End Date equals '9999-12-31'
ELG00005.R.4 (FD2) an eligibility determinant segment (ELIGIBILITY-DETERMINANTS - ELG00005) with Primary Eligibility Group Indicator = 1 must exist for each timespan for wh person is eligible for Medicaid or CHIP.
DE No|Data Element Name|Definition| CODING REQUIREMENT|CIP134|NON-COV-DAYS|The number of days of inpatient care not covered by the payer for this sequence as qualified b payer organization. The number of non-covereddays does not refer to days not covered for other service.1.Value must be a positive integer2.Value must be between 0:9999999999 (inclusive)3.Conditional
DE No|Data Element Name|Definition| CODING REQUIREMENT|CLT084|NON-COV-DAYS||1.(value must satisfy the requirements of Non-Covered Days (CE)2.(S) value must be 5 digits less
|DE No|Data Element Name|Definition||CIP265|OPERATING-PROV-NPI-NUM|A National Provi Identifier (NPI) is a unique 10-digit identification number issued to health care providers in 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, intelligen free numeric identifier (10-digit number).|
|DE NO| DATA ELEMENT NAME| DEFINITION||COT200|ORIGINATION-ADDR-LN2|The street address of the origination point from which a patient is transported either from home or Lo 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 conditional.|
|DE No|Data Element Name|Definition| CODING REQUIREMENT||COT202|ORIGINATION-STA 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 healthcare provider to a health care provider for healthcare services or vice versa.|1.Value must be in State Code List (VVL)2. Value must b characters3. conditional4. (transportation claim) value is mandatory and must be provided all transportation claims|
|DE No|Data Element Name|Definition| CODING REQUIREMENT||CIP197|OUTLIER-CODE| Th 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 denotes thesource for developing the DRG. https://www.resdac.org/cms-data/variables/me drgoutlier-stay-code1.(LV) value must be in Outlier Code List (VVL)2.(FD1) (Day Outlier) If Outlier Code is 01, then Outlier Days (CIP.002.198) must be populated.3.(S) value must be characters4.(N) conditional5.(FD1) if value equals '00' or '09', then DRG Outlier Amount (CIP.002.194) must not be populated|

DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|TPL044|POLICY-OWNER-FIRST-NAME|Individual's first name; first name component of full name (e.g. First Name, M Initial, Last Name).|1.Value must be 30 characters or less2. Value must not contain a pipe asterisk symbols3.(FD1) if TPL Health Insurance Coverage Indicator (TPL.002.020) equals " then value is mandatory|

DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|TPL045|POLICY-OWNER-LAST-NAME|Individual's last name; last name component of full name (e.g. First Name, Mid Initial, Last Name).1.Value must be 30 characters or less2. Value must not contain a pipe o asterisk symbols3.(N) Mandatory

|DE No|Data Element Name|Definition||CRX075|PRESCRIBING-PROV-NPI-NUM|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 N to identify themselves in a standard way throughout their industry. The NPI is a 10-position intelligence-free numeric identifier (10-digit number).|

DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|ELG045|PRIMARY-LANGUAGE-ENGL-PROF-CODE

DE No|Data Element Name|Definition| CODING REQUIREMENT|CIP070|PROCEDURE-CODE-1 1.When populated, there must be a corresponding Procedure Code Flag2.If associated Procedure Code Flag List (VVL) value indicates an ICD-9-CM encoding '02', then value must a valid ICD-9-CM procedure code3. If associated Procedure Code Flag List (VVL) value indic an ICD-10-CM encoding '07', then value must be a valid ICD-10-CM procedure code4. If associated Procedure Code Flag List (VVL) value indicates an "Other" encoding '10-87', the State must provide T-MSIS system with State-specific procedure code list, and value must valid State-specific procedure code5. Value must be 8 characters or less6.(N) conditional

|DE No|Data Element Name|Definition||PRV081|PROV-IDENTIFIER|A data element to captur various ways used to distinguish providers from one another on claims and other interactio between providers and other entities. The specific type of identifier is defined in the corresponding value in the PROVIDER-IDENTIFIER-TYPE data element.|

|DE No|Data Element Name|Definition||PRV078|PROV-IDENTIFIER-ISSUING-ENTITY-ID|A free field to capture the identity of the entity that issued the provider identifier in the PROV-IDENTIFIER data element. For (State Tax ID), if associated Provider Identifier Type (DE) val equal to 6, then value must be the name of the state's taxation division. For (Other), if associated Provider Identifier Type (DE) value is equal to 8, thenvalue must be the name o entity that issued the identifier.|

DE No|Data Element Name| CODING REQUIREMENT|PRV043|PROV-LOCATION-ID|1.(IV) valu must not contain a pipe symbol2.(S) value must be 5 characters or less

DE No|Data Element Name|Definition| CODING REQUIREMENT|PRV064|PROV-LOCATION-ID (IV) value must not contain a pipe symbol2.(S) value must be 5 characters or less
DE No|Data Element Name|Definition| CODING REQUIREMENT|PRV.076|PROV-LOCATION-ID (IV) value must not contain a pipe symbol2.(S) value must be 5 characters or less
DE No|Data Element Name|Definition| CODING REQUIREMENT|PRV129|PROV-LOCATION-ID (IV) value must not contain a pipe symbol2.(S) value must be 5 characters or less
DE NO| DATA ELEMENT NAME COMPUTING|PRV046|ADDR-TYPE
SIZEX(12)
SIZEX(12)
|DE No|Data Element Name|Definition||ELG266|REASON-FOR-CHANGE|A code to identify th reason for changing the MSIS Identification Number of a beneficiary and only required for I IDENTIFIER-TYPE '2-OldMSIS Identification Number'. For example, If MSIS Identification Nur of a beneficiary is being changed due to 'Merge with other MSIS ID' or 'Unmerge'.|
|DE No|Data Element Name|Definition||CIP190|REFERRING-PROV-NPI-NUM|A National Provi Identifier (NPI) is a unique 10-digit identification number issued to health care providers in 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, intelliger free numeric identifier (10-digit number).||CLT136|REFERRING-PROV-NPI-NUM|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 N to identify themselves in a standard way throughout their industry. The NPI is a 10-position intelligence-free numeric identifier (10-digit number).||COT118|REFERRING-PROV-NPI-NUM National Provider Identifier (NPI) is a unique 10-digit identification number issued to health providers in the United States by CMS. Healthcare providers acquire their unique 10-digit N to identify themselves in a standard way throughout their industry. The NPI is a 10-position intelligence-free numeric identifier (10-digit number).|

|DE No|Data Element Name|Definition||CLT213|SERVICING-PROV-NPI-NUM|A National Provi Identifier (NPI) is a unique 10-digit identification number issued to health care providers in 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, intelliger free numeric identifier (10-digit number).||COT190|SERVICING-PROV-NPI-NUM|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 N to identify themselves in a standard way throughout their industry. The NPI is a 10-position intelligence-free numeric identifier (10-digit number).|

DE NO|DATA ELEMENT NAME|DEFINITION|CODING REQUIREMENTELG090|SSI-IND| A flag indicating if the individual receives Supplemental Security Income (SSI) administered via th Social Security Administration (SSA).| 1.(LV) value must be in SSI Indicator List (VVL)2.(S) v must be 1 character3.(N) conditional4.(FD1) value must equal '0' when SSI Status equals '(or is not populated|

DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|ELG091|SSI-STATE-SUPPLEMENT-STATUS-CODE|Indicates the individual's State Supplemental Income Status.|1 (LV) value must be in SSI State Supplement Status Code List (VVL)2.(FD1) (individual not receiving Federal SSI) If SSI State Supplemental Status Code is "001" or "002", then SSI Sta cannot be "000" or "003"3.(S) value must be 3 characters4.(N) conditional5.(FD1) value m not be populated when SSI Status is not populated

DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|ELG092|SSI-STATUS| Indicates the individual's SSI Status.|1.(LV) value must be in SSI Status List (VVL)2.(S) valu must be 3 characters3.(N) conditional4.(FD1) value must be populated when SSI Indicator equals '1'

DE No|Data Element Name|CODING REQUIREMENT|ELG093|STATE-SPEC-ELIG-GROUP|If val in the range [000000 .. 999999], then associated Date of Death value must not be before start of the reporting period.|

DE No|Data Element Name|Definition| CODING REQUIREMENT|PRV027|TEACHING-IND||1.(L value must be in Teaching Indicator List (VVL)2.(S) value must be 1 character3.(N) conditio

|DE No|Data Element Name|Definition||CIP115|TOT-COPAY-AMT|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.1.(GS) value must satis the requirements of Total Medicare Deductible Amount (CE)

DE No|Data Element Name|Definition| CODING REQUIREMENT|TPL.076|TPL-ENTITY-ADDR-T 1.(LV) value must be in TPL Entity Address Type List (VVL)2.(S) value must be 2 characters conditional
|DE NO| DATA ELEMENT NAMETPL092|NATIONAL-HEALTH-CARE-ENTITY-ID-TYPE
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTTPL092|NATIONAL-HEALTH-C ENTITY-ID-TYPE|X(1)|TPL|TPL-ENTITY-CONTACT-INFORMATION-TPL00006
|DE NO| DATA ELEMENT NAMETPL093|NATIONAL-HEALTH-CARE-ENTITY-ID
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTTPL093|NATIONAL-HEALTH-C ENTITY-ID|X(10)|TPL|TPL-ENTITY-CONTACT-INFORMATION-TPL00006
|DE NO| DATA ELEMENT NAMETPL094|NATIONAL-HEALTH-CARE-ENTITY-NAME
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTTPL094|NATIONAL-HEALTH-C ENTITY-NAME|X(50)|TPL|TPL-ENTITY-CONTACT-INFORMATION-TPL00006
DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|TPL067|TYPE-OF-OTHER- THIRD-PARTY-LIABILITY|This code identifies the other types of liabilities an individual may h which are not necessarily defined as a health insurance plan listed INSURANCE-TYPE-PLAN (FDN) If value equals "Other". then Policy Owner (TPL.003.044-047) information is not required2.(S) value must be 1 character3.(LV) value must be in Type of Other Third Party Liability List (VVL)4.(N) mandatory
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCIP100|TYPE-OF-CLAIM|A code to indicate what type of payment is covered in this claim.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCIP104|SOURCE-LOCATION|The field denotes the claims payment system from which the claim was extracted.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCIP112|TOT-BILLED-AMT|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 [3, C, or W], then value must equal amou the provider billed to the managed care plan. Total Billed Amount is not expected on finan transactions.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCIP113|TOT-ALLOWED-AMT|The clai
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 Allow
Amount is determined by the managed care organization.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCIP114|TOT-MEDICAID-PAID-AMT|Th
total amount paid by Medicaid/CHIP or the managed care plan on this claim or adjustment
the claim header level, which is the sum of the amounts paid by Medicaid or the managed
plan at the detail level for the claim.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCIP251|REVENUE-CHARGE|The total
amount billed for the related Revenue Code. Total amount billed includes both covered an
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
the managed care plan.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCIP252|ALLOWED-AMT|The maximu
amount displayed at the claim line level as determined by the payer as being 'allowable' u
the provisions of the contract prior to the determination of actual payment. On Fee for Ser
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.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCIP254|MEDICAID-PAID-AMT|The am paid by Medicaid/CHIP agency or the managed care plan on this claim or adjustment at the claim detail level.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCLT052|TYPE-OF-CLAIM|A code to indicate what type of payment is covered in this claim.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCLT056|SOURCE-LOCATION|The fiel denotes the claims payment system from which the claim was extracted.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCLT063|TOT-BILLED-AMT|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 [3, C, or W], then value must equal amou the provider billed to the managed care plan. Total Billed Amount is not expected on finan transactions.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCLT064|TOT-ALLOWED-AMT|The cla 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 Allo Amount is determined by the managed care organization.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCLT065|TOT-MEDICAID-PAID-AMT|Th total amount paid by Medicaid/CHIP or the managed care plan on this claim or adjustment the claim header level, which is the sum of the amounts paid by Medicaid or the managed plan at the detail level for the claim.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCLT204|REVENUE-CHARGE|The tota amount billed for the related Revenue Code. Total amount billed includes both covered an 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 the managed care plan.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCLT205|ALLOWED-AMT|The maximu amount displayed at the claim line level as determined by the payer as being 'allowable' u the provisions of the contract prior to the determination of actual payment. On Fee for Ser 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.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCLT208|MEDICAID-PAID-AMT|The am paid by Medicaid/CHIP agency or the managed care plan on this claim or adjustment at the claim detail level.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCOT033|BEGINNING-DATE-OF-SERVI For services received during a single encounter with a provider, the date the service cover 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 serv covered by this claim began. For capitation premium payments, the date on which the per 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.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCOT034|ENDING-DATE-OF-SERVICE| services received during a single encounter with a provider, the date the service covered b this claim was received. For services involving multiple encounters on different days, or pe of care extending over two or more days, the date on which the service covered by this cla ended. For capitation premium payments, the date on which the period of coverage relate this payment ends/ended. For financial transactions reported to the OT file, populate with last day of the time period covered by this financial transaction.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCOT037|TYPE-OF-CLAIM|A code to indicate what type of payment is covered in this claim.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCOT041|SOURCE-LOCATION|The fiel denotes the claims payment system from which the claim was extracted.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCOT048|TOT-BILLED-AMT|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 [3, C, or W], then value must equal amou the provider billed to the managed care plan. Total Billed Amount is not expected on finan transactions.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCOT049|TOT-ALLOWED-AMT|The cla 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 Allow Amount is determined by the managed care organization.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCOT050|TOT-MEDICAID-PAID-AMT|T total amount paid by Medicaid/CHIP or the managed care plan on this claim or adjustment the claim header level, which is the sum of the amounts paid by Medicaid or the managed plan at the detail level for the claim.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCOT066|PLAN-ID-NUMBER|A unique number assigned by the state which represents a distinct comprehensive managed care p prepaid health plan, primary care case management program, a program for all-inclusive c for the elderly entity, or other approved plans.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCOT112|BILLING-PROV-NUM|A uniqu identification number assigned by the state to a provider or capitation plan. This data elem should represent the entity billing for the service. For encounter records, if associated Typ Claim value equals 3, C, or W, then value must be the state identifier of the provider or en (billing or reporting) to the managed care plan.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCOT113|BILLING-PROV-NPI-NUM|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 b admitting provider except for Long Term Care.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCOT166|BEGINNING-DATE-OF-SERVI For services received during a single encounter with a provider, the date the service cover 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 serv covered by this claim began. For capitation premium payments, the date on which the per 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.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCOT167|ENDING-DATE-OF-SERVICE| services received during a single encounter with a provider, the date the service covered b this claim was received. For services involving multiple encounters on different days, or pe of care extending over two or more days, the date on which the service covered by this cla ended. For capitation premium payments, the date on which the period of coverage relate this payment ends/ended. For financial transactions reported to the OT file, populate with last day of the time period covered by this financial transaction.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCOT174|BILLED-AMT|The amount bi 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 mana care plan.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCOT175|ALLOWED-AMT|The maximu amount displayed at the claim line level as determined by the payer as being 'allowable' u the provisions of the contract prior to the determination of actual payment. On Fee for Ser 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.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCOT178|MEDICAID-PAID-AMT|The amount paid by Medicaid/CHIP agency or the managed care plan on this claim or adjustme the claim detail level.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCOT186|TYPE-OF-SERVICE|A code to categorize the services provided to a Medicaid or CHIP enrollee.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCRX029|TYPE-OF-CLAIM|A code to indicate what type of payment is covered in this claim.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCRX032|SOURCE-LOCATION|The fiel denotes the claims payment system from which the claim was extracted.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCRX039|TOT-BILLED-AMT|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 [3, C, or W], then value must equal amou the provider billed to the managed care plan. Total Billed Amount is not expected on finan transactions.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCRX040|TOT-ALLOWED-AMT|The cla 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 Allow Amount is determined by the managed care organization.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCRX041|TOT-MEDICAID-PAID-AMT|T total amount paid by Medicaid/CHIP or the managed care plan on this claim or adjustment the claim header level, which is the sum of the amounts paid by Medicaid or the managed plan at the detail level for the claim.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCRX121|BILLED-AMT|The amount bi at the claim detail level as submitted by the provider. For encounter records, Type of Clain 3, C, or W, this field should be populated with the amount that the provider billed the man care plan.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCRX122|ALLOWED-AMT|The maximu
amount displayed at the claim line level as determined by the payer as being 'allowable' u
the provisions of the contract prior to the determination of actual payment. On Fee for Ser
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.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCRX125|MEDICAID-PAID-AMT|The
amount paid by Medicaid/CHIP agency or the managed care plan on this claim or adjustme
the claim detail level.

DE NO| DATA ELEMENT NAME COMPUTING|CODING REQUIREMENTCIP194|DRG-OUTLIER-AM
Value must not be populated when Outlier Code (CIP.002.197) is '01' ,'02' or '10'

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|CODING REQUIREMENTCIP202|
REMITTANCE-NUM|The Remittance Advice Number is a sequential number that identifies th
current Remittance Advice (RA) produced for a provider. The number is incremented by on
each time a new RA is generated. The first five (5) positions are Julian date following a YYD
format. The RA is the detailed explanation of the reason for the payment amount.|"First fiv
characters of the value must be a Julian date express in the form YYDDD (e.g. 19095, 95th
of 20(19))"

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|CODING REQUIREMENTCLT144|
REMITTANCE-NUM|The Remittance Advice Number is a sequential number that identifies th
current Remittance Advice (RA) produced for a provider. The number is incremented by on
each time a new RA is generated. The first five (5) positions are Julian date following a YYD
format. The RA is the detaile dexplanation of the reason for the payment amount.|"First fiv
characters of the value must be a Julian date express in the form YYDDD (e.g. 19095, 95th
of 20(19))"

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|CODING REQUIREMENTCOT126|
REMITTANCE-NUM|The Remittance Advice Number is a sequential number that identifies th
current Remittance Advice (RA) produced for a provider. The number is incremented by on
each time a new RA is generated. The first five (5) positions are Julian date following a YYD
format. The RA is the detailed explanation of the reason for the payment amount.|"First fiv
characters of the value must be a Julian date express in the form YYDDD (e.g. 19095, 95th
of 20(19))"

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|CODING REQUIREMENTCRX081|
REMITTANCE-NUM|The Remittance Advice Number is a sequential number that identifies th
current Remittance Advice (RA) produced for a provider. The number is incremented by on
each time a new RA is generated. The first five (5) positions are Julian date following a YYD
format. The RA is the detailed explanation of the reason for the payment amount.|"First fiv
characters of the value must be a Julian date express in the form YYDDD (e.g. 19095, 95th
of 20(19))"

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|CIP132|PAYMENT-LEVEL-IND|The fie
denotes whether the payment amount was determined at the claim header or line/detail le

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|CLT082|PAYMENT-LEVEL-IND|The fi
denotes whether the payment amount was determined at the claim header or line/detail le

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|COT068|PAYMENT-LEVEL-IND|The fi
denotes whether the payment amount was determined at the claim header or line/detail le

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|CRX058|PAYMENT-LEVEL-IND|The fi
denotes whether the payment amount was determined at the claim header or line/detail le

DE NO| DATA ELEMENT NAME COMPUTING|CODING REQUIREMENT|ELG252|ENROLLMENT-T

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|CIP293|TOT-BENEFICIARY-COINSURANCE-LIABLE-AMOUNT|The total copayment amount on a claim that the beneficia 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.CLT240|TOT-BENEFICIARY-COINSURANCE-LIABLE-AMOUNT|The total copayment amount on a claim that the beneficiary is obligated to pay f 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 t copayment.COT231|TOT-BENEFICIARY-COINSURANCE-LIABLE-AMOUNT|The total copaymer amount on a claim that the beneficiary is obligated to pay for covered services. This is the Medicaid or contract negotiated beneficiary copayment liability for covered service on the claim. Do not subtract out any payments made toward the copayment.CRX164|TOT-BENEFICIARY-COINSURANCE-LIABLE-AMOUNT|The total copayment amount on a claim that 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 subtrac any payments made toward the copayment.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|CIP294|TOT-BENEFICIARY-DEDUCTI LIABLE-AMOUNT|The total deductible amount on a claim the beneficiary is obligated to pay covered services. This amount is the total Medicaid or contract negotiated beneficiary deductible liability for covered services on the claim. Do not subtract out any payments ma toward the deductible.CLT241|TOT-BENEFICIARY-DEDUCTIBLE-LIABLE-AMOUNT|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 for cove services on the claim. Do not subtract out any payments made toward the deductible.COT TOT-BENEFICIARY-DEDUCTIBLE-LIABLE-AMOUNT|The total deductible amount on a claim th beneficiary is obligated to pay for covered services. This amount is the total Medicaid or contract negotiated beneficiary deductible liability for covered services on the claim. Do no subtract out any payments made toward the deductible.CRX165|TOT-BENEFICIARY-DEDUCTIBLE-LIABLE-AMOUNT|The total deductible amount on a claim the beneficiary is obligated to pay for covered services. This amount is the total Medicaid or contract negotia beneficiary deductible liability for covered services on the claim. Do not subtract out any payments made toward the deductible.

DE NO| DATA ELEMENT NAME COMPUTING|CODING REQUIREMENT|ELG040|CITIZENSHIP-IN Value must be in [0, 1] or not populated

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|PRV024|PROV-ORGANIZATION-NAM The name of the provider when the provider is an organization. If the provider organizatior name exceeds 60 characters submit only the first 60 characters of the name.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|CIP099|MEDICAID-PAID-DATE|The d Medicaid paid this claim or adjustment.CLT051|MEDICAID-PAID-DATE|The date Medicaid pa this claim or adjustment.COT036|MEDICAID-PAID-DATE|The date Medicaid paid this claim c adjustment.CRX028|MEDICAID-PAID-DATE|The date Medicaid paid this claim or adjustment
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|ELG095|ELIGIBILITY-CHANGE-REASO The reason for a complete loss/termination in an individual's eligibility for Medicaid and CH The end date of the segment in which the value is reported must represent the date that t 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.
N/A
N/A
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|MCR020|MANAGED-CARE-CONTRAC EFF-DATE|The first calendar day on which all of the other data elements in the same segm were effective.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|CIP296|IHS-SERVICE-IND|This data element indicates services received by Medicaid-eligible individuals who are American Indi Alaska Native (AI/AN) through facilities of the Indian Health Service (IHS), whether operate IHS or by Tribes.CLT243|IHS-SERVICE-IND|This data element indicates services received by Medicaid-eligible individuals who are American Indian or Alaska Native (AI/AN) through fac of the Indian Health Service (IHS), whether operated by IHS or by Tribes.COT234|IHS-SERV IND|This data element indicates 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.CRX172|IHS-SERVICE-IND|This data element indicate services received by Medicaid-eligible individuals who are American Indian or Alaska Nativ (AI/AN) through facilities of the Indian Health Service (IHS), whether operated by IHS or by Tribes.
The date Medicaid paid this claim or adjustment.
The date Medicaid paid this claim or adjustment.
The date Medicaid paid this claim or adjustment.
The date Medicaid paid this claim or adjustment.
The reason for a complete loss/termination in an individual's eligibility for Medicaid and CH The end date of the segment in which the value is reported must represent the date that t 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.
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-blog/entry/4756 provider may be reported with multiple active record segments with the same Provider Classification Type if different Provider Classification Code values apply.

This data element indicates 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.
1. Value must be 1 character2. Value must be in [0, 1] or not populated
This data element indicates 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.
1. Value must be 1 character2. Value must be in [0, 1] or not populated
This data element indicates 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.
1. Value must be 1 character2. Value must be in [0, 1] or not populated
This data element indicates 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.
1. Value must be 1 character2. Value must be in [0, 1] or not populated
The date Medicaid paid this claim or adjustment.
The date Medicaid paid this claim or adjustment. For Encounter Records (Type of Claim = 3 W), the date the managed care organization paid the provider for the claim or adjustment.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|ELG034|MARITAL-STATUS|A code to classify eligible individual's marital/domestic-relationship status. An eligible individual who younger than 12 years should have a marital status of never married orunknown. This ele should be reported by the state when the information is material to eligibility (i.e., institutionalization).|
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|ELG074|TYPE-OF-LIVING-ARRANGEMENT|A free-form text field to describe the type of living arrangement used for th 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.|

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|ELG095|ELIGIBILITY-CHANGE-REASO The reason for a complete loss/termination in an individual's eligibility for Medicaid and CH The end date of the segment in which the value is reported must represent the date that t 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. I a single termination in eligibility for a single individual there are multiple distinct co-occurr 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' (Othe '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 stat 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 o value over another.|
CRX - CLAIM PERSCRIPTION
CRX - CLAIM PERSCRIPTION
Mandatory
1. Value must be in Income Code List (VVL)2. Value must be 2 characters3. Mandatory
Mandatory
1. Value must be in Funding Code List (VVL)2. Value must be 1 character3. Mandatory
1. Value must be 3 characters2. Mandatory3. Value must not equal '086' if Sex (ELG.002.0 equals 'M'4. Value must satisfy the requirements of Type of Service (Inpatient Claim) List (
Mandatory
Value must be in Funding Code List (VVL)2. Value must be 1 character3. Conditional
1. Value must be in Funding Code List (VVL)2. Value must be 1 character3. Mandatory
1. Value must be 3 characters2. Mandatory3. Value must satisfy the requirements of Type Service (Long Term Claim) List (VVL)
Mandatory
1. Value must be in Funding Code List (VVL)2. Value must be 1 character3. Mandatory
The Medicaid provider ID of the Ordering Provider is the individual who requested the serv or items being reported on this service line. Examples include, but are not limited to, provi ordering diagnostic tests and medical equipment or supplies

The NPI of Ordering Provider represents the individual who requested the service or items being reported on this service line. Example include, but are not limited to, provider orderi diagnostic tests and medical equipment or supplies.
1. Value must be 3 characters2. Mandatory3. When value is in [119-122], Servicing Provide Num (COT.002.190) should not be populated4. Value must satisfy the requirements of Typ Service (Other Claim) List (VVL)5. When value is in [119-122], Servicing Provider Taxonom (COT.003.191) should not be populated6. When value is in [119-122], Referring Provider N Num (COT.002.118) should not be populated7. Value must be 3 characters8. Mandatory9. When value is in [119-122], Billing Provider NPI Num (COT.002.113) should not be populate When value is in [119-122], Billing Provider Taxonomy (COT.002.114) should not be populated11. When value is in [119-122], Referring Provider Taxonomy (COT.002.119) sho not be populated12. When value is not in ['025','085'], Sex (ELG.002.023) equals 'M'13. Wh value is in [119-122], Servicing Provider Num (COT.002.189) should not be populated
Mandatory
1. Value must be in Funding Code List (VVL)2. Value must be 1 character3. Mandatory
Conditional

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 then Primary Eligibility Group Indicator (ELG.005.086) must be "1" (Yes)5. Conditional6. 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 characters9. 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 populated11. If value equals "10", then CHIP Code (ELG.003.05 must be "03" (S-CHIP) and Medicare Beneficiary Identifier (ELG.003.051) must be populate 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"
Value must be in Funding Code List (VVL)2. Value must be 1 character3. Conditional
1. Value must be in Funding Source Non-Federal Share List (VVL)2. Value must be 2 characters3. Conditional
1. Value must be in Funding Code List (VVL)2. Value must be 1 character3. Conditional
1. Value must be in Funding Source Non-Federal Share List (VVL)2. Value must be 2 characters3. Conditional
1. Value must be in Funding Code List (VVL)2. Value must be 1 character3. Conditional
1. Value must be in Funding Source Non-Federal Share List (VVL)2. Value must be 2 characters3. Conditional
A National Provider Identifier (NPI) is a unique 10-digit identification number issued to heal care providers in the United States by CMS. Healthcare providers acquire their unique 10-d NPIs to identify themselves in a standard way throughout their industry. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number).|Value must be 10 digits, consisting of 9 numeric digits followed by one check digit calculated using the Luhn formul (algorithm).The NPI of Ordering Provider represents the individual who requested the servi items being reported on this service line. Example include, but are not limited to, provider ordering diagnostic tests and medical equipment or supplies.[Ordering provider informatio only captured at the line level in the X12 837P format but in v3.0.0 of the T-MSIS file layou only captured at the header level. This discrepancy will be addressed in a future version of T-MSIS OT file layout. Until Ordering provider information has been moved from the T-MSIS claim header to the line, there is no need to report it at the header.]
1. Value must be in Funding Code List (VVL)2. Value must be 1 character3. Conditional
1. Value must be in Funding Source Non-Federal Share List (VVL)2. Value must be 2 characters3. Conditional

1. Value must be 3 characters2. Mandatory3. Value must satisfy the requirements of Type Service (RX Claim) List (VVL)
1. Value must be in Funding Code List (VVL)2. Value must be 1 character3. Only required if Type-of-claim is not equal to '3', 'C', 'W', '6'4. Conditional
1. Value must be in Funding Source Non-Federal Share List (VVL)2. Value must be 2 characters3. Only required if Type-of-claim is not equal to '3', 'C', 'W', '6'4. Conditional
1. Value must be 3 characters2. Mandatory3. Value must not equal '086' if Sex (ELG.002.0 equals 'M'4. Value must be in ['001', '058', '060', '084', '086', '090', '091', '092', '093', '123 '132', '135', '136', '137'] when associated Claim Type is CIP (Inpatient Claim)
Value must be 3 characters2. Mandatory3. Value must not equal '086' if Sex (ELG.002.023 equals 'M'4. Value must be in ['001', '058', '060', '084', '086', '090', '091', '092', '093', '123 '132', '135', '136', '137'] when associated Claim Type is CIP (Inpatient Claim)
1. Value must be in Funding Code List (VVL)2. Value must be 1 character3. Only required if Type-of-claim is not equal to '3', 'C', 'W', '6'4. Conditional
Value must be in Funding Code List (VVL)2. Value must be 1 character3. Only required if T of-claim is not equal to '3', 'C', 'W', '6'4. Conditional
1. Value must be in Funding Source Non-Federal Share List (VVL)2. Value must be 2 characters3. Only required if Type-of-claim is not equal to '3', 'C', 'W', '6'4. Conditional
1. Value must be 3 characters2. Mandatory3. Value must be in ['009', '044', '045', '046', '0 '048', '050', '059', '133', '136', '137', '146', '147'] when associated Claim Type is CLT (Long Term Claim)
1. Value must be in Funding Code List (VVL)2. Value must be 1 character3. Only required i Type-of-claim is not equal to '3', 'C', 'W', '6'4. Conditional
1. Value must be in Funding Source Non-Federal Share List (VVL)2. Value must be 2 characters3. Only required if Type-of-claim is not equal to '3', 'C', 'W', '6'4. Conditional
1. Value must be 3 characters2. Mandatory3. When value is in [119-122], Servicing Provide Num (COT.002.190) should not be populated4. Value must be in ['002', '003', '004', '005', ' '007', '008', '010', '011', '012', '013', '014', '015', '016', '017', '018', '019', '020', '021', '022 '023', '024', '025', '026', '027', '028', '029', '030', '031', '032', '035', '036', '037', '038', '039 '040', '041', '042', '043', '049', '050', '051', '052', '053', '054', '055', '056', '057', '058', '060 '061', '062', '063', '064', '065', '066', '067', '068', '069', '070', '071', '072', '073', '074', '075 '076', '077', '078', '079', '080', '081', '082', '083', '084', '085', '086', '087', '088', '089', '115 '119', '120', '121', '122', '127', '131', '134', '135', '136', '137', '138', '139', '140', '141', '142 '143', '144', '145', '147'] when associated Claim Type is COT (Other Claim)5. When value is [119-122], Servicing Provider Taxonomy (COT.003.191) should not be populated6. When v is in [119-122], Referring Provider NPI Num (COT.002.118) should not be populated7. Valu must be 3 characters8. Mandatory9. When value is in [119-122], Billing Provider NPI Num (COT.002.113) should not be populated10. When value is in [119-122], Billing Provider Taxonomy (COT.002.114) should not be populated11. When value is in [119-122], Referrin Provider Taxonomy (COT.002.119) should not be populated12. When value is not in ['025','085'], Sex (ELG.002.023) equals 'M'13. When value is in [119-122], Servicing Provid Num (COT.002.189) should not be populated

1. Value must be in Funding Code List (VVL)2. Value must be 1 character3. Only required if Type-of-claim is not equal to '3', 'C', 'W', '6'4. Conditional
Value must be in Funding Code List (VVL)2. Value must be 1 character3. Only required if Type-of-claim is not equal to '3', 'C', 'W', '6'4. Conditional
1. Value must be in Funding Source Non-Federal Share List (VVL)2. Value must be 2 characters3. Only required if Type-of-claim is not equal to '3', 'C', 'W', '6'4. Conditional
1. Value must be 3 characters2. Mandatory3. Value must be in ['011', '018', '033', '034', '0 '085', '089', '127', '131', '136', '137', '145'] when associated Claim Type is CRX (RX Claim)
The field denotes whether the payment amount was determined at the claim header or line/detail level.

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The field denotes whether the payment amount was determined at the claim header or line/detail level.
A data element to identify the Medicaid/CHIP programs, waivers and demonstrations in wh the provider participates. If Affiliated Program Type = 2 (Health Plan State-assigned health ID), then the value in Affiliated Program ID is the state-assigned plan ID of the health plan which a provider is enrolled to provide services. If Affiliated Program Type = 3 (Waiver), th the value in Affiliated Program ID is the core Federal Waiver ID in which a provider is allow to deliver services to eligible beneficiaries. If Affiliated Program Type = 4 (Health Home En then the value in Affiliated Program ID is the name of a health home in which a provider is participating. If Affiliated Program Type = 5 (Other), then the value in Affiliated Program ID an identifier for something other than a health plan, waiver, or health home entity.

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 t eligibility (i.e., institutionalization).
DE NO||DATA ELEMENT NAME COMPUTING|||DEFINITIONPRV120|AFFILIATED-PROGRAM-ID|| data element to identify the Medicaid/CHIP programs, waivers and demonstrations in whic provider participates.If Affiliated Program Type = 2 (Health Plan State-assigned health plan then the value in Affiliated Program ID is the state-assigned plan ID of the health plan in w a provider is enrolled to provide services. If Affiliated Program Type = 3 (Waiver), then the value in Affiliated Program ID is the core Federal Waiver ID in which a provider isallowed to deliver services to eligible beneficiaries. If Affiliated Program Type = 4 (Health Home Entity then the value in Affiliated Program ID is the name of a health home in which a provider is participating. If Affiliated Program Type = 5 (Other), then the value in Affiliated Program ID an identifier for something other than a health plan, waiver, or health home entity.
Value must be between -99999999999.99 and 99999999999.992. Value must be expresse a number with 2-digit precision (e.g. 100.50)3. Value must be populated when Outlier Cod (CIP.002.197) is '01' ,'02' or '10'4. Conditional
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Value must be populated, if Outlier Code (CIP.002.197) equals '00' or '09'4. Conditional
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Value must not be populated, if Outlier ((CIP.002.197) equals '00' or '09'4. Conditional
The Remittance Advice Number is a sequential number that identifies the current Remittan Advice (RA) produced for a provider. The number is incremented by one each time a new R generated. The first five (5) positions are Julian date following a YYDDD format. The RA is t detailed explanation of the reason for the payment amount.
1. Value must be 30 characters or less2. First five (5) characters of the value must be a Jul date express in the form YYDDD (e.g. 19095, 95th day of 20(19))3. Value must not contain pipe or asterisk symbols4. Mandatory

The Remittance Advice Number is a sequential number that identifies the current Remittar Advice (RA) produced for a provider. The number is incremented by one each time a new F generated. The first five (5) positions are Julian date following a YYDDD format. The RA is t detailed explanation of the reason for the payment amount.
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1. Value must be 30 characters or less2. First five (5) characters of the value must be a Jul date express in the form YYDDD (e.g. 19095, 95th day of 20(19))3. Value must not contain pipe or asterisk symbols4. Mandatory
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be ir Citizenship Indicator List (VVL)4. If value is coded as '0', then associated Immigration Statu (ELG.003.042) value must be in [1, 2, 3]5. If value is coded as '1', then associated Immigr Status (ELG.003.042) value must equal '8'6. Value must be 1 character7. Mandatory

Value must be in Restricted Benefits Code List (VVL)2. (Restricted Benefits) if value is "3" a Dual Eligible Code (ELG.005.085) value is "05", then Eligibility Group (ELG.005.087) must b "24"3. (Restricted Benefits) if value is "3" and Dual Eligible Code (ELG.005.085) value is "0 then Eligibility Group (ELG.005.087) must be "26"4. (Restricted Benefits) if value is "1" and Dual Eligible Code (ELG.005.085) value is "02", then Eligibility Group (ELG.005.087) must b "23"5. (Restricted Benefits) if value is "1" and Dual Eligible Code (ELG.005.085) value is "0 then Eligibility Group (ELG.005.087) must be "25"6. (Restricted Benefits) if value is "3", the Dual Eligible Code (ELG.005.085) cannot be "00"7. Mandatory8. If value is populated, then Eligibility Group (ELG.005.087) must be populated.9. If value is "6" then Eligibility Group(ELG.DE.087) must be in ("35", "70")10. If value is "1" or "7" then Eligibility Group (EGL.DE.087) must be in ("72", "73", "74", "75") and State Plan Option Type (ELG.DE.163) equal to "06"11. (Restricted Pregnancy-Related) if value is "4", then associated Sex (ELG.002.023) value must be "F"12. (Non-Citizen) if value is "2", then associated Citizensh Indicator (ELG.003.040) value must not be equal to "1"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 segment14. Value must be 1 character15. (Restricted Benefits) value is "3" and Dual Eligible Code (ELG.005.085) value is "01", then Eligibility Group (ELG.005.087) must be "23"16. (Restricted Benefits) if value is "3" and Dual Eligible Code (ELG.005.085) value is "03", then Eligibility Group (ELG.005.087) must be "25"17. (Restrict Benefits) if value is "G", then Dual Eligible Code (ELG.005.085) must be in (‘01’, ‘03', ‘06’)
1. Value must be in Restricted Benefits Code List (VVL)2. (Restricted Benefits) if value is "3 and Dual Eligible Code (ELG.005.085) value is "05", then Eligibility Group (ELG.005.087) m be "24"3. (Restricted Benefits) if value is "3" and Dual Eligible Code (ELG.005.085) value is "06", then Eligibility Group (ELG.005.087) must be "26"4. (Restricted Benefits) if value is " and Dual Eligible Code (ELG.005.085) value is "02", then Eligibility Group (ELG.005.087) m be "23"5. (Restricted Benefits) if value is "1" and Dual Eligible Code (ELG.005.085) value is "04", then Eligibility Group (ELG.005.087) must be "25"6. (Restricted Benefits) if value is " then Dual Eligible Code (ELG.005.085) cannot be "00"7. Mandatory8. If value is populated, Eligibility Group (ELG.005.087) must be populated.9. If value is "6" then Eligibility Group(ELG.DE.087) must be in ("35", "70")10. If value is "1" or "7" then Eligibility Group (EGL.DE.087) must be in ("72", "73", "74", "75") and State Plan Option Type (ELG.DE.163) equal to "06"11. (Restricted Pregnancy-Related) if value is "4", then associated Sex (ELG.002.023) value must be "F"12. (Non-Citizen) if value is "2", then associated Citizensh Indicator (ELG.003.040) value must not be equal to "1"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 segment14. Value must be 1 character15. (Restricted Benefits) value is "3" and Dual Eligible Code (ELG.005.085) value is "01", then Eligibility Group (ELG.005.087) must be "23"16. (Restricted Benefits) if value is "3" and Dual Eligible Code (ELG.005.085) value is "03", then Eligibility Group (ELG.005.087) must be "25"

1. Value must be 3 characters2. Conditional
1. Mandatory2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN4. Value must be 20 characters or less5. When Type of Claim not in D, X, Z, U, V, Y, W), 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) a Enrollment End Date (ELG.021.254)6. When Type of Claim (CIP.002.100) equals 4, D or X (sum payment) value must begin with an '&'
1. Mandatory2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN4. Value must be 20 characters or less5. When Type of Claim (CIP.002.100) = 4, D or X (lump sum payment) value must begin with an '&'
1. Mandatory2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN4. Value must be 20 characters or less5. Populated value must beg with an '&', when TYPE-OF-CLAIM = 4, D or X (lump sum payment)6. The Beginning Date o Service on the claim must fall between (ELG.021.253) enrollment effective and (ELG.021.2 end date
1. Mandatory2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN4. Value must be 20 characters or less5. When Type of Claim (CLT.002.052) equals 4, D or X (lump sum payment) value must begin with an '&'
1. Mandatory2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN4. Value must be 20 characters or less5. Populated value must beg with an '&', when Type of Claim (COT.002.037) = 4, D or X (lump sum payment)6. Value m 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 Date (ELG.021.254)
1. Mandatory2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN4. Value must be 20 characters or less5. When Type of Claim (COT.002.037) equals 4, D or X (lump sum payment) value must begin with an '&'
1. Mandatory2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN4. Value must be 20 characters or less5. 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)
1. Mandatory2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN4. Value must be 20 characters or less5. When TYPE-OF-CLAIM = 4 X (lump sum payment), value must begin with an '&'

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DE No|DE Name|Coding Requirement|CIP022|MSIS-IDENTIFICATION-NUM|For SSN States (i. SSN Indicator = 1), value must be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|CIP022|MSIS-IDENTIFICATION-NUM|For Non-SSN Stat (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN|
DE NO| DATA ELEMENT NAME COMPUTING|CODING REQUIREMENT|CIP194|DRG-OUTLIER-A Value must not be populated when Outlier Code (CIP.002.197) is '01' ,'02' or '10'|
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|CODING REQUIREMENT|CIP202| REMITTANCE-NUM|The Remittance Advice Number is a sequential number that identifies th current Remittance Advice (RA) produced for a provider. The number is incremented by or each time a new RA is generated. The first five (5) positions are Julian date following a YYD format. The RA is the detailed explanation of the reason for the payment amount.|"First fiv characters of the value must be a Julian date express in the form YYDDD (e.g. 19095, 95th of 20(19))"
DE No|DE Name|Coding Requirement|CIP234|MSIS-IDENTIFICATION-NUM|For SSN States (i. SSN Indicator = 1), value must be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|CIP234|MSIS-IDENTIFICATION-NUM|For Non-SSN Stat (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN|

DE No|DE Name|Coding Requirement|CLT022|MSIS-IDENTIFICATION-NUM|For SSN States (i SSN Indicator = 1), value must be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|CLT022|MSIS-IDENTIFICATION-NUM|For Non-SSN Stat (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN|
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|CODING REQUIREMENT|CLT144| REMITTANCE-NUM|The Remittance Advice Number is a sequential number that identifies th current Remittance Advice (RA) produced for a provider. The number is incremented by on each time a new RA is generated. The first five (5) positions are Julian date following a YYD format. The RA is the detaile dexplanation of the reason for the payment amount.|"First fiv characters of the value must be a Julian date express in the form YYDDD (e.g. 19095, 95th of 20(19))"
DE No|DE Name|Coding Requirement|CLT187|MSIS-IDENTIFICATION-NUM|For SSN States (i SSN Indicator = 1), value must be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|CLT187|MSIS-IDENTIFICATION-NUM|For Non-SSN Stat (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|COT022|MSIS-IDENTIFICATION-NUM|For SSN States (SSN Indicator = 1), value must be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|COT022|MSIS-IDENTIFICATION-NUM|For Non-SSN Sta (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN|
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|CODING REQUIREMENT|COT126| REMITTANCE-NUM|The Remittance Advice Number is a sequential number that identifies th current Remittance Advice (RA) produced for a provider. The number is incremented by on each time a new RA is generated. The first five (5) positions are Julian date following a YYD format. The RA is the detailed explanation of the reason for the payment amount.|"First fiv characters of the value must be a Julian date express in the form YYDDD (e.g. 19095, 95th of 20(19))"
DE No|DE Name|Coding Requirement|COT157|MSIS-IDENTIFICATION-NUM|For SSN States (SSN Indicator = 1), value must be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|COT157|MSIS-IDENTIFICATION-NUM|For Non-SSN Sta (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|CRX022|MSIS-IDENTIFICATION-NUM|For SSN States (SSN Indicator = 1), value must be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|CRX022|MSIS-IDENTIFICATION-NUM|For Non-SSN Sta (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN|
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|CODING REQUIREMENT|CRX081| REMITTANCE-NUM|The Remittance Advice Number is a sequential number that identifies th current Remittance Advice (RA) produced for a provider. The number is incremented by on each time a new RA is generated. The first five (5) positions are Julian date following a YYD format. The RA is the detailed explanation of the reason for the payment amount.|"First fiv characters of the value must be a Julian date express in the form YYDDD (e.g. 19095, 95th of 20(19))"|
DE No|DE Name|Coding Requirement|CRX111|MSIS-IDENTIFICATION-NUM|For SSN States (SSN Indicator = 1), value must be equal to eligible individual's SSN|

DE No|DE Name|Coding Requirement|CRX111|MSIS-IDENTIFICATION-NUM|For Non-SSN Sta (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN|
A code indicating the family income level.
This data element provides the beneficiary's or their household's income as a percentage the federal poverty level. Used to assign the beneficiary to the eligibility group that covere their Medicaid or CHIP benefits. If the beneficiary's income was assessed using multiple methodologies (MAGI and Non-MAGI), report the one that applies to their primary eligibility group.
1. Mandatory2. For SSN States (i.e. SSN Indicator = 1), value must be equal to eligible individual's SSN3. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN4. Value must be 20 characters or less
DE No|DE Name|Coding Requirement|ELG019|MSIS-IDENTIFICATION-NUM|For SSN States (i SSN Indicator = 1), value must be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG019|MSIS-IDENTIFICATION-NUM|For Non-SSN Sta (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG033|MSIS-IDENTIFICATION-NUM|For SSN States (i SSN Indicator = 1), value must be equal to eligible individual's SSN|

DE No|DE Name|Definition|ELG038|INCOME-CODE|A code indicating the family income leve
DE NO| DATA ELEMENT NAME COMPUTING|CODING REQUIREMENT|ELG040|CITIZENSHIP-IN Value must be in [0, 1] or not populated|
DE No|DE Name|Coding Requirement|ELG064|MSIS-IDENTIFICATION-NUM|For SSN States (i SSN Indicator = 1), value must be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG064|MSIS-IDENTIFICATION-NUM|For Non-SSN Sta (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG082|MSIS-IDENTIFICATION-NUM|For SSN States (i SSN Indicator = 1), value must be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG082|MSIS-IDENTIFICATION-NUM|For Non-SSN Sta (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN|
N/A
DE No|DE Name|Coding Requirement|ELG016|MSIS-IDENTIFICATION-NUM|For SSN States (i SSN Indicator = 1), value must be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG016|MSIS-IDENTIFICATION-NUM|For Non-SSN Sta (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG117|MSIS-IDENTIFICATION-NUM|For SSN States (i SSN Indicator = 1), value must be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG117|MSIS-IDENTIFICATION-NUM|For Non-SSN Sta (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG129|MSIS-IDENTIFICATION-NUM|For SSN States (i SSN Indicator = 1), value must be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG129|MSIS-IDENTIFICATION-NUM|For Non-SSN Sta (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG139|MSIS-IDENTIFICATION-NUM|For SSN States (i SSN Indicator = 1), value must be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG139|MSIS-IDENTIFICATION-NUM|For Non-SSN Sta (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG149|MSIS-IDENTIFICATION-NUM|For SSN States (i SSN Indicator = 1), value must be equal to eligible individual's SSN|

DE No|DE Name|Coding Requirement|ELG149|MSIS-IDENTIFICATION-NUM|For Non-SSN Sta (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG162|MSIS-IDENTIFICATION-NUM|For SSN States (i SSN Indicator = 1), value must be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG162|MSIS-IDENTIFICATION-NUM|For Non-SSN Sta (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG171|MSIS-IDENTIFICATION-NUM|For SSN States (i SSN Indicator = 1), value must be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG171|MSIS-IDENTIFICATION-NUM|For Non-SSN Sta (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG181|MSIS-IDENTIFICATION-NUM|For SSN States (i SSN Indicator = 1), value must be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG181|MSIS-IDENTIFICATION-NUM|For Non-SSN Sta (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG191|MSIS-IDENTIFICATION-NUM|For SSN States (i SSN Indicator = 1), value must be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG191|MSIS-IDENTIFICATION-NUM|For Non-SSN Sta (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG203|MSIS-IDENTIFICATION-NUM|For SSN States (i SSN Indicator = 1), value must be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG203|MSIS-IDENTIFICATION-NUM|For Non-SSN Sta (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG212|MSIS-IDENTIFICATION-NUM|For SSN States (i SSN Indicator = 1), value must be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG212|MSIS-IDENTIFICATION-NUM|For Non-SSN Sta (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG223|MSIS-IDENTIFICATION-NUM|For SSN States (i SSN Indicator = 1), value must be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG223|MSIS-IDENTIFICATION-NUM|For Non-SSN Sta (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG232|MSIS-IDENTIFICATION-NUM|For SSN States (i SSN Indicator = 1), value must be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG232|MSIS-IDENTIFICATION-NUM|For Non-SSN Sta (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG241|MSIS-IDENTIFICATION-NUM|For SSN States (i SSN Indicator = 1), value must be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG241|MSIS-IDENTIFICATION-NUM|For Non-SSN Sta (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG251|MSIS-IDENTIFICATION-NUM|For SSN States (i SSN Indicator = 1), value must be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG251|MSIS-IDENTIFICATION-NUM|For Non-SSN Sta (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN|

DE No|DE Name|Coding Requirement|ELG260|MSIS-IDENTIFICATION-NUM|For SSN States (i SSN Indicator = 1), value must be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|ELG260|MSIS-IDENTIFICATION-NUM|For Non-SSN Sta (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN|
DE No|DE Name|Definition|ELG269|ELIGIBLE-FEDERAL-POVERTY-LEVEL-PERCENTAGE|This element provides the beneficiary's or their household's income as a percentage of the fede poverty level. Used to assign the beneficiary to the eligibility group that covered their Med or CHIP benefits. If the beneficiary's income was assessed usingmultiple methodologies (M and Non-MAGI), report the one that applies to their primary eligibility group.
N/A
DE No|DE Name|Coding Requirement|TPL019|MSIS-IDENTIFICATION-NUM|For SSN States (i SSN Indicator = 1), value must be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|TPL019|MSIS-IDENTIFICATION-NUM|For Non-SSN Stat (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|TLP032|MSIS-IDENTIFICATION-NUM|For SSN States (i SSN Indicator = 1), value must be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|TLP032|MSIS-IDENTIFICATION-NUM|For Non-SSN Stat (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|TLP066|MSIS-IDENTIFICATION-NUM|For SSN States (i SSN Indicator = 1), value must be equal to eligible individual's SSN|
DE No|DE Name|Coding Requirement|TLP066|MSIS-IDENTIFICATION-NUM|For Non-SSN Stat (i.e. SSN Indicator = 0), value must not be equal to eligible individual's SSN|
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in 1115A Demonstration Indicator List (VVL)4. Value must be 1 character5. Conditional6. Whe value equals '0', is invalid or not populated, then the associated 1115A Demonstration Indi (ELG.018.233) must equal '0', is invalid or not populated
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in Other Insurance Indicator List (VVL)4. Value must be 1 character5. Conditional
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in Fixed Payment Indicator List (VVL)4. Value must be 1 character5. Conditional

1. Value must be in Medicare Combined Deductible Indicator List (VVL)2. Value must be 1 character3. Value must be in [0, 1] or not populated4. Value must be 1 character5. If value equals '1', then Total Medicare Coinsurance amount must not be populated.6. If value equa '0', then Crossover Indicator must equals '0'7. If value equals '1', then Crossover Indicator equals '1'8. Conditional
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in Forced Claim Indicator List (VVL)4. Value must be 1 character5. Conditional
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in Healthcare Acquired Condition Indicator List (VVL).4. Value must be 1 character5. Conditio
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in Border State Indicator List (VVL)4. Value must be 1 character5. Conditional
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in 1115A Demonstration Indicator List (VVL)4. Value must be 1 character5. Conditional6. Whe value equals '0', is invalid or not populated, the associated 1115A Demonstration Indicator (ELG.018.233) must equal '0', is invalid or not populated
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in Other Insurance Indicator List (VVL)4. Value must be 1 character5. Conditional
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in Fixed Payment Indicator List (VVL)4. Value must be 1 character5. Conditional
1. Value must be in Medicare Combined Deductible Indicator List (VVL)2. Value must be 1 character3. Value must be in [0, 1] or not populated4. Value must be 1 character5. If value equals '1', then Total Medicare Coinsurance amount must not be populated.6. If value equa '0', then Crossover Indicator must equals '0'7. If value equals '1', then Crossover Indicator equals '1'8. Conditional
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in Forced Claim Indicator List (VVL)4. Value must be 1 character5. Conditional
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in Healthcare Acquired Condition Indicator List (VVL).4. Value must be 1 character5. Conditio
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1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in Other Insurance Indicator List (VVL)4. Value must be 1 character5. Conditional
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in Fixed Payment Indicator List (VVL)4. Value must be 1 character5. Conditional

1. Value must be in Medicare Combined Deductible Indicator List (VVL)2. Value must be 1 character3. Value must be in [0, 1] or not populated4. Value must be 1 character5. If value equals '1', then Total Medicare Coinsurance amount must not be populated.6. If value equa '0', then Crossover Indicator must equals '0'7. If value equals '1', then Crossover Indicator equals '1'8. Conditional
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in Forced Claim Indicator List (VVL)4. Value must be 1 character5. Conditional
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1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in Other Insurance Indicator List (VVL)4. Value must be 1 character5. Conditional
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in Fixed Payment Indicator List (VVL)4. Value must be 1 character5. Conditional
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in Forced Claim Indicator List (VVL)4. Value must be 1 character5. Conditional
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in Border State Indicator List (VVL)4. Value must be 1 character5. Conditional
1. Value must be in Medicare Combined Deductible Indicator List (VVL)2. Value must be 1 character3. Value must be in [0, 1] or not populated4. Value must be 1 character5. If value equals '1', then Total Medicare Coinsurance amount must not be populated.6. If value equa '0', then Crossover Indicator must equals '0'7. If value equals '1', then Crossover Indicator equals '1'8. Conditional
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in Pregnancy Indicator List (VVL)4. Value must be 1 character5. Conditional
1. Value must be in Primary Eligibility Group Indicator List (VVL)2. Value must be 1 charact Value must be in [0, 1] or not populated4. Value must be 1 character5. Mandatory
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in American Indian Alaskan Native Indicator List (VVL)4. Value must be 1 character5. Conditio
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in 1115A Demonstration Indicator List (VVL)4. Value must be 1 character5. Conditional
1. Value must be in Adjustment Indicator List (VVL)2. If associated Type of Claim (CE) valu 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]4. Value must be 1 character5. Mandatory

1. Value must be in Claim Denied Indicator List (VVL)2. If value is '0', then Claim Status Category (CE) must equal "F2"3. Value must be 1 character4. Mandatory
1. Value must be in Line Adjustment Indicator List (VVL)2. If associated Type of Claim (CE) value is in [1, 3, 5, A, C, E, U, W, Y], then value must be in [0, 1, 4]3. If associated Type o Claim (CE) value is in [4, D, X], then value must be in [5, 6]4. Value must be 1 character5 Conditional6. If associated Line Adjustment Number is populated, then value must be populated
1. Value must be in Adjustment Indicator List (VVL)2. If associated Type of Claim (CE) valu 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]4. Value must be 1 character5. Mandatory
1. Value must be in Claim Denied Indicator List (VVL)2. If value is '0', then Claim Status Category (CE) must equal "F2"3. Value must be 1 character4. Mandatory
1. Value must be in Line Adjustment Indicator List (VVL)2. If associated Type of Claim (CE) value is in [1, 3, 5, A, C, E, U, W, Y], then value must be in [0, 1, 4]3. If associated Type o Claim (CE) value is in [4, D, X], then value must be in [5, 6]4. Value must be 1 character5 Conditional6. If associated Line Adjustment Number is populated, then value must be populated
1. Value must be in Adjustment Indicator List (VVL)2. If associated Type of Claim (CE) valu 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]4. Value must be 1 character5. Mandatory
1. Value must be in Claim Denied Indicator List (VVL)2. If value is '0', then Claim Status Category (CE) must equal "F2"3. Value must be 1 character4. Mandatory
1. Value must be in Line Adjustment Indicator List (VVL)2. If associated Type of Claim (CE) value is in [1, 3, 5, A, C, E, U, W, Y], then value must be in [0, 1, 4]3. If associated Type o Claim (CE) value is in [4, D, X], then value must be in [5, 6]4. Value must be 1 character5 Conditional6. If associated Line Adjustment Number is populated, then value must be populated
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1. Value must be in Line Adjustment Indicator List (VVL)2. If associated Type of Claim (CE) value is in [1, 3, 5, A, C, E, U, W, Y], then value must be in [0, 1, 4]3. If associated Type o Claim (CE) value is in [4, D, X], then value must be in [5, 6]4. Value must be 1 character5 Conditional6. If associated Line Adjustment Number is populated, then value must be populated
12/08/2022
A code to indicate what type of payment is covered in this claim.
12/08/2022

The field denotes the claims payment system from which the claim was extracted.
12/08/2022
The total amount billed for this claim at the claim header level as submitted by the provide For encounter records, when Type of Claim value is [3, C, or W], then value must equal amount the provider billed to the managed care plan. Total Billed Amount is not expected financial transactions.For sub-capitated encounters from a sub-capitated entity that is not 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-capi network provider.For sub-capitated encounters from a sub-capitated entity that is not a su capitated network provider, report the total amount that the provider billed the sub-capita entity for the service. Report a null value in this field if the provider is a sub-capitated netw provider.
The total amount billed for this claim at the claim header level as submitted by the provide For encounter records, when Type of Claim value is [3, C, or W], then value must equal amount the provider billed to the managed care plan. Total Billed Amount is not expected financial transactions.
12/08/2022
The claim header level maximum amount determined by the payer as being 'allowable' un the provisions of the contract prior to the determination of actual payment. On FFS claims Allowed Amount is determined by the state's MMIS. On managed care encounters the Allow Amount is determined by the managed care organization.
12/08/2022

The total amount paid by Medicaid/CHIP or the managed care plan on this claim or adjustm at the claim header level, which is the sum of the amounts paid by Medicaid or the manag care plan at the detail level for the claim.
12/08/2022
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 rec Type of Claim = 3, C, or W, this field should be populated with the amount that the provide billed to the managed care plan.
12/08/2022
The maximum amount displayed at the claim line level as determined by the payer as bei "allowable" under the provisions of the contract prior to the determination of actual payme On Fee for Service claims the Allowed Amount is determined by the state's MMIS (or PBM). managed care encounters the Allowed Amount is determined by the managed care organization.
12/08/2022
The amount paid by Medicaid/CHIP agency or the managed care plan on this claim or adjustment at the claim detail level.
12/08/2022
A code to indicate what type of payment is covered in this claim.
12/08/2022

The field denotes the claims payment system from which the claim was extracted.
12/08/2022
The total amount billed for this claim at the claim header level as submitted by the provide For encounter records, when Type of Claim value is [3, C, or W], then value must equal amount the provider billed to the managed care plan. Total Billed Amount is not expected financial transactions.
12/08/2022
The claim header level maximum amount determined by the payer as being 'allowable' un the provisions of the contract prior to the determination of actual payment. On FFS claims Allowed Amount is determined by the state's MMIS. On managed care encounters the Allo Amount is determined by the managed care organization.
12/08/2022
The total amount paid by Medicaid/CHIP or the managed care plan on this claim or adjustn at the claim header level, which is the sum of the amounts paid by Medicaid or the manag care plan at the detail level for the claim.
12/08/2022

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 rec Type of Claim = 3, C, or W, this field should be populated with the amount that the provide billed to the managed care plan.
12/08/2022
The maximum amount displayed at the claim line level as determined by the payer as bei "allowable" under the provisions of the contract prior to the determination of actual payme On Fee for Service claims the Allowed Amount is determined by the state's MMIS (or PBM). managed care encounters the Allowed Amount is determined by the managed care organization.
12/08/2022
The amount paid by Medicaid/CHIP agency or the managed care plan on this claim or adjustment at the claim detail level.
12/08/2022
For services received during a single encounter with a provider, the date the service cover 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 serv covered by this claim began. For capitation premium payments, the date on which the per 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.

For services received during a single encounter with a provider, the date the service cover 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 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, pop with the last day of the time period covered by this financial transaction.

12/08/2022

A code to indicate what type of payment is covered in this claim.

12/08/2022

The field denotes the claims payment system from which the claim was extracted.

12/08/2022

The total amount billed for this claim at the claim header level as submitted by the provide For encounter records, when Type of Claim value is [3, C, or W], then value must equal amount the provider billed to the managed care plan. Total Billed Amount is not expected financial transactions.

12/08/2022

The claim header level maximum amount determined by the payer as being 'allowable' un the provisions of the contract prior to the determination of actual payment. On FFS claims Allowed Amount is determined by the state's MMIS. On managed care encounters the Allow Amount is determined by the managed care organization.

12/08/2022

The total amount paid by Medicaid/CHIP or the managed care plan on this claim or adjustn at the claim header level, which is the sum of the amounts paid by Medicaid or the manag care plan at the detail level for the claim.

A unique number assigned by the state which represents a distinct comprehensive manag care plan, prepaid health plan, primary care case management program, a program for all inclusive care for the elderly entity, or other approved plans.

12/08/2022

A unique identification number assigned by the state to a provider or capitation plan. This element should represent the entity billing for the service. For encounter records, if associ Type of Claim value equals 3, C, or W, then value must be the state identifier of the provid entity (billing or reporting) to the managed care plan.

12/08/2022

The National Provider ID (NPI) of the billing entity responsible for billing a patient for health services. The billing provider can also be servicing, referring, or prescribing provider. Can I admitting provider except for Long Term Care.

8/6/2023

12/08/2022

For services received during a single encounter with a provider, the date the service cover 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 serv covered by this claim began. For capitation premium payments, the date on which the per 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.

12/08/2022

For services received during a single encounter with a provider, the date the service cover 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 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, pop with the last day of the time period covered by this financial transaction.

12/08/2022

The amount billed at the claim detail level as submitted by the provider. For encounter rec Type of Claim = 3, C, or W, this field should be populated with the amount that the provide billed the managed care plan.

12/08/2022

The maximum amount displayed at the claim line level as determined by the payer as bein "allowable" under the provisions of the contract prior to the determination of actual payme On Fee for Service claims the Allowed Amount is determined by the state's MMIS (or PBM). managed care encounters the Allowed Amount is determined by the managed care organization.

12/08/2022

The amount paid by Medicaid/CHIP agency or the managed care plan on this claim or adjustment at the claim detail level.

12/08/2022

A code to indicate what type of payment is covered in this claim.

12/08/2022

The field denotes the claims payment system from which the claim was extracted.
12/08/2022
The total amount billed for this claim at the claim header level as submitted by the provide For encounter records, when Type of Claim value is [3, C, or W], then value must equal amount the provider billed to the managed care plan. Total Billed Amount is not expected financial transactions.
12/08/2022
The claim header level maximum amount determined by the payer as being 'allowable' un the provisions of the contract prior to the determination of actual payment. On FFS claims Allowed Amount is determined by the state's MMIS. On managed care encounters the Allo Amount is determined by the managed care organization.
12/08/2022
The total amount paid by Medicaid/CHIP or the managed care plan on this claim or adjustn at the claim header level, which is the sum of the amounts paid by Medicaid or the manag care plan at the detail level for the claim.
12/08/2022

The amount billed at the claim detail level as submitted by the provider. For encounter rec Type of Claim = 3, C, or W, this field should be populated with the amount that the provide billed the managed care plan.
12/08/2022
The maximum amount displayed at the claim line level as determined by the payer as bein "allowable" under the provisions of the contract prior to the determination of actual payme On Fee for Service claims the Allowed Amount is determined by the state's MMIS (or PBM). managed care encounters the Allowed Amount is determined by the managed care organization.
12/08/2022
The amount paid by Medicaid/CHIP agency or the managed care plan on this claim or adjustment at the claim detail level.
12/08/2022
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 va value lists.
12/08/2022

The reason for a complete loss/termination in an individual's eligibility for Medicaid and CH The end date of the segment in which the value is reported must represent the date that t 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 a single termination in eligibility for a single individual there are multiple distinct co-occurr 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' (Othe '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 stat 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 o 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.|
The reason for a complete loss/termination in an individual's eligibility for Medicaid and CH The end date of the segment in which the value is reported must represent the date that t 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 a single termination in eligibility for a single individual, there are multiple distinct co-occur 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' (Othe '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 stat 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 o value over another.
12/08/2022
The first calendar day on which all of the other data elements in the same segment were effective.
12/08/2022
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.
12/08/2022
The total coinsurance amount on a claim that the beneficiary is obligated to pay for covere services. This is the total Medicaid or contract negotiated beneficiary coinsurance liability f covered service on the claim. Do not subtract out any payments made toward the copaym
12/08/2022

The total deductible amount on a claim the beneficiary is obligated to pay for covered serv This amount is the total Medicaid or contract negotiated beneficiary deductible liability for covered services on the claim. Do not subtract out any payments made toward the deduc
12/08/2022
The total coinsurance amount on a claim that the beneficiary is obligated to pay for covere services. This is the total Medicaid or contract negotiated beneficiary coinsurance liability f covered service on the claim. Do not subtract out any payments made toward the copaym
12/08/2022
The total deductible amount on a claim the beneficiary is obligated to pay for covered serv This amount is the total Medicaid or contract negotiated beneficiary deductible liability for covered services on the claim. Do not subtract out any payments made toward the deduc
12/08/2022
The total coinsurance amount on a claim that the beneficiary is obligated to pay for covere services. This is the total Medicaid or contract negotiated beneficiary coinsurance liability f covered service on the claim. Do not subtract out any payments made toward the copaym
12/08/2022
The total deductible amount on a claim the beneficiary is obligated to pay for covered serv This amount is the total Medicaid or contract negotiated beneficiary deductible liability for covered services on the claim. Do not subtract out any payments made toward the deduc
CRX - CLAIM PRESCRIPTION
12/08/2022
The total coinsurance amount on a claim that the beneficiary is obligated to pay for covere services. This is the total Medicaid or contract negotiated beneficiary coinsurance liability f covered service on the claim. Do not subtract out any payments made toward the copaym
12/08/2022
The total deductible amount on a claim the beneficiary is obligated to pay for covered serv This amount is the total Medicaid or contract negotiated beneficiary deductible liability for covered services on the claim. Do not subtract out any payments made toward the deduc
8/9/2023
A code to indicate what type of payment is covered in this claim.For sub-capitated encount from a sub-capitated entity or sub-capitated network provider, report TYPE-OF-CLAIM = '3' Medicaid sub-capitated encounter record or “C” for an S-CHIP sub-capitated encounter rec
CRX - CLAIM PRESCRIPTION

1. Value of the CC component must be "20"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 yea never April 31st or Sept 31st)4. Value must be less than current date5. Value must be equ or after the value of associated End of Time Period (CE)6. Mandatory
1. Value of the CC component must be "20"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 yea never April 31st or Sept 31st)4. Value must be equal to or earlier than associated Date File Created (CE)5. Value must be before associated End of Time Period (CE)6. Mandatory
1. Value must be 8 characters in the form "CCYYMMDD"2. Value of the CC component mus "20"3. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never A 31st or Sept 31st)4. Value must be equal to or earlier than associated Date File Created (C Value must be equal to or after associated Start of Time Period (CE)6. Mandatory
1. Value must be unique within record segment over all records associated with a given Re ID (CE)2. Value must be 11 digits or less3. Mandatory
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Value must be les than or equal to associated Discharge Date (CE) value in the claim header.4. Value must b greater than or equal to associated eligible Date of Birth (CE) value.5. Value must be less t or equal to associated eligible Date of Death (CE) value.6. Mandatory7. Value must be betw Enrollment Effective Date (ELG.021.253) and Enrollment End Date (ELG.021.254)8. (capita payment) when associated Type of Claim (CIP.002.100) is not '2','B' or 'V' and Type of Serv (CIP.002.257) is not '119, '120', '121', 122' value must be before Adjudication Date (CIP.003.286)
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Value must be le than or equal to associated Adjudication Date (CE) value.4. Value must be greater than or equal to associated Admission Date (CE) value.5. Value must be greater than or equal to associated eligible Date of Birth (CE) value.6. Value must be less than or equal to associat eligible Date of Death (CE) value.7. Conditional8. If associated Adjustment Indicator (CIP.002.026) does not equal "1" (Non-denied claims) and Patient Status (CIP.002.199) is n equal to "30" value must be populated.9. When populated, Discharge Hour (CIP.002.097) r be populated
1. Value must be a positive integer2. Value must be between 0:9999 (inclusive)3. Value m not include commas or other non-numeric characters4. Value must be equal to the numbe claim lines (e.g. Original Claim Line Number (CE) or Adjustment Claim Line Number (CE) instances) reported in the associated claim record being reported5. Value must be 4 chara or less6. Mandatory
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Must have an associated Occurrence Code (CE)4. Must be greater than or equal to Occurrence Code Effe Date5. Conditional

1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Must have an associated Occurrence Code (CE)4. Must be greater than or equal to Occurrence Code Effe Date5. Conditional
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1. Value must be unique within record segment over all records associated with a given Re ID (CE)2. Value must be 11 digits or less3. Mandatory
1. Value of the CC component must be "20"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 yea never April 31st or Sept 31st)4. Value must be less than current date5. Value must be equ or after the value of associated End of Time Period (CE)6. Mandatory
1. Value of the CC component must be "20"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 yea never April 31st or Sept 31st)4. Value must be equal to or earlier than associated Date File Created (CE)5. Value must be before associated End of Time Period (CE)6. Mandatory

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1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Value must be le than or equal to associated Discharge Date (CE) value in the claim header.4. Value must b greater than or equal to associated eligible Date of Birth (CE) value.5. Value must be less t or equal to associated eligible Date of Death (CE) value.6. Mandatory7. When associated T of Claim (CLT.002.052) is not '2','B' or 'V' (capitated payment) value must be before Adjudication Date (CLT.002.050)8. When associated Type of Claim (CLT.002.052) is not '2' 'V' (capitated payment) and Type of Service (CLT.003.211) is not '119, '120', '121', 122' va must be before Adjudication Date (CLT.003.233)
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Value must be le than or equal to associated Adjudication Date (CE) value.4. Value must be greater than or equal to associated Admission Date (CE) value.5. Value must be greater than or equal to associated eligible Date of Birth (CE) value.6. Value must be less than or equal to associate eligible Date of Death (CE) value.7. Conditional8. When populated, Discharge Hour (CLT.002.047) must be populated
1. Value must be a positive integer2. Value must be between 0:9999 (inclusive)3. Value m not include commas or other non-numeric characters4. Value must be equal to the numbe claim lines (e.g. Original Claim Line Number (CE) or Adjustment Claim Line Number (CE) instances) reported in the associated claim record being reported5. Value must be 4 chara or less6. Mandatory
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Must have an associated Occurrence Code (CE)4. Must be greater than or equal to Occurrence Code Effe Date5. Conditional
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1. Value must be unique within record segment over all records associated with a given Re ID (CE)2. Value must be 11 digits or less3. Mandatory
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. If associated Type of Claim (CE) value e '3, C, W', then value is mandatory and must be provided4. Conditional
1. Value of the CC component must be "20"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 yea never April 31st or Sept 31st)4. Value must be less than current date5. Value must be equ or after the value of associated End of Time Period (CE)6. Mandatory
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1. Value must be 8 characters in the form "CCYYMMDD"2. Value of the CC component mus "20"3. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never A 31st or Sept 31st)4. Value must be equal to or earlier than associated Date File Created (C Value must be equal to or after associated Start of Time Period (CE)6. Mandatory
1. Value must be unique within record segment over all records associated with a given Re ID (CE)2. Value must be 11 digits or less3. Mandatory
1. Value must be a positive integer2. Value must be between 0:9999 (inclusive)3. Value m not include commas or other non-numeric characters4. Value must be equal to the numbe claim lines (e.g. Original Claim Line Number (CE) or Adjustment Claim Line Number (CE) instances) reported in the associated claim record being reported5. Value must be 4 chara or less6. Mandatory
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1. Value must be unique within record segment over all records associated with a given Re ID (CE)2. Value must be 11 digits or less3. Mandatory
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. If associated Type of Claim (CE) value e '3, C, W', then value is mandatory and must be provided4. Conditional
1. Value must be 60 characters or less2. Value must not be equal to associated Address Li (CE) or Address Line 3 (CE) value(s)3. Value must not contain a pipe or asterisk symbols4. Conditional
1. Value must be 60 characters or less2. Value must not be equal to associated Address Li (CE) or Address Line 3 (CE) value(s)3. There must be an Address Line 1 (CE) in order to hav Address Line 2 (CE)4. Value must not contain a pipe or asterisk symbols5. Conditional
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1. Value of the CC component must be "20"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 yea never April 31st or Sept 31st)4. Value must be less than current date5. Value must be equ or after the value of associated End of Time Period (CE)6. Mandatory
1. Value of the CC component must be "20"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 yea never April 31st or Sept 31st)4. Value must be equal to or earlier than associated Date File Created (CE)5. Value must be before associated End of Time Period (CE)6. Mandatory
1. Value must be 8 characters in the form "CCYYMMDD"2. Value of the CC component mus "20"3. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never A 31st or Sept 31st)4. Value must be equal to or earlier than associated Date File Created (C Value must be equal to or after associated Start of Time Period (CE)6. Mandatory
1. Value must be unique within record segment over all records associated with a given Re ID (CE)2. Value must be 11 digits or less3. Mandatory

1. Value must be a positive integer2. Value must be between 0:9999 (inclusive)3. Value m not include commas or other non-numeric characters4. Value must be equal to the numbe claim lines (e.g. Original Claim Line Number (CE) or Adjustment Claim Line Number (CE) instances) reported in the associated claim record being reported5. Value must be 4 chara or less6. Mandatory
1. Value must be unique within record segment over all records associated with a given Re ID (CE)2. Value must be 11 digits or less3. Mandatory
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. If associated Type of Claim (CE) value e '3, C, W', then value is mandatory and must be provided4. Conditional
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1. Value must be unique within record segment over all records associated with a given Re ID (CE)2. Value must be 11 digits or less3. Mandatory
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Children enrolle the Separate CHIP prenatal program option should have a date of birth missing or a date o birth equal to the pregnant mother's date of birth4. When Conception to Birth Indicator (ELG.005.094) does not equal '1' and Eligibility Group (ELG.005.087) does not equal '64' va must be less than or equal to associated End of Time Period (CE) value5. Value must be les than or equal to associated Date File Created (ELG.001.008) value6. Mandatory7. When Conception to Birth Indicator (ELG.005.094) does not equal '1' and Eligibility Group (ELG.005.087) does not equal '64' value minus Start of Time Period (ELG.001.10) must be than 125 years
1. Value must be unique within record segment over all records associated with a given Re ID (CE)2. Value must be 11 digits or less3. Mandatory
1. Value must be unique within record segment over all records associated with a given Re ID (CE)2. Value must be 11 digits or less3. Mandatory
1. Value must be 60 characters or less2. Value must not be equal to associated Address Li (CE) or Address Line 3 (CE) value(s)3. Value must not contain a pipe or asterisk symbols4. Mandatory5. When populated, the associated Address Type is required

1. Value must be 60 characters or less2. Value must not be equal to associated Address Li (CE) or Address Line 3 (CE) value(s)3. There must be an Address Line 1 (CE) in order to hav Address Line 2 (CE)4. Value must not contain a pipe or asterisk symbols5. Conditional
1. Value must be 60 characters or less2. Value must not be equal to associated Address Li (CE) or Address Line 2 (CE) value(s)3. If Address Line 2 is not populated, then value should be populated4. Value must not contain a pipe or asterisk symbols5. Conditional
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1. Value of the CC component must be "20"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 yea never April 31st or Sept 31st)4. Value must be less than current date5. Value must be equ or after the value of associated End of Time Period (CE)6. Mandatory
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1. Value must be 60 characters or less2. Value must not be equal to associated Address Li (CE) or Address Line 2 (CE) value(s)3. If Address Line 2 is not populated, then value should be populated4. Value must not contain a pipe or asterisk symbols5. Conditional
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1. Value must be in Adjustment Indicator List (VVL)2. If associated Type of Claim value is in 3, 5, A, C, E, U, W, Y], then value must be in [0, 1, 4]3. If associated Type of Claim value D, X', then value must be in [5, 6]4. Value must be 1 character5. Mandatory
1. Value must be in Diagnosis Code Flag List(VVL)2. Value must be 1 character
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Value must be less than associated Tota Billed Amount (CE) - (Total Medicare Coinsurance Amount (CE) + Total Medicare Deductibl Amount (CE))4. Conditional
1. Value must be associated with a populated Waiver Type (CE)2. Value must be 20 charac or less3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associa Claim Waiver Type value must be 01 or in [21-30]4. (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. Conditional
1. Value must be 10 digits, consisting of 9 numeric digits followed by one check digit calcu using the Luhn formula (algorithm)2. Conditional3. Value must have an associated Provide Identifier Type equal to '2'
1. Value must be in Revenue Code List (VVL)2. A Revenue Code (CE) value requires an associated Revenue Charge (CE)3. Value must be 4 characters or less4. Mandatory
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Value must be less than or equal to associated Total Billed Amount (CE) value.4. When populated, associated claim line Reven Charge must be populated5. Conditional
1. Value must be in Adjustment Indicator List (VVL)2. If associated Type of Claim value is in 3, 5, A, C, E, U, W, Y], then value must be in [0, 1, 4]3. If associated Type of Claim value D, X', then value must be in [5, 6]4. Value must be 1 character5. Mandatory

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1. Value must be 10 digits, consisting of 9 numeric digits followed by one check digit calcu using the Luhn formula (algorithm)2. Value must have an associated Provider Identifier Typ equal to '2'3. Conditional
1. Value must be in Revenue Code List (VVL)2. A Revenue Code (CE) value requires an associated Revenue Charge (CE)3. Value must be 4 characters or less4. Mandatory
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1. Value must be in Adjustment Indicator List (VVL)2. If associated Type of Claim value is i 3, 5, A, C, E, U, W, Y], then value must be in [0, 1, 4]3. If associated Type of Claim value D, X', then value must be in [5, 6]4. Value must be 1 character5. Mandatory
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1. Value must be 3 characters2. Conditional3. Must be a 3 digit value from the Type-of-Ser valid value list
1. Value must be associated with a populated Waiver Type (CE)2. Value must be 20 chara or less3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associa Claim Waiver Type value must be 01 or in [21-30]4. (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. Value must have a corresponding value in Waiver Type (ELG.012.173)6. Mandatory
1. Value must be 10-digit number2. Optional
1. Must contain the '@' symbol2. May contain uppercase and lowercase Latin letters A to Z a to z3. May contain digits 0-94. Must contain a dot '.' that is not the first or last character provided that it does not appear consecutively5. Value must be 60 characters or less6. Op
1. Value must be unique within record segment over all records associated with a given Re ID (CE)2. Value must be 11 digits or less3. Mandatory
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1. Value must be 30 characters or less2. Conditional3. When Type of Claim not in ('Z','3','C','W',"2","B","V"," 4","D","X") then value may match (PRV.002.019) Submitting Sta Provider ID or4. When Type of Claim not in ('Z','3','C','W',"2","B","V"," 4","D","X") then valu may match (PRV.005.081) Provider Identifier where the Provider Identifier5. Discharge Dat (CIP.002.096) may be between Provider Attributes Effective Date (PRV.002.020) and Provi Attributes End Date (PRV.002.021) or6. Discharge Date (CIP.002.096) may be between Pro Identifier Effective Date (PRV.005.079) and Provider Identifier End Date (PRV.005.080)
Value must be 10 digits2. Value must have an associated Provider Identifier Type equal to Value must exist in the NPPES NPI data file 4. Conditional5. When populated, value must m Provider Identifier (PRV.005.081) and Facility Group Individual Code (PRV.002.028) must e '01'6. When Type of Claim is in ['1','3','A','C'], then value must be populated 7. NPPES Entity Type Code associated with this NPI must equal ‘2’ (Organization)
1. Value must be 10 digits, consisting of 9 numeric digits followed by one check digit calcu using the Luhn formula (algorithm)2. Value must have an associated Provider Identifier Ty equal to '2'3. Conditional4. When populated, value must match Provider Identifier (PRV.005.081) and Facility Group Individual Code (PRV.002.028) must equal '01'
1. Value must be in CMS 64 Category for Federal Reimbursement List (VVL)2. Value must b characters3. (Federal Funding under Title XXI) if value equals '02', then the eligible's CHIP (ELG.003.054) must be in ['2', '3']4. (Federal Funding under Title XIX) if value equals '01' th the eligible's CHIP Code (ELG.003.054) must be '1'5. Conditional6. If Type of Claim is in ['1','2','5','A','B','E','U','V','Y'] and the Total Medicaid Paid Amount is populated on the corresponding claim header, then value must be reported7. If Type of Claim is in ['4','D'] a the Service Tracking Payment Amount on the relevant record is populated, then value mus reported8. When Type of Claim is in [‘1’, ‘A’], value must be populated
Value must be in CMS 64 Category for Federal Reimbursement List (VVL)2. Value must be characters3. (Federal Funding under Title XXI) if value equals '02', then the eligible's CHIP (ELG.003.054) must be in ['2', '3']4. (Federal Funding under Title XIX) if value equals '01' th the eligible's CHIP Code (ELG.003.054) must be '1'5. Conditional6. If Type of Claim is in ['1','2','5','A','B','E','U','V','Y'] 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'] a the Service Tracking Payment Amount on the relevant record is populated, then value mus reported.8. When Type of Claim is in [‘1’, ‘A’], value must be populated

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1. Value must be 30 characters or less2. Conditional3. When Type of Claim not in ('Z','3','C','W","2","B","V"," 4","D","X") then value may match (PRV.002.019) Submitting Sta Provider ID or4. When Type of Claim not in ('Z','3','C','W","2","B","V"," 4","D","X") then valu may match (PRV.005.081) Provider Identifier where the Provider Identifier5. Ending Date o Service (CLT.002.049) may be between Provider Attributes Effective Date (PRV.002.020) a Provider Attributes End Date (PRV.002.021) or6. Ending Date of Service (CLT.002.049) may between Provider Identifier Effective Date (PRV.005.079) and Provider Identifier End Date (PRV.005.080)
1. Value must be 10 digits, consisting of 9 numeric digits followed by one check digit calcu using the Luhn formula (algorithm)2. Value must have an associated Provider Identifier Ty equal to '2'3. Conditional4. When Type of Claim (CLT.002.052) not in ('3','C','W') then value must match Provider Identifier (PRV.002.081)
1. Value must be 30 characters or less2. Conditional3. When Type of Claim not in ('Z','3','C','W","2","B","V"," 4","D","X") then value may match (PRV.002.019) Submitting Sta Provider ID or4. When Type of Claim not in ('Z','3','C','W","2","B","V"," 4","D","X") then valu may match (PRV.005.081) Provider Identifier where the Provider Identifier Type (PRV.005.0 equal to '1' 5. When Type of Claim is in ['1','3','A','C'], then value must be populated 6. Wh Type of Claim in ('1','3','A','C') then associated Provider Medicaid Enrollment Status Code (PRV.007.100) must be in ['01', '02', '03', '04', '05', '06'] (active)7. Must have an enrollmen where the Ending Date of Service (COT.003.167) may be between Provider Attributes Effec Date (PRV.002.020) and Provider Attributes End Date (PRV.002.021) or8. Must have an enrollment where the Ending Date of Service (COT.003.167) may be between Provider Iden Effective Date (PRV.005.079) and Provider Identifier End Date (PRV.005.080) 9. When Type Service (COT.003.186) is not in ['119', '120', '122'], value must be reported in Provider Identifier (PRV.005.080) with an associated Provider Identifier Type (PRV.005.081) equal to

1. Value must be 30 characters or less2. Conditional3. When Type of Claim not in ('Z','3','C','W',"2","B","V"," 4","D","X") then value may match (PRV.002.019) Submitting Sta Provider ID or4. When Type of Claim not in ('Z','3','C','W',"2","B","V"," 4","D","X") then valu may match (PRV.005.081) Provider Identifier where the Provider Identifier5. 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 Must have an enrollment where the Ending Date of Service (COT.003.167) may be betwee Provider Identifier Effective Date (PRV.005.079) and Provider Identifier End Date (PRV.005.080)7. When Type of Service (COT.003.186) is not in ['119', '120', '122'], value m be reported in Provider Identifier (PRV.005.080) with an associated Provider Identifier Type (PRV.005.081) equal to '1'
1. Situational2. Value must be between -99999999999.99 and 99999999999.993. Value m be expressed as a number with 2-digit precision (e.g. 100.50)
1. Conditional2. Value must be 11 digits or less left of the decimal i.e. 99999999999.99
1. Value must be 30 characters or less2. Conditional3. When Type of Claim not in ('Z','3','C','W',"2","B","V"," 4","D","X") then value may match (PRV.002.019) Submitting Sta Provider ID or4. When Type of Claim not in ('Z','3','C','W',"2","B","V"," 4","D","X") then valu may match (PRV.005.081) Provider Identifier where the Provider Identifier5. Prescription Fi Date (CRX.002.085) may be between Provider Attributes Effective Date (PRV.002.020) and Provider Attributes End Date (PRV.002.021) or6. Prescription Fill Date (CRX.002.085) may b between Provider Identifier Effective Date (PRV.005.079) and Provider Identifier End Date (PRV.005.080)
1. Value must be 10 digits 2. Value must have an associated Provid Identifier Type (PRV.005.007) 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 Individua Code (PRV.002.028) must equal '01' 6. When Type of Claim is in ['1','3','A','C'], then value must be populated 7. When Type of Claim in ('3','C','W') then value must match Provider Identifier (PRV.002.081) NPPES Entity Type Code associated with this NPI must equal ‘2’ (Organization)

1. Value must be 10 digits, consisting of 9 numeric digits followed by one check digit calcu using the Luhn formula (algorithm)2. Value must have an associated Provider Identifier Ty equal to '2'3. Conditional4. When Type of Claim not in ('3','C','W') then value must match Provider Identifier (PRV.002.081)
1. Value must be 1 character2. Value must be in [0, 1, 2] or not populated3. Value must be Citizenship Indicator List (VVL)4. If value is coded as '0', then associated Immigration Statu (ELG.003.042) value must be in [1, 2, 3]5. If value is coded as '1', then associated Immigr Status (ELG.003.042) value must equal '8'6. Value must be 1 character7. Mandatory
1. Value must be in Conception to Birth Indicator List (VVL)2. Value must be 1 character3. must be in [0, 1] or not populated4. If the value is equal to "1", then the Eligibility Group (ELG.005.087) must equal "64"5. If the value is equal to "1", then any associated claims m indicate the Program Type = '14' (State Plan CHIP)6. If the value is equal to "1", then CHIP (ELG.003.054) must equal "3" (Individual was not Medicaid Expansion CHIP eligible, but wa included in a separate title XXI CHIP Program)7. Value must be 1 character8. Conditional
1. Value must be 500 characters or less2. Value must not contain a pipe or asterisk symbo Optional
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"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 CF 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 mem of a tribe, band, or other organized group of Indians, including those tribes, bands, or grou terminated since 1940 and those recognized now or in the future by the State in which the 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 an Indian for any purpose; or iv. Is determined to be an Indian under regulations promulga 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 wh complete Appendix B of the Marketplace/Medicaid application and respond affirmatively to two questions shown below are considered to meet the definition of an American Indian/Alaskan Native. Are you a member of a federally recognized tribe? Has this person e gotten a service from the Indian Health Service, a tribal health program, or urban Indian he program, or through a referral from one of these programs?
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Optional
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Must have an associated Third Party Coinsurance Amount4. Conditional
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Optional
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Must have an associated Third Party Copayment Amount4. Situational
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1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Optional
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1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Optional
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Must have an associated Third Party Copayment Amount4. Situational
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Must have an associated Third Party Copayment Amount4. Optional
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Optional
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1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Optional
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Must have an associated Third Party Coinsurance Amount4. Conditional
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Optional
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Must have an associated Third Party Copayment Amount4. Optional
1. Value must be 10 characters or less2. Value must not include the pipe ("|") symbol3. Mandatory
Optional
1. Value must be 50 characters or less2. Value must not contain a pipe or asterisk symbols associated Adjustment Indicator value is 0, then value must not be populated4. Conditiona
1. Value must be in Crossover Indicator List (VVL)2. Value must be 1 character3. Value mu in [0, 1] or not populated4. If Crossover Indicator value is "1", the associated Dual Eligible (ELG.005.085) value must be in "01", "02", "04", "08", "09", or "10" for the same time peri (by date of service)5. Value must be 1 character6. If the Type of Claim value is in ["1", "3", "C"], then value is mandatory and must be reported.7. Conditional

1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres 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 claim4. Conditional5. Value should not be populated w 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' value must be greater th or equal to the sum of all claim line Revenue Charges (CIP.003.251)
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Must have an associated Medicaid Paid Date4. If Total Medicare Coinsurance Amount and Total Medicare Deductible Amount is reported it must equal Total Medicaid Paid Amount5. When Payment Level Indicator equals value must equal the sum of line level Medicaid Paid Amounts.6. Conditional7. Value must be greater than Total Allowed Amount (CIP.002.113)
1. Value must be in Health Home Provider Indicator List (VVL)2. Value must be 1 character Value must be in [0, 1] or not populated4. If there is an associated Health Home Entity Nam value, then value must be "1"5. Value must be 1 character6. Conditional
1. Value must be associated with a populated Waiver Type2. Value must be 20 characters less3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associate Claim Waiver Type value must be 01 or in [21-30]4. (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. Conditional
1. Value must be 10 digits, consisting of 9 numeric digits followed by one check digit calcu using the Luhn formula (algorithm)2. Value must have an associated Provider Identifier Typ equal to '2'3. Conditional
Optional
1. Value must be in Copay Waived Indicator List (VVL)2. Value must be 1 character3. Optio
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Conditional
1. Value must be 10 digits, consisting of 9 numeric digits followed by one check digit calcu using the Luhn formula (algorithm)2. Value must have an associated Provider Identifier Typ equal to '2'3. Conditional
Optional

1. Value must be 50 characters or less2. Value must not contain a pipe or asterisk symbols associated Adjustment Indicator value is 0, then value must not be populated4. Conditiona
1. Value must be in XIX MBESCBES Category of Service List (VVL)2. Value must be 5 chara or less3. Conditional4. (Medicaid Claim) if the associated CMS-64 Category for Federal Reimbursement value is '1', then a valid value is mandatory and must be reported5. If valu 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
1. Value must be in XXI MBESCBES Category of Service List (VVL)2. Conditional3. (CHIP Cla the associated CMS-64 Category for Federal Reimbursement value is '2', then a valid value mandatory and must be reported4. If XIX MBESCBES Category of Service is populated then value must not be populated5. Value must be 3 characters or less
Optional
1. Value must be 1 character2. Value must be in [0, 1]
Value must be 10 characters or less2. Value must be in the Data Dictionary Version List (V Mandatory
1. Value must be 10 characters or less2. Value must not include the pipe ("|") symbol3. Mandatory
Optional
1. Value must be 50 characters or less2. Value must not contain a pipe or asterisk symbols associated Adjustment Indicator value is 0, then value must not be populated4. Conditiona
1. Value must be in Crossover Indicator List (VVL)2. Value must be 1 character3. Value mu in [0, 1] or not populated4. If Crossover Indicator value is "1", the associated Dual Eligible (ELG.005.085) value must be in "01", "02", "04", "08", "09", or "10" for the same time peri (by date of service)5. Value must be 1 character6. If the Type of Claim value is in ["1", "3", "C"], then value is mandatory and must be reported.7. Conditional
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres 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 claim4. Conditional5. Value should not be populated 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 be greater than or equal to the sum of all claim line Revenue Charges (CLT.003.204)

1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Must have an associated Medicaid Paid Date4. If Total Medicare Coinsurance Amount and Total Medicare Deductible Amount is reported it must equal Total Medicaid Paid Amount5. When Payment Level Indicator equals value must equal the sum of line level Medicaid Paid Amounts.6. Conditional7. Value must be greater than Total Allowed Amount8. Value must be populated, when Type of Claim is i ‘A’]9. Value must not be populated or equal to ‘0.00’ when associated Claim Status is in ['2 '026', '87', '087', '542', '585', '654']10. Value should not be populated, when associated Ty Claim value is in [‘4’, ‘D’] 11. Value must be less than Total Allowed Amount12. Value must be populated when the associated Type of Claim (CLT.002.052) is i [‘5’, ‘E’]
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Must have an associated Medicaid Paid Date4. If Total Medicare Coinsurance Amount and Total Medicare Deductible Amount is reported it must equal Total Medicaid Paid Amount5. When Payment Level Indicator equals value must equal the sum of line level Medicaid Paid Amounts.6. Conditional7. Value must be greater than Total Allowed Amount
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. If associated Crossover Indicator value i (not a crossover claim), then value should not be populated.4. (Medicare Enrolled) if assoc Dual Eligible Code (ELG.005.085) value is in ["01", "02", "03", "04", "05", "06", "08", "09", "10"], then value is mandatory and must be provided5. Conditional6. When populated, val must be less than or equal to Total Billed Amount
1. Value must be in Health Home Provider Indicator List (VVL)2. Value must be 1 character Value must be in [0, 1] or not populated4. If there is an associated Health Home Entity Nar value, then value must be "1"5. Value must be 1 character6. Conditional
1. Value must be associated with a populated Waiver Type2. Value must be 20 characters less3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associate Claim Waiver Type value must be 01 or in [21-30]4. (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. Conditional
1. Value must be 10 digits, consisting of 9 numeric digits followed by one check digit calcu using the Luhn formula (algorithm)2. Value must have an associated Provider Identifier Ty equal to '2'3. Conditional
Optional

1. Value must be in Copay Waived Indicator List (VVL)2. Value must be 1 character3. Optic
1. Value must be 10 digits, consisting of 9 numeric digits followed by one check digit calcu using the Luhn formula (algorithm)2. Value must have an associated Provider Identifier Ty equal to '2'3. Conditional
Optional
1. Value must be 50 characters or less2. Value must not contain a pipe or asterisk symbols associated Adjustment Indicator value is 0, then value must not be populated4. Conditiona
1. Value must be in XIX MBESCBES Category of Service List (VVL)2. Value must be 5 chara or less3. Conditional4. (Medicaid Claim) if the associated CMS-64 Category for Federal Reimbursement value is '1', then a valid value is mandatory and must be reported5. If valu 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
1. Value must be in XXI MBESCBES Category of Service List (VVL)2. Conditional3. (CHIP Cla the associated CMS-64 Category for Federal Reimbursement value is '2', then a valid value mandatory and must be reported4. If XIX MBESCBES Category of Service is populated ther value must not be populated5. Value must be 3 characters or less
Optional
1. Value must be 1 character2. Value must be in [0, 1]
1. Value must be 10 characters or less2. Value must not include the pipe ("|") symbol3. Mandatory
Optional
1. Value must be 50 characters or less2. Value must not contain a pipe or asterisk symbols associated Adjustment Indicator value is 0, then value must not be populated4. Conditiona
1. Value must be in Crossover Indicator List (VVL)2. Value must be 1 character3. Value mu in [0, 1] or not populated4. If Crossover Indicator value is "1", the associated Dual Eligible (ELG.005.085) value must be in "01", "02", "04", "08", "09", or "10" for the same time peri (by date of service)5. Value must be 1 character6. If the Type of Claim value is in ["1", "3", "C"], then value is mandatory and must be reported.7. Conditional
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres 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 claim4. Conditional5. Value should not be populated associated Type of Claim is in [2, 4, 5, B, D E or X]

1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Must have an associated Medicaid Paid Date4. If Total Medicare Coinsurance Amount and Total Medicare Deductible Amount is reported it must equal Total Medicaid Paid Amount5. When Payment Level Indicator equals value must equal the sum of line level Medicaid Paid Amounts.6. Conditional7. Value must be greater than Total Allowed Amount (COT.002.049)8. Value must not be populated or eq to ‘0.00’ when associated Claim Status is in ['26', '026', '87', '087', '542', '585', '654']9. Val should not be populated, when associated Type of Claim value is in [‘4’, ‘D’] 10. Value must not be greater than Total Allowed Amount (COT.002.049) 11. Value must be populated, when Type of Claim (COT.002.037) is in [‘2’, '5', ‘B’, 'E']
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Must have an associated Medicaid Paid Date4. If Total Medicare Coinsurance Amount and Total Medicare Deductible Amount is reported it must equal Total Medicaid Paid Amount5. When Payment Level Indicator equals value must equal the sum of line level Medicaid Paid Amounts.6. Conditional7. Value must be greater than Total Allowed Amount (COT.002.049)
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. If associated Crossover Indicator value i (not a crossover claim), then value should not be populated.4. (Medicare Enrolled) if assoc Dual Eligible Code (ELG.005.085) value is in ["01", "02", "03", "04", "05", "06", "08", "09", " "10"], then value is mandatory and must be provided5. Conditional6. When populated, val must be less than or equal to Total Billed Amount
1. Value must be in Health Home Provider Indicator List (VVL)2. Value must be 1 character Value must be in [0, 1] or not populated4. If there is an associated Health Home Entity Nar value, then value must be "1"5. Value must be 1 character6. Conditional
1. Value must be associated with a populated Waiver Type2. Value must be 20 characters less3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associate Claim Waiver Type value must be 01 or in [21-30]4. (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. Conditional
1. Value must be 10 digits, consisting of 9 numeric digits followed by one check digit calcu using the Luhn formula (algorithm)2. Value must have an associated Provider Identifier Ty equal to '2'3. Conditional

Not Applicable
Not Applicable
Optional
1. Value must not contain a pipe or asterisk symbols2. Value must 50 characters or less3. Conditional
Value must be 10 digits2. Value must have an associated Provider Identifier Type equal to Conditional4. When Type of Service (COT.003.186) equals '121', value must not be popula Value must exist in the NPPES NPI data file
1. Value must be 10 digits, consisting of 9 numeric digits followed by one check digit calcu using the Luhn formula (algorithm)2. Value must have an associated Provider Identifier Ty equal to '2'3. Conditional4. When Type of Service (COT.003.186) equals '121', value must be populated
Optional
1. Value must be 50 characters or less2. Value must not contain a pipe or asterisk symbols associated Adjustment Indicator value is 0, then value must not be populated4. Conditiona
1. Value must be in XIX MBESCBES Category of Service List (VVL)2. Value must be 5 chara or less3. Conditional4. (Medicaid Claim) if the associated CMS-64 Category for Federal Reimbursement value is '1', then a valid value is mandatory and must be reported5. If valu 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
1. Value must be in XXI MBESCBES Category of Service List (VVL)2. Conditional3. (CHIP Cla the associated CMS-64 Category for Federal Reimbursement value is '2', then a valid value mandatory and must be reported4. If XIX MBESCBES Category of Service is populated ther value must not be populated5. Value must be 3 characters or less
Optional
1. Value must be 1 character2. Value must be in [0, 1]
1. Value must be 10 characters or less2. Value must not include the pipe ("|") symbol3. Mandatory
Optional
1. Value must be 50 characters or less2. Value must not contain a pipe or asterisk symbols associated Adjustment Indicator value is 0, then value must not be populated4. Conditiona

1. Value must be in Crossover Indicator List (VVL)2. Value must be 1 character3. Value mu in [0, 1] or not populated4. If Crossover Indicator value is "1", the associated Dual Eligible (ELG.005.085) value must be in "01", "02", "04", "08", "09", or "10" for the same time peri (by date of service)5. Value must be 1 character6. If the Type of Claim value is in ["1", "3", "C"], then value is mandatory and must be reported.7. Conditional
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres 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 claim4. Conditional5. Value should not be populated associated Type of Claim is in [2, 4, 5, B, D E or X]
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Must have an associated Medicaid Paid Date4. If Total Medicare Coinsurance Amount and Total Medicare Deductible Amount is reported it must equal Total Medicaid Paid Amount5. When Payment Level Indicator equals value must equal the sum of line level Medicaid Paid Amounts.6. Conditional
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. If associated Crossover Indicator value i (not a crossover claim), then value should not be populated.4. (Medicare Enrolled) if assoc Dual Eligible Code (ELG.005.085) value is in ["01", "02", "03", "04", "05", "06", "08", "09", "10"], then value is mandatory and must be provided5. Conditional6. When populated, val must be less than or equal to Total Billed Amount
1. Value must be in Health Home Provider Indicator List (VVL)2. Value must be 1 character Value must be in [0, 1] or not populated4. If there is an associated Health Home Entity Nar value, then value must be "1"5. Value must be 1 character6. Conditional
1. Value must be associated with a populated Waiver Type2. Value must be 20 characters less3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associate Claim Waiver Type value must be 01 or in [21-30]4. (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. Conditional
Optional
1. Value must be in Copay Waived Indicator List (VVL)2. Value must be 1 character3. Optio
1. Value must be 10 digits, consisting of 9 numeric digits followed by one check digit calcu using the Luhn formula (algorithm)2. Value must have an associated Provider Identifier Typ equal to '2'3. When Type of Claim not in ('3','C','W') then value must match Provider Identi (PRV.005.081)4. Mandatory

1. Value must be 10 digits, consisting of 9 numeric digits followed by one check digit calcu using the Luhn formula (algorithm)2. Value must have an associated Provider Identifier Ty equal to '2'3. Conditional
Optional
1. Value must be 50 characters or less2. Value must not contain a pipe or asterisk symbols associated Adjustment Indicator value is 0, then value must not be populated4. Conditiona
Conditional
1. Conditional2. Value must be 5 digits or less left of the decimal i.e. 99999.99
1. Value must be in XIX MBESCBES Category of Service List (VVL)2. Value must be 5 chara or less3. Conditional4. (Medicaid Claim) if the associated CMS-64 Category for Federal Reimbursement value is '1', then a valid value is mandatory and must be reported5. If valu 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
1. Value must be in XXI MBESCBES Category of Service List (VVL)2. Conditional3. (CHIP Cla the associated CMS-64 Category for Federal Reimbursement value is '2', then a valid value mandatory and must be reported4. If XIX MBESCBES Category of Service is populated ther value must not be populated5. Value must be 3 characters or less
Optional
1. Value must be 1 character2. Value must be in [0, 1]
1. Value must be 10 characters or less2. Value must not include the pipe ("|") symbol3. Mandatory
Optional
Optional
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in Veteran Indicator List (VVL)4. Value must be 1 character5. Conditional6. Value must be populated when Immigration Status (ELG.003.042) is in ['1', '2', '3']
Optional
1. Value must be 10-digit number2. Conditional
Optional
1. Value must be in Eligibility Group List (VVL)2. If value is "26", then Dual Eligible Code va must be "06"3. Conditional4. 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 [" "73", "74", "75"], then associated Restricted Benefits Code value must equal "1" or "7" an State Plan Option Type must equal "06"6. If associated CHIP Code value is "2", then value 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 characters9. If value is "23", the 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
Optional

Optional
Optional
Optional
1. Value must be 30 characters or less2. Mandatory
Optional
Optional
Optional
1. Value must have a corresponding value in Waiver Type (ELG.012.173)2. Value must be characters or less3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", associated Claim Waiver Type value must be 01 or in [21-30]4. (1115 demonstration waive value begins with "11-W-" or "21-W-", then the value must include slash “/” in the 11th pos followed by a version number [0-9] in the 12th position 5. (1915(b) or 1915(c) waivers) If v begins with the two-letter state abbreviation followed by a period (.), the associated Claim Waiver Type value must be in [02-20, 32, 33]6. Value must have a corresponding value in Waiver Type (ELG.012.173)7. Mandatory
Value must have a corresponding value in Waiver Type (ELG.012.173)2. Value must be 20 characters or less3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", associated Claim Waiver Type value must be 01 or in [21-30]4. (1115 demonstration waive value begins with "11-W-" or "21-W-", then the value must include slash “/” in the 11th pos followed by a version number [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]6. Value must have a corresponding va in Waiver Type (ELG.012.173)7. Mandatory
1. Value must have a corresponding value in Waiver Type (ELG.012.173)2. Value must be characters or less3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", associated Claim Waiver Type value must be 01 or in [21-30]4. (1915(b) or 1915(c) waiver 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. Value must have a corresponding va in Waiver Type (ELG.012.173)6. Mandatory
1. Value must be associated with a populated Waiver Type2. Value must be 20 characters less3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associate Claim Waiver Type value must be 01 or in [21-30]4. (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. Value must have a corresponding value in Waiver Type (ELG.012.173)6. Mandatory
Optional
1. Value must be 30 characters or less2. Mandatory
Optional
Optional

Optional
1. Value must be 25 characters or less2. Value is required when Ethnicity Code (ELG.015.2 equals '4' (Other)3. Conditional
Optional
Optional
Optional
Optional
Optional
1. Value must be 20 characters or less2. Mandatory3. Must not contain a pipe symbol
Optional
1. Value must be 10 characters or less2. Value must not include the pipe ("|") symbol3. Mandatory
Optional
Optional
Optional
1. Value must be 10-digit number2. Optional
Optional
Must contain the '@' symbol2. May contain uppercase and lowercase Latin letters A to Z ar to z3. May contain digits 0-94. Must contain a dot '.' that is not the first or last character ar provided that it does not appear consecutively5. Value must be 60 characters or less6. Situational
1. Must contain the '@' symbol2. May contain uppercase and lowercase Latin letters A to Z a to z3. May contain digits 0-94. Must contain a dot '.' that is not the first or last character provided that it does not appear consecutively5. Value must be 60 characters or less6. Op
Optional
Optional
1. Value must be 10 characters or less2. Value must not include the pipe ("|") symbol3. Mandatory
1. Value must be in Facility Group Individual Code List (VVL)2. Value must be 2 characters3 Mandatory4. (individual) if value equals '03', then Provider First Name (PRV.002.028) must populated5. (organization) if value does not equal '03', then Provider Middle Initial (PRV.002.029) must not be populated6. (individual) if value equals '03', then Provider Last Name (PRV.002.030) must be populated7. (individual) if value equals '03', then Provider Se (PRV.002.031) must be populated8. (individual) if value equals '03', then Provider Date of I (PRV.002.034) must be populated9. (organization) if value equals '01' or '02', then Provide Date of Death (PRV.002.035) must not be populated

1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Conditional4. If populated, value must be on or after individual's Date of Birth5. Value must be less than o equal to associated End of Time Period (PRV.001.010)6. There can only be one value on all records when the value is populated7. When populated, the difference between value and of Birth (PRV.002.034) must be 18 years or greater
1. Value must be 10 characters or less2. Value must not include the pipe ("|") symbol3. Mandatory
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be ir Health Insurance Coverage Indicator List (VVL)4. Value must be 1 character5. Mandatory6. When value equals '1', there must be one corresponding TPL Medicaid Eligible Person Heal Insurance Coverage Information (TPL.003) segment with the same MSIS ID.
Optional
1. Value must be 28 characters or less2. Value must not contain a pipe or asterisk symbols Optional
Optional
1. Value must be in State Code List (VVL)2. Value must be 2 characters3. Optional
Optional
1. Value may only be 5 digits (0-9) (Example: 91320) or 9 digits (0-9) (Example: 91320001 Optional
Optional
1. Value must be 10-digit number2. Optional
Optional
1. Value must be 10 characters or less2. Value must not contain a pipe or asterisk symbols Optional
Optional
1. Value must be 30 characters or less2. Value must not contain a pipe or asterisk symbols Optional
Optional
Optional
Optional
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Optional
Optional
Optional
Optional
Optional
Optional
Optional
Optional
Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calendar (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. When populated, must have an associated Third Party Copayment Amount 4. Situational

Optional
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Optional
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. If associated Crossover Indicator value i then the Medicare Paid Amount must not be populated.4. Conditional5. If value is populate Crossover Indicator must be equal to "1"
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Conditional
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. If associated Type of Claim (CE) value e '3, C, W', then value is mandatory and must be provided4. Conditional
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. If associated Crossover Indicator value i then the Medicare Paid Amount must not be populated.4. Conditional5. If value is populate Crossover Indicator must be equal to "1"
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Conditional

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1. Value must be 12 digits or less2. Value must be a valid National Drug Code3. Mandatory Value must have an associated Metric Decimal Quantity (CRX.003.144)5. Value must have associated Unit of Measure (CRX.003.133)
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Conditional4. Value should not be popul if associated Crossover Indicator value is '0' (not a crossover claim)5. If value is greater tha '0,' then Crossover Indicator must be '1'
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. If associated Crossover Indicator value i then the Medicare Paid Amount must not be populated.4. Conditional5. If value is populate Crossover Indicator must be equal to "1"
A data element to capture the version of the T-MSIS data dictionary that was used to build file. Use the version number specified on the Cover Sheet of the data dictionary".
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The street address of the destination point to which a patient is transported either from ho or Long term care facility to a health care provider for healthcare services or vice versa. Fo transportation claims only. Required if state has captured this information, otherwise it is conditional.
A data element to capture the version of the T-MSIS data dictionary that was used to build file. Use the version number specified on the Cover Sheet of the data dictionary".
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The amount the beneficiary or his or her representative (e.g., their guardian) paid towards coinsurance for the covered services on the claim. Do not include coinsurance payments m by a third party/s on behalf of the beneficiary.
The amount the beneficiary or his or her representative (e.g., their guardian) paid towards copayment for the covered services on the claim. Do not include copayment payments ma by a third party/s on behalf of the beneficiary.

The amount the beneficiary or his or her representative (e.g., their guardian) paid towards deductible for the covered services on the claim. Do not include deductible payments mad a third party/s on behalf of the beneficiary.
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The amount the beneficiary or his or her representative (e.g., their guardian) paid towards copayment for the covered services on the claim. Do not include copayment payments ma by a third party/s on behalf of the beneficiary.
The amount the beneficiary or his or her representative (e.g., their guardian) paid towards deductible for the covered services on the claim. Do not include deductible payments mad a third party/s on behalf of the beneficiary.
The quantity of a service or product that is rendered for a specific date of service or billing span as reported by revenue code or procedure code on the claim line. For use with CLAIM and CLAIMRX claims. For CLAIMIP and CLAIMOT claims/encounter records, use the Service Quantity Actual field.
The maximum allowable quantity of a service that may be rendered per date of service or month. For use with CLAIMOT and CLAIMRX claims. For CLAIMIP and CLAIMOT claims/encou records, use the Revenue center -quantity Allowed field. NOTE: One prescription for 100 25 milligram tablets results in Prescription Quantity allowed=100.This field is only applicable 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 Med 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 value in Prescription Quantity allowed must correspond with the value in Unit of measure.

The maximum allowable quantity of a service that may be rendered per date of service or month. For use with CLAIMOT and CLAIMRX claims. For CLAIMIP and CLAIMOT claims/encou records, use theRevenue center -quantity Allowedfield. NOTE: One prescription for 100 250 milligram tablets results inPrescription Quantity allowed=100.This field is only applicable w 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 Med 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 value inPrescription Quantity allowedmust correspond with the value in Unit of measure.
A code to categorize the services provided to a Medicaid or CHIP enrollee.
The amount the beneficiary or his or her representative (e.g., their guardian) paid towards coinsurance for the covered services on the claim. Do not include coinsurance payments m by a third party/s on behalf of the beneficiary.
The amount the beneficiary or his or her representative (e.g., their guardian) paid towards copayment for the covered services on the claim. Do not include copayment payments ma by a third party/s on behalf of the beneficiary.
The amount the beneficiary or his or her representative (e.g., their guardian) paid towards deductible for the covered services on the claim. Do not include deductible payments mad a third party/s on behalf of the beneficiary.
Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calendar (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. When populated, must have an associated Third Party Copayment Amount 4. Situational
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Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calendar (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. When populated, must have an associated Third Party Copayment Amount4. Situational
1. Value must be in SSN Indicator List (VVL)2. Value must be 1 character3. Mandatory
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in Claim Indicator List (VVL).4. Value must be 1 character5. Conditional

1. Value must be 30 characters or less2. Conditional3. When Type of Claim not in ('Z','3','C','W","2","B","V"," 4","D","X") then value may match (PRV.005.081) Provider Identi or4. When Type of Claim not in ('Z','3','C','W","2","B","V"," 4","D","X") then value may matc (PRV.002.019) Submitting State Provider ID
1. Value must be 10 digits, consisting of 9 numeric digits followed by one check digit calcu using the Luhn formula (algorithm)2. Value must have an associated Provider Identifier Ty equal to '2'3. Conditional
1. Value must be 10 digits, consisting of 9 numeric digits followed by one check digit calcu using the Luhn formula (algorithm)2. Value must have an associated Provider Identifier Ty equal to '2'3. Conditional
1. Value must be in SSN Indicator List (VVL)2. Value must be 1 character3. Mandatory
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in Claim Indicator List (VVL).4. Value must be 1 character5. Conditional
1. Value must be 30 characters or less2. Conditional3. When Type of Claim not in ('Z','3','C','W","2","B","V"," 4","D","X") then value may match (PRV.005.081) Provider Identi or4. When Type of Claim not in ('Z','3','C','W","2","B","V"," 4","D","X") then value may matc (PRV.002.019) Submitting State Provider ID
1. Value must be 10 digits, consisting of 9 numeric digits followed by one check digit calcu using the Luhn formula (algorithm)2. Value must have an associated Provider Identifier Ty equal to '2'3. Conditional4. When Type of Claim (CLT.002.052) not in ('3','C','W') then value must match Provider Identifier (PRV.005.081)
1. Value must be in SSN Indicator List (VVL)2. Value must be 1 character3. Mandatory
1. Value must be 30 characters or less2. Conditional3. When Type of Claim not in ('Z','3','C','W","2","B","V"," 4","D","X") then value may match (PRV.005.081) Provider Identi or4. When Type of Claim not in ('Z','3','C','W","2","B","V"," 4","D","X") then value may matc (PRV.002.019) Submitting State Provider ID
1. Value must be 10 digits, consisting of 9 numeric digits followed by one check digit calcu using the Luhn formula (algorithm)2. Value must have an associated Provider Identifier Ty equal to '2'3. Conditional4. When Type of Claim (COT.002.037) not in ('3','C','W') then valu must match Provider Identifier (PRV.005.081)
1. Value must be in SSN Indicator List (VVL)2. Value must be 1 character3. Mandatory
1. Value must be 10 digits, consisting of 9 numeric digits followed by one check digit calcu using the Luhn formula (algorithm)2. Value must have an associated Provider Identifier Ty equal to '2'3. Mandatory

1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in SSDI Indicator List (VVL)4. Value must be 1 character5. Conditional
1. Value must be in SSI State Supplement Status Code List (VVL)2. Value must be 3 characters3. (individual not receiving Federal SSI)If value is "001" or "002", then SSI Status (ELG.005.092) must be "001" or "002"4. (Individual not receiving Federal SSI)If value is "00 "002", then SSI Indicator (ELG.005.090) must be '1'5. Value must not be populated or must '000' when SSI Status (ELG.005.092) is not populated or is '000'
1. Value must be in SSN Indicator List (VVL)2. Value must be 1 character3. Mandatory
Not Applicable
Value must be in Adjustment Indicator List (VVL)2. If associated Type of Claim value is in [5, A, C, E, U, W, Y], then value must be in [0, 1, 4]3. If associated Type of Claim value is ' X', then value must be in [5, 6]4. Value must be 1 character5. Mandatory6. If value is in [‘5’, ‘6’], then associated Adjustment ICN must not be populated7. If value is in [‘4’, ‘1’] the Adjustment ICN must be populated8. Value must equal ‘1’, when associated Claim Status equals ‘686’
Not Applicable
Value must be in Adjustment Indicator List (VVL)2. If associated Type of Claim value is in [5, A, C, E, U, W, Y], then value must be in [0, 1, 4]3. If associated Type of Claim value is ' X', then value must be in [5, 6]4. Value must be 1 character5. Mandatory6. If value is in [‘5’, ‘6’], then associated Adjustment ICN must not be populated7. If value is in [‘4’, ‘1’] the Adjustment ICN must be populated8. Value must equal ‘1’, when associated Claim Status equals ‘686’
Not Applicable
Value must be in Adjustment Indicator List (VVL)2. If associated Type of Claim value is in [5, A, C, E, U, W, Y], then value must be in [0, 1, 4]3. If associated Type of Claim value is ' X', then value must be in [5, 6]4. Value must be 1 character5. Mandatory6. If value is in [‘5’, ‘6’], then associated Adjustment ICN must not be populated7. If value is in [‘4’, ‘1’] the Adjustment ICN must be populated8. Value must equal ‘1’, when associated Claim Status equals ‘686’
Not Applicable
Value must be in Adjustment Indicator List (VVL)2. If associated Type of Claim value is in [5, A, C, E, U, W, Y], then value must be in [0, 1, 4]3. If associated Type of Claim value is ' X', then value must be in [5, 6]4. Value must be 1 character5. Mandatory6. If value is in [‘5’, ‘6’], then associated Adjustment ICN must not be populated7. If value is in [‘4’, ‘1’] the Adjustment ICN must be populated8. Value must equal ‘1’, when associated Claim Status equals ‘686’
Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calendar (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. When populated, valu must have an associated Third Party Coinsurance Amount 4. Conditional
Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calendar (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. When populated, valu must have an associated Third Party Coinsurance Amount 4. Conditional

Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calendar (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. When populated, valu must have an associated Third Party Coinsurance Amount 4. Conditional
Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calendar (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. When populated, valu must have an associated Third Party Coinsurance Amount 4. Conditional
A data element to capture the version of the T-MSIS data dictionary that was used to build file. Use the version number specified on the Cover Sheet of the data dictionary".
CIP030|CIP.002.030|ADMITTING-DIAGNOSIS-CODE|Admitting Diagnosis Code|Conditional|T ICD-9/10-CM Diagnosis Code provided at the time of admission by the physician. Since the Admitting Diagnosis is formulated before all tests and examinations are complete, it may b stated in the form of a problem or symptom and it may differ from any of the final diagnos recorded in the medical record.|CIP030 Values|CIP00002|CLAIM-HEADER-RECORD-IP|X(7)|N 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 Diag Code List (VVL) 3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Code 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 charact 7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 charac 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| Conditional|A flag that identifies the coding system used for the Admitting Diagnosis Code CIP031 Values|CIP00002|CLAIM-HEADER-RECORD-IP|X(1)|N/A|190|190|1. Value must be in Diagnosis Code Flag List(VVL) 2. Value must be 1 character

CIP032|CIP.002.032|DIAGNOSIS-CODE-1|Diagnosis Code 1|Conditional|The primary/principa
ICD-9/10-CM diagnosis code as reported on the claim.|CIP032 Values|CIP00002|CLAIM-HEA
RECORD-IP|X(7)|N/A|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 Diag
Code List (VVL)
3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10
Diagnosis Code 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 charact
7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 charac
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 popul

CIP033|CIP.002.033|DIAGNOSIS-CODE-FLAG-1|Diagnosis Code Flag 1|Conditional|Flag used
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.|CIP033 Values|CIP00002|CLAIM-
HEADER-RECORD-IP|X(1)|N/A|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 hi volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* 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 tha prospective in nature.
Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given 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.|CIP034 Values|CIP00002|CLAIM-HEADER-RECORD-IP|X(1)|N/A|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 diag 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 (w the exception of removing
the decimal). For example: 210.5 is coded as "2105".|CIP035 Values|CIP00002|CLAIM-HEA RECORD-IP|X(7)|N/A|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 Diag Code List (VVL)
3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Code 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 charact
7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 charac
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 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.|CIP036 Values|CIP00002|CLAIM-HEADER-RECORD-IP|X(1)|N/A|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 hi volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* 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 tha prospective in nature.
Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given 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.|CIP037 Values|CIP00002|CLAIM-HEADER-RECORD-IP|X(1)|N/A|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 diag
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 (w
the exception of removing
the decimal). For example: 210.5 is coded as "2105".|CIP038 Values|CIP00002|CLAIM-HEA
RECORD-IP|X(7)|N/A|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 Diag
Code List (VVL)
3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10
Diagnosis Code 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 charact
7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 charac
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
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.|CIP039 Values|CIP00002|CLAIM-
HEADER-RECORD-IP|X(1)|N/A|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 hi volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* 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 tha prospective in nature.
Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given 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.|CIP040 Values|CIP00002|CLAIM-HEADER-RECORD-IP|X(1)|N/A|217|217|1. Value must be in Diagnosis POA Flag List (VVL)
2. Value must be 1 character
3. Conditional

CIP041|CIP.002.041|DIAGNOSIS-CODE-4|Diagnosis Code 4|Conditional|ICD-9 or ICD-10 diag 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 (w the exception of removing
the decimal). For example: 210.5 is coded as "2105".|CIP041 Values|CIP00002|CLAIM-HEA RECORD-IP|X(7)|N/A|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 Diag Code List (VVL)
3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Code 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 charact
7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 charac
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 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.|CIP042 Values|CIP00002|CLAIM-HEADER-RECORD-IP|X(1)|N/A|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 hi volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* 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 tha prospective in nature.
Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given 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.|CIP043 Values|CIP00002|CLAIM-HEADER-RECORD-IP|X(1)|N/A|226|226|1. Value must be in Diagnosis POA Flag List (VVL)
2. Value must be 1 character
3. Conditional

CIP044|CIP.002.044|DIAGNOSIS-CODE-5|Diagnosis Code 5|Conditional|ICD-9 or ICD-10 diag
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 (w
the exception of removing
the decimal). For example: 210.5 is coded as "2105".|CIP044 Values|CIP00002|CLAIM-HEA
RECORD-IP|X(7)|N/A|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 Diag
Code List (VVL)
3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10
Diagnosis Code 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 charact
7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 charac
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
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.|CIP045 Values|CIP00002|CLAIM-
HEADER-RECORD-IP|X(1)|N/A|234|234|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

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 hi volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* 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 tha prospective in nature.
Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given 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.|CIP046 Values|CIP00002|CLAIM-HEADER-RECORD-IP|X(1)|N/A|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 diag 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 (w the exception of removing
the decimal). For example: 210.5 is coded as "2105".|CIP047 Values|CIP00002|CLAIM-HEA RECORD-IP|X(7)|N/A|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 Diag Code List (VVL)
3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Code 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 charact
7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 charac
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 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.|CIP048 Values|CIP00002|CLAIM-HEADER-RECORD-IP|X(1)|N/A|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 hi volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* 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 tha prospective in nature.
Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given 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.|CIP049 Values|CIP00002|CLAIM-HEADER-RECORD-IP|X(1)|N/A|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 diag
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 (w
the exception of removing
the decimal). For example: 210.5 is coded as "2105".|CIP050 Values|CIP00002|CLAIM-HEA
RECORD-IP|X(7)|N/A|245|251|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 Diag
Code List (VVL)
3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10
Diagnosis Code 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 charact
7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 charac
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
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.|CIP051 Values|CIP00002|CLAIM-
HEADER-RECORD-IP|X(1)|N/A|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 hi volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* 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 tha prospective in nature.
Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given 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.|CIP052 Values|CIP00002|CLAIM-HEADER-RECORD-IP|X(1)|N/A|253|253|1. Value must be in Diagnosis POA Flag List (VVL)
2. Value must be 1 character
3. Conditional

CIP053|CIP.002.053|DIAGNOSIS-CODE-8|Diagnosis Code 8|Conditional|ICD-9 or ICD-10 diag 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 (w the exception of removing
the decimal). For example: 210.5 is coded as "2105".|CIP053 Values|CIP00002|CLAIM-HEA RECORD-IP|X(7)|N/A|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 Diag Code List (VVL)
3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Code 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 charact
7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 charac
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 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.|CIP054 Values|CIP00002|CLAIM-HEADER-RECORD-IP|X(1)|N/A|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.
POA indicator is used to identify certain preventable conditions that are: (a) high cost or hi volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* 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 tha prospective in nature.
Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given 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.|CIP055 Values|CIP00002|CLAIM-HEADER-RECORD-IP|X(1)|N/A|262|262|1. Value must be in Diagnosis POA Flag List (VVL)
2. Value must be 1 character
3. Conditional

CIP056|CIP.002.056|DIAGNOSIS-CODE-9|Diagnosis Code 9|Conditional|ICD-9 or ICD-10 diag
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 (w
the exception of removing
the decimal). For example: 210.5 is coded as "2105".|CIP056 Values|CIP00002|CLAIM-HEA
RECORD-IP|X(7)|N/A|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 Diag
Code List (VVL)
3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10
Diagnosis Code 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 charact
7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 charac
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
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.|CIP057 Values|CIP00002|CLAIM-
HEADER-RECORD-IP|X(1)|N/A|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 hi volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* 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 tha prospective in nature.
Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given 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.|CIP058 Values|CIP00002|CLAIM-HEADER-RECORD-IP|X(1)|N/A|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 (w the exception of removing
the decimal). For example: 210.5 is coded as "2105".|CIP059 Values|CIP00002|CLAIM-HEA RECORD-IP|X(7)|N/A|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 Diag Code List (VVL)
3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Code 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 charact
7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 charac
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 us
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.|CIP060 Values|CIP00002|CLAIM-
HEADER-RECORD-IP|X(1)|N/A|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 hi
volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)*
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 tha
prospective in nature.
Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given
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.|CIP061 Values|CIP00002|CLAIM-
HEADER-RECORD-IP|X(1)|N/A|280|280|1. Value must be in Diagnosis POA Flag List (VVL)
2. Value must be 1 character
3. Conditional

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 (w the exception of removing
the decimal). For example: 210.5 is coded as "2105".|CIP062 Values|CIP00002|CLAIM-HEA RECORD-IP|X(7)|N/A|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 Diag Code List (VVL)
3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Code 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 charact
7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 charac
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 us 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.|CIP063 Values|CIP00002|CLAIM-HEADER-RECORD-IP|X(1)|N/A|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 hi volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* 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 tha prospective in nature.
Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given 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.|CIP064 Values|CIP00002|CLAIM-HEADER-RECORD-IP|X(1)|N/A|289|289|1. Value must be in Diagnosis POA Flag List (VVL)
2. Value must be 1 character
3. Conditional

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 (w the exception of removing
the decimal). For example: 210.5 is coded as "2105".|CIP065 Values|CIP00002|CLAIM-HEA RECORD-IP|X(7)|N/A|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 Diag Code List (VVL)
3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Code 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 charact
7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 charac
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 us 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.|CIP066 Values|CIP00002|CLAIM-HEADER-RECORD-IP|X(1)|N/A|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

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 hi volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* 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 tha prospective in nature.
Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given 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.|CIP067 Values|CIP00002|CLAIM-HEADER-RECORD-IP|X(1)|N/A|298|298|1. Value must be in Diagnosis POA Flag List (VVL)
2. Value must be 1 character
3. Conditional

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.|CIP123 Values|CIP00002|CLAIM-HEADER-RECORD-IP|X(2)|N/A|602|603|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 mand 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
attributed to any one beneficiary paid to the provider.|N/A|CIP00002|CLAIM-HEADER-RECO
IP|S9(11)V99|N/A|604|616|1. Value must be between -99999999999.99 and 99999999999.
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

CIP248|CIP.003.248|IMMUNIZATION-TYPE|Immunization Type|Conditional|This field identifie
the type of immunization provided in order to track additional detail not currently containe
Current Procedural Terminology (CPT) codes.|CIP248 Values|CIP00003|CLAIM-LINE-RECORD
X(2)|N/A|187|188|1. Value must be in Immunization Type List (VVL)
2. Value must be 2 characters
3. Conditional

CIP268|CIP.003.268|BENEFIT-TYPE|Benefit Type|Mandatory|The benefit category correspor
to the service reported on the claim or encounter record. Note: The code definitions in the
value list originate from the Medicaid and CHIP Program Data System (MACPro) benefit typ
list. See Appendix H: Benefit Types|CIP268 Values|CIP00003|CLAIM-LINE-RECORD-IP|X(3)|N
330|332|1. Value must be in Benefit Type Code List (VVL)
2. Value must be 3 characters
3. Mandatory

CIP270|CIP.003.270|XIX-MBESCBES-CATEGORY-OF-SERVICE|XIX MBESCBES Category of Se
Conditional|A code indicating the category of service for the paid claim. The category of se
is the line item from the CMS-64 form that states use to report their expenditures and requ
federal financial participation.|CIP270 Values|CIP00003|CLAIM-LINE-RECORD-IP|X(5)|N/A|33
339|1. Value must be in XIX MBESCBES Category of Service List (VVL)
2. Value must be 5 characters or less
3. Conditional
4. (Medicaid Claim) if the associated CMS-64 Category for Federal Reimbursement value is
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 Se
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 a request federal financial participation.|CIP271
Values|CIP00003|CLAIM-LINE-RECORD-IP|X(3)|N/A|340|342|1. Value must be in XXI MBESCI
Category of Service List (VVL)
2. Conditional
3. (CHIP Claim) if the associated CMS-64 Category for Federal Reimbursement value is '2', 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

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.|CIP279 Values|
CIP00003|CLAIM-LINE-RECORD-IP|X(14)|N/A|856|869|1. Value must be 14 characters or les
2. Value must not contain a pipe or asterisk symbols
3. Value must be in HCPCS Rate List (VVL)
4. Conditional

CLT027|CLT.002.027|ADMITTING-DIAGNOSIS-CODE|Admitting Diagnosis Code|Conditional|T
ICD-9/10-CM Diagnosis Code provided at the time of admission by the physician.|CLT027
Values|CLT00002|CLAIM-HEADER-RECORD-LT|X(7)|N/A|160|166|1. When populated, a Diag
Code Flag is required
2. If associated Diagnosis Code Flag value is "1" (ICD-9), then value must be in ICD-9 Diag
Code List (VVL)
3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10
Diagnosis Code 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 charact
7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 charac
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|
Conditional|A flag that identifies the coding system used for the Admitting Diagnosis Code
CLT028 Values|CLT00002|CLAIM-HEADER-RECORD-LT|X(1)|N/A|167|167|1. Value must be i
Diagnosis Code Flag List(VVL)
2. Value must be 1 character

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 (w the exception of removing
the decimal). For example: 210.5 is coded as "2105".|CLT029 Values|CLT00002|CLAIM-HEADER-RECORD-LT|X(7)|N/A|168|174|1. When populated, a Diagnosis Code Flag is requir
2. If associated Diagnosis Code Flag value is "1" (ICD-9), then value must be in ICD-9 Diag Code List (VVL)
3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Code 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 charact
7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 charac
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.002.052) in ("1", "3", "A", "C", "U", "W") then value must be populated.

CLT030|CLT.002.030|DIAGNOSIS-CODE-FLAG-1|Diagnosis Code Flag 1|Conditional|Flag use 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.|CLT030 Values|CLT00002|CLAIM-HEADER-RECORD-LT|X(1)|N/A|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 hi volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* 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 tha prospective in nature.
Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given 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.|CLT031 Values|CLT00002|CLAIM-HEADER-RECORD-LT|X(1)|N/A|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 their claim (w the exception of removing
the decimal). For example: 210.5 is coded as "2105".|CLT032 Values|CLT00002|CLAIM-HEADER-RECORD-LT|X(7)|N/A|177|183|1. When populated, a Diagnosis Code Flag is requir
2. If associated Diagnosis Code Flag value is "1" (ICD-9), then value must be in ICD-9 Diag Code List (VVL)
3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Code 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 charact
7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 charac
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 use 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.|CLT033 Values|CLT00002|CLAIM-HEADER-RECORD-LT|X(1)|N/A|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 hi volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* 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 tha prospective in nature.
Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given 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.|CLT034 Values|CLT00002|CLAIM-HEADER-RECORD-LT|X(1)|N/A|185|185|1. Value must be in Diagnosis POA Flag List (VVL)
2. Value must be 1 character
3. Conditional

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 (w the exception of removing
the decimal). For example: 210.5 is coded as "2105".|CLT035 Values|CLT00002|CLAIM-HEADER-RECORD-LT|X(7)|N/A|186|192|1. When populated, a Diagnosis Code Flag is requir
2. If associated Diagnosis Code Flag value is "1" (ICD-9), then value must be in ICD-9 Diag Code List (VVL)
3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Code 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 charact
7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 charac
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 use 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.|CLT036 Values|CLT00002|CLAIM-HEADER-RECORD-LT|X(1)|N/A|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 hi volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* 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 tha prospective in nature.
Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given 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.|CLT037 Values|CLT00002|CLAIM-HEADER-RECORD-LT|X(1)|N/A|194|194|1. Value must be in Diagnosis POA Flag List (VVL)
2. Value must be 1 character
3. Conditional

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 (w the exception of removing
the decimal). For example: 210.5 is coded as "2105".|CLT038 Values|CLT00002|CLAIM-HEADER-RECORD-LT|X(7)|N/A|195|201|1. When populated, a Diagnosis Code Flag is requir
2. If associated Diagnosis Code Flag value is "1" (ICD-9), then value must be in ICD-9 Diag Code List (VVL)
3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Code 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 charact
7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 charac
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 use 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.|CLT039 Values|CLT00002|CLAIM-HEADER-RECORD-LT|X(1)|N/A|202|202|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

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 hi volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* 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 tha prospective in nature.
Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given 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.|CLT040 Values|CLT00002|CLAIM-HEADER-RECORD-LT|X(1)|N/A|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 (w the exception of removing
the decimal). For example: 210.5 is coded as "2105".|CLT041 Values|CLT00002|CLAIM-HEADER-RECORD-LT|X(7)|N/A|204|210|1. When populated, a Diagnosis Code Flag is requir
2. If associated Diagnosis Code Flag value is "1" (ICD-9), then value must be in ICD-9 Diag Code List (VVL)
3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Code 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 charact
7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 charac
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 use 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.|CLT042 Values|CLT00002|CLAIM-HEADER-RECORD-LT|X(1)|N/A|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 hi volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* 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 tha prospective in nature.
Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given 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.|CLT043 Values|CLT00002|CLAIM-HEADER-RECORD-LT|X(1)|N/A|212|212|1. Value must be in Diagnosis POA Flag List (VVL)
2. Value must be 1 character
3. Conditional

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.|CLT073 Values|CLT00002|CLAIM-HEADER-RECORD-LT|X(2)|N/A|416|417|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 mand and must be reported
3. Value must be 2 characters
4. Conditional

CLT074|CLT.002.074|SERVICE-TRACKING-PAYMENT-AMT|Service Tracking Payment Amoun Conditional|On service tracking claims, the payment amount is the lump sum that cannot l attributed to any one beneficiary paid to the provider.|N/A|CLT00002|CLAIM-HEADER-RECO LT|S9(11)V99|N/A|418|430|1. Value must be between -99999999999.99 and 9999999999
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

CLT146|CLT.002.146|DAILY-RATE|Daily Rate|Conditional|The amount a policy will pay per d for a covered service.|N/A|CLT00002|CLAIM-HEADER-RECORD-LT|S9(5)V99|N/A|928|934|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)

CLT201|CLT.003.201|IMMUNIZATION-TYPE|Immunization Type|Not Applicable|[No longer essential - Both data element and associated requirement(s); preserved for file submissior integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]|CLT201 Values|CLT00003|CLAIM-LINE-RECORD-LT|X(2)|N/A|187|188|Not Applicable

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 Syste (MACPro) benefit type list. See Appendix H: Benefit Types|CLT218 Values|CLT00003|CLAIM LINE-RECORD-LT|X(3)|N/A|337|339|1. Value must be in Benefit Type Code List (VVL)
2. Value must be 3 characters
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 categ service is the line item from the CMS-64 form that states use to report their expenditures a request federal financial participation.|CLT224 Values|CLT00003|CLAIM-LINE-RECORD-LT|X N/A|351|355|1. Value must be in XIX MBESCBES Category of Service List (VVL)
2. Value must be 5 characters or less
3. Conditional
4. (Medicaid Claim) if the associated CMS-64 Category for Federal Reimbursement value is 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 cate of service is the line item from the CMS-21 form that states use to report their expenditure and request federal financial participation.|CLT225 Values|CLT00003|CLAIM-LINE-RECORD- X(3)|N/A|356|358|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', 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

CLT231|CLT.003.231|HCPCS-RATE|HCPCS Rate|Conditional|This data element is expected t capture data from the HIPAA 837I claim loop 2400 SV206 or UB-04 FL 44.|CLT231 Values| CLT00003|CLAIM-LINE-RECORD-LT|X(14)|N/A|884|897|1. Value must be 14 characters or le
2. Value must not contain a pipe or asterisk symbols
3. Value must be in HCPCS Rate List (VVL)
4. Conditional

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 (w the exception of removing
the decimal). For example: 210.5 is coded as "2105".|COT027 Values|COT00002|CLAIM-HEADER-RECORD-OT|X(7)|N/A|160|166|1. When populated, a Diagnosis Code Flag is requir
2. If associated Diagnosis Code Flag value is "1" (ICD-9), then value must be in ICD-9 Diag Code List (VVL)
3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Code 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 charact
7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 charac
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 us 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.|COT028 Values|COT00002|CLAIM-HEADER-RECORD-OT|X(1)|N/A|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 hi volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)* 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 tha prospective in nature.
Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given 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.|COT029 Values|COT00002|CLAIM-HEADER-RECORD-OT|X(1)|N/A|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 (w the exception of removing
the decimal). For example: 210.5 is coded as "2105".|COT030 Values|COT00002|CLAIM-HEADER-RECORD-OT|X(7)|N/A|169|175|1. When populated, a Diagnosis Code Flag is requir
2. If associated Diagnosis Code Flag value is "1" (ICD-9), then value must be in ICD-9 Diag Code List (VVL)
3. If associated Diagnosis Code Flag value is "2" (ICD-10), then value must be in ICD-10 Diagnosis Code 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 charact
7. If associated Diagnosis Code Flag value is "2" (ICD-10), value must not exceed 7 charac
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 us
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.|COT031 Values|COT00002|CLAIM-
HEADER-RECORD-OT|X(1)|N/A|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 hi
volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG)*
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 tha
prospective in nature.
Each Diagnosis Code Flag is associated with one, and only one, Diagnosis Code in a given
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.|COT032 Values|COT00002|CLAIM-
HEADER-RECORD-OT|X(1)|N/A|177|177|1. Value must be in Diagnosis POA Flag List (VVL)
2. Value must be 1 character
3. Conditional

COT059|COT.002.059|SERVICE-TRACKING-TYPE|Service Tracking Type|Conditional|A code t
categorize service tracking claims. A "service tracking claim" is used to report lump sum
payments that cannot be attributed to a single enrollee.|COT059 Values|COT00002|CLAIM-
HEADER-RECORD-OT|X(2)|N/A|361|362|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 mand
and must be reported
3. Value must be 2 characters
4. Conditional

COT060|COT.002.060|SERVICE-TRACKING-PAYMENT-AMT|Service Tracking Payment Amou
Conditional|On service tracking claims, the payment amount is the lump sum that cannot
attributed to any one beneficiary paid to the provider.|N/A|COT00002|CLAIM-HEADER-REC
OT|S9(11)V99|N/A|363|375|1. Value must be between -99999999999.99 and 9999999999
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

COT150|COT.002.150|UNDER-SUPERVISION-OF-PROV-NPI|Under Supervision of Provider NP
Applicable|[No longer essential - Both data element and associated requirement(s); preser
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)|N/A|1024|10
Not Applicable

COT228|COT.002.228|ORDERING-PROV-NUM|Ordering Provider Number|Conditional|The
Medicaid provider ID of the Ordering Provider is the individual who requested the services
items being reported on this service line. Examples include, but are not limited to, provide
ordering diagnostic tests and medical equipment or supplies.
 [Ordering provider information is only captured at the line level in the X12 837P format bu
v3.0.0 of the T-MSIS file layout it is only captured at the header level. This discrepancy will
addressed in a future version of the T-MSIS OT file layout. Until Ordering provider informat
has been moved from the T-MSIS claim header to the line, there is no need to report it at t
header.]
|N/A|COT00002|CLAIM-HEADER-RECORD-OT|X(30)|N/A|1539|1568|1. Value must be 30
characters or less
2. Conditional

COT229|COT.002.229|ORDERING-PROV-NPI-NUM|Ordering Provider NPI Number|Conditiona
NPI of Ordering Provider represents the individual who requested the service or items bein
reported on this service line. Example include, but are not limited to, provider ordering
diagnostic tests and medical equipment or supplies.

[Ordering provider information is only captured at the line level in the X12 837P format bu
v3.0.0 of the T-MSIS file layout it is only captured at the header level. This discrepancy will
addressed in a future version of the T-MSIS OT file layout. Until Ordering provider informat
has been moved from the T-MSIS claim header to the line, there is no need to report it at t
header.]
|N/A|COT00002|CLAIM-HEADER-RECORD-OT|X(10)|N/A|1569|1578|1. Value must be 10 digi
consisting of 9 numeric digits followed by one check digit calculated using the Luhn formul
(algorithm)
2. Value must have an associated Provider Identifier Type equal to '2'
3. Conditional

COT173|COT.003.173|IMMUNIZATION-TYPE|Immunization Type|Not Applicable|[No longer
essential - Both data element and associated requirement(s); preserved for file submissior
integrity. See Data Dictionary v2.3 for specific definition and coding requirement
description(s).]|COT173 Values|COT00003|CLAIM-LINE-RECORD-OT|X(2)|N/A|207|208|Not
Applicable

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 Syste
(MACPro) benefit type list. See Appendix H: Benefit Types|COT209 Values|COT00003|CLAIM
LINE-RECORD-OT|X(3)|N/A|715|717|1. Value must be in Benefit Type Code List (VVL)
2. Value must be 3 characters
3. Mandatory

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 categ
service is the line item from the CMS-64 form that states use to report their expenditures a
request federal financial participation.|COT211 Values|COT00003|CLAIM-LINE-RECORD-OT|
N/A|720|724|1. Value must be in XIX MBESCBES Category of Service List (VVL)
2. Value must be 5 characters or less
3. Conditional
4. (Medicaid Claim) if the associated CMS-64 Category for Federal Reimbursement value is
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 cate of service is the line item from the CMS-21 form that states use to report their expenditure and request federal financial participation.|COT212 Values|COT00003|CLAIM-LINE-RECORD X(3)|N/A|725|727|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', 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
N/A
N/A

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, segmen
and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared
Identification Numbers' for information on reporting the MSIS Identification Numbers ID for
pregnant women, unborn children, mothers, and their deemed newborns younger than 1 y
of age who share the same MSIS Identification Number.
https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/4757
|N/A|CRX00002|CLAIM-HEADER-RECORD-RX|X(20)|N/A|134|153|1. Mandatory
2. Value must be 20 characters or less
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|An indicato
specifying whether the claim is a crossover claim where a portion is paid by Medicare.|CRX
Values|CRX00002|CLAIM-HEADER-RECORD-RX|X(1)|N/A|154|154|1. Value must be in Cross
Indicator List (VVL)
2. Value must be 1 character
3. Value must be in [0, 1] or not populated
4. If Crossover Indicator value is "1", the associated Dual Eligible Code (ELG.005.085) valu
must be in "01", "02", "04", "08", "09", or "10" for the same time period (by date of service
5. Value must be 1 character
6. If the Type of Claim value is in ["1", "3", "A", "C"], then value is mandatory and must be
reported.
7. Conditional

CRX025|CRX.002.025|ADJUSTMENT-IND|Adjustment Indicator|Mandatory|Indicates the type
adjustment record.
|CRX025 Values|CRX00002|CLAIM-HEADER-RECORD-RX|X(1)|N/A|156|156|1. Value must be
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 [
4]
3. If associated Type of Claim value is '4, D, X', then value must be in [5, 6]
4. Value must be 1 character
5. Mandatory

CRX039|CRX.002.039|TOT-BILLED-AMT|Total Billed Amount|Conditional|The total amount b
for this claim at the claim header level as submitted by the provider. For encounter record
when Type of Claim value is [3, C, or W], then value must equal amount the provider bille
the managed care plan. Total Billed Amount is not expected on financial transactions.
For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated netwo
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, re
a null value in this field.
|N/A|CRX00002|CLAIM-HEADER-RECORD-RX|S9(11)V99|N/A|228|240|1. Value must be betw
-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]

CRX050|CRX.002.050|SERVICE-TRACKING-TYPE|Service Tracking Type|Conditional|A code t
categorize service tracking claims. A "service tracking claim" is used to report lump sum
payments that cannot be attributed to a single enrollee.|CRX050 Values|CRX00002|CLAIM-
HEADER-RECORD-RX|X(2)|N/A|323|324|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 mand
and must be reported
3. Value must be 2 characters
4. Conditional

CRX051|CRX.002.051|SERVICE-TRACKING-PAYMENT-AMT|Service Tracking Payment Amoun
Conditional|On service tracking claims, the payment amount is the lump sum that cannot
attributed to any one beneficiary paid to the provider.|N/A|CRX00002|CLAIM-HEADER-RECO
RX|S9(11)V99|N/A|325|337|1. Value must be between -99999999999.99 and 9999999999
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

CRX056|CRX.002.056|PLAN-ID-NUMBER|Plan ID Number|Conditional|A unique number assi
by the state which represents a distinct comprehensive managed care plan, prepaid healt
plan, primary care case management program, a program for all-inclusive care for the elde
entity, or other approved plans.
|N/A|CRX00002|CLAIM-HEADER-RECORD-RX|X(12)|N/A|345|356|1. Value must be 12 charac
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 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 betwee
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 Prescription Fill Date (CRX.002.085) occurs between the
managed care contract eff/end dates (MCR.002.020/021)

CRX070|CRX.002.070|BILLING-PROV-NUM|Billing Provider Number|Conditional|A unique
identification number assigned by the state to a provider or capitation plan. This data elem
should represent the entity billing for the service. For encounter records, if associated Typ
Claim value equals 3, C, or W, then value must be the state identifier of the provider or en
(billing or reporting) to the managed care plan.|N/A|CRX00002|CLAIM-HEADER-RECORD-RX
X(30)|N/A|477|506|1. Value must be 30 characters or less
2. Conditional
3. When Type of Claim not in ('Z','3','C','W","2","B","V"," 4","D","X") 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") then value may match
(PRV.005.081) Provider Identifier where the Provider Identifier
5. Prescription Fill Date (CRX.002.085) may be between Provider Attributes Effective Date
(PRV.002.020) and Provider Attributes End Date (PRV.002.021) or
6. Prescription Fill Date (CRX.002.085) may be between Provider Identifier Effective Date
(PRV.005.079) and Provider Identifier End Date (PRV.005.080)

CRX085|CRX.002.085|PRESCRIPTION-FILL-DATE|Prescription Fill Date|Mandatory|Date the d
device, or supply was dispensed by the provider.
|N/A|CRX00002|CLAIM-HEADER-RECORD-RX|9(8)|N/A|622|629|1. Value must be 8 characte
the form 'CCYYMMDD'
2. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April
or Sept 31st)
3. Value must be on or before associated End of Time Period (CRX.001.010)
4. Value must be on or after associated Start of Time Period (CRX.001.009)
5. Value must be on or after associated Date Prescribed (CRX.002.084)
6. Value must be on or after associated eligible party's Date of Birth (ELG.002.024)
7. Value must be on or before associated eligible party's Date of Death (ELG.002.025)
8. Value must be populated when Adjustment Indicator (CRX.002.025) does not equal '1' a
Type of Claim (CRX.002.029) does not equal 'Z'
9. Mandatory

CRX156|CRX.002.156|DISPENSING-PRESCRIPTION-DRUG-PROV-NUM|Dispensing Prescriptio
Drug Provider Number|Mandatory|The state-specific provider id of the provider who actual
dispensed the prescription medication.|N/A|CRX00002|CLAIM-HEADER-RECORD-RX|X(30)|N
1320|1349|1. Value must be 30 characters or less
2. When Type of Claim not in ('Z','3','C','W","2","B","V"," 4","D","X") 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") then value may match
Provider Identifier (PRV.005.081) where the Provider Identifier Type (PRV.005.077) = '1'
4. Mandatory

N/A

N/A

N/A
N/A
N/A
N/A

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, segmen
and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared
Identification Numbers' for information on reporting the MSIS Identification Numbers ID for
pregnant women, unborn children, mothers, and their deemed newborns younger than 1 y
of age who share the same MSIS Identification Number.
https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/4757
|N/A|CRX00003|CLAIM-LINE-RECORD-RX|X(20)|N/A|22|41|1. Mandatory
2. Value must be 20 characters or less
3. When TYPE-OF-CLAIM = 4, D or X (lump sum payment), value must begin with an '&'

CRX116|CRX.003.116|LINE-ADJUSTMENT-IND|Line Adjustment Indicator|Conditional|A code
indicate the type of adjustment record claim/encounter represents at claim detail level.
|CRX116 Values|CRX00003|CLAIM-LINE-RECORD-RX|X(1)|N/A|148|148|1. 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 [
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. Conditional
6. If associated Line Adjustment Number is populated, then value must be populated

CRX131|CRX.003.131|PRESCRIPTION-QUANTITY-ALLOWED|Prescription Quantity Allowed|
Conditional|The maximum allowable quantity of a drug or service that may be dispensed p
prescription per date of service or per month. Quantity limits are applied to medications w
the majority of appropriate clinical utilizations will be addressed within the quantity allowe
For use with CLAIMOT and CLAIMRX claims. For CLAIMIP and CLAIMLT claims/encounter rec
use the Revenue Center Quantity Actual field.
One prescription for 100 250 milligram tablets results in Prescription Quantity Allowed =10
N/A|CRX00003|CLAIM-LINE-RECORD-RX|S9(8)V999|N/A|290|300|1. Value may include up to
digits to the left of the decimal point, and 3 digits to the right e.g. 12345678.999
2. When populated, corresponding Unit of Measure must be populated
3. Conditional

CRX132|CRX.003.132|PRESCRIPTION-QUANTITY-ACTUAL|Prescription Quantity Actual|Conditional|The quantity of a drug that is dispensed for a prescription as reported ny Natio Drug Code on the claim line. For use with CLAIMOT and CLAIMRX claims. For CLAIMIP and CLAIMLT claims/encounter records, use the Revenue Center Quantity Actual field.|N/A|CRX00003|CLAIM-LINE-RECORD-RX|S9(8)V999|N/A|301|311|1. Value may include up to 8 d to the left of the decimal point, and 3 digits to the right e.g. 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

CRX147|CRX.003.147|IMMUNIZATION-TYPE|Immunization Type|Not Applicable|[No longer essential - Both data element and associated requirement(s); preserved for file submissior integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]|CRX147 Values|CRX00003|CLAIM-LINE-RECORD-RX|X(2)|N/A|373|374|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 Syste (MACPro) benefit type list. See Appendix H: Benefit Types|CRX148 Values|CRX00003|CLAIM LINE-RECORD-RX|X(3)|N/A|375|377|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 Categor Federal Reimbursement|Conditional|A code to indicate the Federal funding source for the payment.|CRX149 Values|CRX00003|CLAIM-LINE-RECORD-RX|X(2)|N/A|378|379|1. Value m be in CMS 64 Category for Federal Reimbursement List (VVL)
2. Value must be 2 characters
3. (Federal Funding under Title XXI) if value equals '02', then the eligible's CHIP Code (ELG.003.054) must be in ['2', '3']
4. (Federal Funding under Title XIX) if value equals '01' then the eligible's CHIP Code (ELG.003.054) must be '1'
5. Conditional
6. If Type of Claim is in ['1','2','5','A','B','E','U','V','Y'] 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 categ service is the line item from the CMS-64 form that states use to report their expenditures a request federal financial participation.|CRX150 Values|CRX00003|CLAIM-LINE-RECORD-RX| N/A|380|384|1. Value must be in XIX MBESCBES Category of Service List (VVL)
2. Value must be 5 characters or less
3. Conditional
4. (Medicaid Claim) if the associated CMS-64 Category for Federal Reimbursement value is 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 cate of service is the line item from the CMS-21 form that states use to report their expenditure and request federal financial participation.|CRX151 Values|CRX00003|CLAIM-LINE-RECORD X(3)|N/A|385|387|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', 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

CRX172|CRX.003.172|IHS-SERVICE-IND|IHS Service Indicator|Mandatory|To indicate Servic 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. |CRX172 Values|CRX00003|CLAIM-LINE-RECORD-RX|X(1)|N/A|995|995|1. Value must be 1 character
2. Value must be in [0, 1]

N/A

N/A
N/A
N/A
N/A
N/A

N/A
N/A
N/A
N/A
N/A
N/A
N/A

N/A
N/A
N/A
N/A
N/A

N/A
N/A
N/A
N/A
N/A

N/A
N/A
N/A
N/A

N/A
N/A
N/A
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, segmer and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared Identification Numbers' for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 y of age who share the same MSIS Identification Number. https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/4757 |N/A|ELG00002|PRIMARY-DEMOGRAPHICS-ELIGIBILITY|X(20)|N/A|22|41|1. Mandatory 2. Value must be 20 characters or less

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, segmen
and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared
Identification Numbers' for information on reporting the MSIS Identification Numbers ID for
pregnant women, unborn children, mothers, and their deemed newborns younger than 1 y
of age who share the same MSIS Identification Number.
https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/4757
|N/A|ELG00003|VARIABLE-DEMOGRAPHICS-ELIGIBILITY|X(20)|N/A|22|41|1. Mandatory
2. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individua
SSN
3. Value must be 20 characters or less

ELG046|ELG.003.046|PRIMARY-LANGUAGE-CODE|Primary Language Code|Conditional|A co
indicating the language that is the individuals' preferred spoken or written language.|ELG0
Values|ELG00003|VARIABLE-DEMOGRAPHICS-ELIGIBILITY|X(3)|N/A|120|122|1. Value must b
Primary Language Code List (VVL)
2. Value must be 3 characters
3. Conditional

N/A

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, segmen and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared Identification Numbers' for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 y of age who share the same MSIS Identification Number.
https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/4757
|N/A|ELG00004|ELIGIBLE-CONTACT-INFORMATION|X(20)|N/A|22|41|1. Mandatory
2. Value must be 20 characters or less

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, segmen and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared Identification Numbers' for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 y of age who share the same MSIS Identification Number.
https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/4757
|N/A|ELG00005|ELIGIBILITY-DETERMINANTS|X(20)|N/A|22|41|1. Mandatory
2. Value must be 20 characters or less

ELG084|ELG.005.084|MEDICAID-BASIS-OF-ELIGIBILITY|Medicaid Basis Of Eligibility|Not Applicable|[No longer essential - Both data element and associated requirement(s); preser for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]|ELG084 Values|ELG00005|ELIGIBILITY-DETERMINANTS|X(2)|N/ 55|Not Applicable

ELG095|ELG.005.095|ELIGIBILITY-CHANGE-REASON|Eligibility Change Reason|Conditional|T reason for a complete loss/termination in an individual's eligibility for Medicaid and The end date of the segment in which the value is reported must represent the date that t 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. I a single termination in eligibility for a single individual there are multiple distinct co-occurr values in the state's system explaining the reason for the termination, and if one of multiple co-occurring values maps to T-MSIS ELIGIBILITY-CHANGE-REASON value '21' (Other) or '22' (Unknown), then the state should not repor co-occurring value '21' and/or '22' to T-MSIS. If there are multi co-occurring distinct values between '01' and '19', then the sta should choose whichever is first in the state's system. Of the values that could logic co-occur in the range of '01' through '19', CMS does not curren 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 populat at the time someone loses CHIP eligibility they become eligible for and enrolled in Medicai |ELG095 Values|ELG00005|ELIGIBILITY-DETERMINANTS|X(2)|N/A|79|80|1. Value must be in Eligibility Change Reason List (VVL) 2. Value must be 2 characters 3. Conditional
ELG096|ELG.005.096|MAINTENANCE-ASSISTANCE-STATUS|Maintenance Assistance Status| Applicable|[No longer essential - Both data element and associated requirement(s); preser for file submission integrity. See Data Dictionary v2.3 for specific definition and coding requirement description(s).]|ELG096 Values|ELG00005|ELIGIBILITY-DETERMINANTS|X(1)|N/ 81|Not Applicable
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N/A

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, segmen and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared Identification Numbers' for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 y of age who share the same MSIS Identification Number.
https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/4757
|N/A|ELG00006|HEALTH-HOME-SPA-PARTICIPATION-INFORMATION|X(20)|N/A|22|41|1. Mandatory
2. Value must be 20 characters or less

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, segmen and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared Identification Numbers' for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 y of age who share the same MSIS Identification Number.
https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/4757
|N/A|ELG00007|HEALTH-HOME-SPA-PROVIDERS|X(20)|N/A|22|41|1. Mandatory
2. Value must be 20 characters or less

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, segmen
and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared
Identification Numbers' for information on reporting the MSIS Identification Numbers ID for
pregnant women, unborn children, mothers, and their deemed newborns younger than 1 y
of age who share the same MSIS Identification Number.
https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/4757
|N/A|ELG00008|HEALTH-HOME-CHRONIC-CONDITIONS|X(20)|N/A|22|41|1. Mandatory
2. Value must be 20 characters or less

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, segmen
and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared
Identification Numbers' for information on reporting the MSIS Identification Numbers ID for
pregnant women, unborn children, mothers, and their deemed newborns younger than 1 y
of age who share the same MSIS Identification Number.
https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/4757
|N/A|ELG00009|LOCK-IN-INFORMATION|X(20)|N/A|22|41|1. Mandatory
2. Value must be 20 characters or less

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, segmen
and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared
Identification Numbers' for information on reporting the MSIS Identification Numbers ID for
pregnant women, unborn children, mothers, and their deemed newborns younger than 1 y
of age who share the same MSIS Identification Number.
https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/4757
|N/A|ELG00010|MFP-INFORMATION|X(20)|N/A|22|41|1. Mandatory
2. Value must be 20 characters or less

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, segmen and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared Identification Numbers' for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 y of age who share the same MSIS Identification Number.
https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/4757
|N/A|ELG00011|STATE-PLAN-OPTION-PARTICIPATION|X(20)|N/A|22|41|1. Mandatory
2. Value must be 20 characters or less

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, segmen and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared Identification Numbers' for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 y of age who share the same MSIS Identification Number.
https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/4757
|N/A|ELG00012|WAIVER-PARTICIPATION|X(20)|N/A|22|41|1. Mandatory
2. Value must be 20 characters or less

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, segmen and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared Identification Numbers' for information on reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothers, and their deemed newborns younger than 1 y of age who share the same MSIS Identification Number.
https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/4757
|N/A|ELG00013|LTSS-PARTICIPATION|X(20)|N/A|22|41|1. Mandatory
2. Value must be 20 characters or less

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, segmen
and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared
Identification Numbers' for information on reporting the MSIS Identification Numbers ID for
pregnant women, unborn children, mothers, and their deemed newborns younger than 1 y
of age who share the same MSIS Identification Number.
https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/4757
|N/A|ELG00014|MANAGED-CARE-PARTICIPATION|X(20)|N/A|22|41|1. Mandatory
2. Value must be 20 characters or less

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, segmen
and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared
Identification Numbers' for information on reporting the MSIS Identification Numbers ID for
pregnant women, unborn children, mothers, and their deemed newborns younger than 1 y
of age who share the same MSIS Identification Number.
https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/4757
|N/A|ELG00015|ETHNICITY-INFORMATION|X(20)|N/A|22|41|1. Mandatory
2. Value must be 20 characters or less

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, segmen
and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared
Identification Numbers' for information on reporting the MSIS Identification Numbers ID for
pregnant women, unborn children, mothers, and their deemed newborns younger than 1 y
of age who share the same MSIS Identification Number.
https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/4757
|N/A|ELG00016|RACE-INFORMATION|X(20)|N/A|22|41|1. Mandatory
2. Value must be 20 characters or less

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, segmen
and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared
Identification Numbers' for information on reporting the MSIS Identification Numbers ID for
pregnant women, unborn children, mothers, and their deemed newborns younger than 1 y
of age who share the same MSIS Identification Number.
https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/4757
|N/A|ELG00017|DISABILITY-INFORMATION|X(20)|N/A|22|41|1. Mandatory
2. Value must be 20 characters or less

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, segmen
and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared
Identification Numbers' for information on reporting the MSIS Identification Numbers ID for
pregnant women, unborn children, mothers, and their deemed newborns younger than 1 y
of age who share the same MSIS Identification Number.
https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/4757
|N/A|ELG00018|1115A-DEMONSTRATION-INFORMATION|X(20)|N/A|22|41|1. Mandatory
2. Value must be 20 characters or less

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, segmen
and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared
Identification Numbers' for information on reporting the MSIS Identification Numbers ID for
pregnant women, unborn children, mothers, and their deemed newborns younger than 1 y
of age who share the same MSIS Identification Number.
https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/4757
|N/A|ELG00020|HCBS-CHRONIC-CONDITIONS-NON-HEALTH-HOME|X(20)|N/A|22|41|1. Mand
2. Value must be 20 characters or less

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, segmen
and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared
Identification Numbers' for information on reporting the MSIS Identification Numbers ID for
pregnant women, unborn children, mothers, and their deemed newborns younger than 1 y
of age who share the same MSIS Identification Number.
https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/4757
|N/A|ELG00021|ENROLLMENT-TIME-SPAN-SEGMENT|X(20)|N/A|22|41|1. Mandatory
2. Value must be 20 characters or less

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, segmen
and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared
Identification Numbers' for information on reporting the MSIS Identification Numbers ID for
pregnant women, unborn children, mothers, and their deemed newborns younger than 1 y
of age who share the same MSIS Identification Number.
https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/4757
|N/A|ELG00022|ELG-IDENTIFIERS|X(20)|N/A|22|41|1. Mandatory
2. Value must be 20 characters or less

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TPL019|TPL.002.019|MSIS-IDENTIFICATION-NUM|MSIS Identification Number|Mandatory|A s 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-ass eligible individual identifier. MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity of data distributed over multiples files, segments and reporti periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identifica Numbers' for information on reporting the MSIS Identification Numbers ID for pregnant wor unborn children, mothers, and their deemed newborns younger than 1 year of age who sh the same MSIS Identification Number. https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/4757 |N/A|TPL00002|TPL-MEDICAID-ELIGIBLE-PERSON-MAIN|X(20)|N/A|22|41|1. Mandatory 2. Value must be 20 characters or less

TPL032|TPL.003.032|MSIS-IDENTIFICATION-NUM|MSIS Identification Number|Mandatory|A s
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-ass
eligible individual identifier. MSIS Identification Numbers are a unique 'key' value used to
maintain referential integrity of data distributed over multiples files, segments and reporti
periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identifica
Numbers' for information on reporting the MSIS Identification Numbers ID for pregnant wor
unborn children, mothers, and their deemed newborns younger than 1 year of age who sha
the same MSIS Identification Number.
https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/4757
|N/A|TPL00003|TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO|X(2
N/A|22|41|1. Mandatory
2. Value must be 20 characters or less

TPL066|TPL.005.066|MSIS-IDENTIFICATION-NUM|MSIS Identification Number|Mandatory|A s
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-ass
eligible individual identifier. MSIS Identification Numbers are a unique 'key' value used to
maintain referential integrity of data distributed over multiples files, segments and reporti
periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identifica
Numbers' for information on reporting the MSIS Identification Numbers ID for pregnant wor
unborn children, mothers, and their deemed newborns younger than 1 year of age who sha
the same MSIS Identification Number.
https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/4757
|N/A|TPL00005|TPL-MEDICAID-ELIGIBLE-OTHER-THIRD-PARTY-COVERAGE-INFORMATION|X(2
N/A|22|41|1. Mandatory
2. Value must be 20 characters or less

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
the version number specified on the Cover Sheet of the data dictionary".|DATA-DICTIONAR
VERSION|CIP00001|FILE-HEADER-RECORD-IP|X(10)|2|9|18|1. Value must be 10 characters
less
2. Value must not include the pipe ("|") symbol
3. 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 C Plan Information, Inpatient, Long-Term Care, Other, and Pharmacy Claim).|FILE-NAME|CIP00001|FILE-HEADE RECORD-IP|X(8)|6|32|39|1. Value must equal 'CLAIM-IP'
2. Mandatory

CIP020|CIP.002.020|ICN-ADJ|Adjustment ICN|Conditional|A unique claim number assigned b 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 0, then value must not be populated
4. Conditional

CIP022|CIP.002.022|MSIS-IDENTIFICATION-NUM|MSIS Identification Number|Mandatory|A st 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 da distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757 |N/A|CIP00002|CLAIM-HEADER-RECORD-IP|X(20)|7|134|153|1. Mandatory
2. Value must be 20 characters or less.
3. When Type of Claim not in (U, W), value must match MSIS Identification Number (ELG.021.251) and the Admission Date (CIP.002.094) must be between Enrollment Effectiv Date (ELG.021.253) and Enrollment End Date (ELG.021.254).

CIP023|CIP.002.023|CROSSOVER-INDICATOR|Crossover Indicator|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. Value mus in Crossover Indicator List (VVL)
2. Value must be 1 character
3. Value must be in [0, 1] or not populated
4. If Crossover Indicator value is "1", the associated Dual Eligible Code (ELG.005.085) valu must be in "01", "02", "04", "08", "09", or "10" for the same time period (by date of service
5. Value must be 1 character
6. Mandatory

CIP026|CIP.002.026|ADJUSTMENT-IND|Adjustment Indicator|Mandatory|Indicates the type o adjustment record.
|ADJUSTMENT-IND|CIP00002|CLAIM-HEADER-RECORD-IP|X(1)|11|158|158|1. Value must be Adjustment Indicator List (VVL).
2. Value must be in [0, 1, 4].
3. Value must be 1 character.
4. Mandatory

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 hospital stay referenced by this claim. The principal procedure and related info should be recorded in Procedure Code1, Procedure Code Date-1, and Procedure Code Flag 1. The principal procedure is performed for definitive
treatment rather than for diagnostic or exploratory purposes. It is closely related to either principal diagnosis or to complications that arise during other treatments. Use Procedure 2 through Procedure Code 6 (and related data elements) to record secondary, tertiary, etc procedures.|N/A|CIP00002|CLAIM-HEADER-RECORD-IP|X(8)|17|191|198|1. When populated there must be a corresponding Procedure Code Flag
2. If associated Procedure Code Flag List (VVL) value indicates an ICD-9-CM encoding '02', value must be a valid ICD-9-CM procedure code
3. 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. If associated Procedure Code Flag List (VVL) value indicates an "Other" encoding '10-87' then State must provide T-MSIS system with State-specific procedure code list, and value m be a valid State-specific procedure code
5. Value must be 8 characters or less
6. Value must be in Procedure Code List (VVL)
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 hospital stay referenced by this claim. The principal procedure and related info should be recorded in Procedure Code 1, Procedure Code 1, and Procedure Code Flag 1. The princip procedure is performed for definitive
treatment rather than for diagnostic or exploratory purposes. It is closely related to either principal diagnosis or to complications that arise during other treatments. Use Procedure 2 through Procedure Code 6 (and related data elements) to record secondary, tertiary, etc procedures.|N/A|CIP00002|CLAIM-HEADER-RECORD-IP|X(8)|20|209|216|1. When populated, there must be a corresponding Procedure Code Flag
2. If associated Procedure Code Flag List (VVL) value indicates an ICD-9-CM encoding '02', value must be a valid ICD-9-CM procedure code
3. 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. If associated Procedure Code Flag List (VVL) value indicates an "Other" encoding '10-87' then State must provide T-MSIS system with State-specific procedure code list, and value m be a valid State-specific procedure code
5. Value must be 8 characters or less
6. Value must be in Procedure Code List (VVL)
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 hospital stay referenced by this claim. The principal procedure and related info should be recorded in Procedure Code 1, Procedure Code Date 1, and Procedure Code Flag 1. The principal procedure is performed for definitive
treatment rather than for diagnostic or exploratory purposes. It is closely related to either principal diagnosis or to complications that arise during other treatments. Use Procedure 2 through Procedure Code 6 (and related data elements) to record secondary, tertiary, etc procedures.|N/A|CIP00002|CLAIM-HEADER-RECORD-IP|X(8)|23|227|234|1. When populated, there must be a corresponding Procedure Code Flag
2. If associated Procedure Code Flag List (VVL) value indicates an ICD-9-CM encoding '02', value must be a valid ICD-9-CM procedure code
3. 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. If associated Procedure Code Flag List (VVL) value indicates an "Other" encoding '10-87' then State must provide T-MSIS system with State-specific procedure code list, and value m be a valid State-specific procedure code
5. Value must be 8 characters or less
6. Value must be in Procedure Code List (VVL)
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 hospital stay referenced by this claim. The principal procedure and related info should be recorded in Procedure Code 1, Procedure Code Date 1, and Procedure Code Flag 1. The principal procedure is performed for definitive
treatment rather than for diagnostic or exploratory purposes. It is closely related to either principal diagnosis or to complications that arise during other treatments. Use Procedure 2 through Procedure Code 6 (and related data elements) to record secondary, tertiary, etc procedures.|N/A|CIP00002|CLAIM-HEADER-RECORD-IP|X(8)|26|245|252|1. When populated there must be a corresponding Procedure Code Flag
2. If associated Procedure Code Flag List (VVL) value indicates an ICD-9-CM encoding '02', value must be a valid ICD-9-CM procedure code
3. 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. If associated Procedure Code Flag List (VVL) value indicates an "Other" encoding '10-87' then State must provide T-MSIS system with State-specific procedure code list, and value m be a valid State-specific procedure code
5. Value must be 8 characters or less
6. Value must be in Procedure Code List (VVL)
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 hospital stay referenced by this claim. The principal procedure and related info should be recorded in Procedure Code 1, Procedure Code Date 1, and Procedure Code Flag 1. The principal procedure is performed for definitive
treatment rather than for diagnostic or exploratory purposes. It is closely related to either principal diagnosis or to complications that arise during other treatments. Use Procedure 2 through Procedure Code 6 (and related data elements) to record secondary, tertiary, etc procedures.|N/A|CIP00002|CLAIM-HEADER-RECORD-IP|X(8)|29|263|270|1. When populated there must be a corresponding Procedure Code Flag
2. If associated Procedure Code Flag List (VVL) value indicates an ICD-9-CM encoding '02', value must be a valid ICD-9-CM procedure code
3. 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. If associated Procedure Code Flag List (VVL) value indicates an "Other" encoding '10-87' then State must provide T-MSIS system with State-specific procedure code list, and value m be a valid State-specific procedure code
5. Value must be 8 characters or less
6. Value must be in Procedure Code List (VVL)
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 hospital stay referenced by this claim. The principal procedure and related info should be recorded in Procedure Code 1, Procedure Code Date 1, and Procedure Code Flag 1. The principal procedure is performed for definitive
treatment rather than for diagnostic or exploratory purposes. It is closely related to either principal diagnosis or to complications that arise during other treatments. Use Procedure 2 through Procedure Code 6 (and related data elements) to record secondary, tertiary, etc procedures.|N/A|CIP00002|CLAIM-HEADER-RECORD-IP|X(8)|32|281|288|1. When populated there must be a corresponding Procedure Code Flag
2. If associated Procedure Code Flag List (VVL) value indicates an ICD-9-CM encoding '02', value must be a valid ICD-9-CM procedure code
3. 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. If associated Procedure Code Flag List (VVL) value indicates an "Other" encoding '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. Value must be 8 characters or less
6. Value must be in Procedure Code List (VVL)
7. Conditional

CIP100|CIP.002.100|TYPE-OF-CLAIM|Type of Claim|Mandatory|A code to indicate what type payment is covered in this claim.
For sub-capitated encounters from a sub-capitated entity or sub-capitated network provide report TYPE-OF-CLAIM = "3" for a Medicaid sub-capitated encounter record or “C” for an S- sub-capitated encounter record.
|TYPE-OF-CLAIM|CIP00002|CLAIM-HEADER-RECORD-IP|X(1)|41|335|335|1. Value must be in Type of Claim List (VVL)
2. Value must be 1 character
3. Mandatory
4. When value equals 'Z', claim denied indicator must equal '0'

CIP104|CIP.002.104|SOURCE-LOCATION|Source Location|Mandatory|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 netwo 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 t 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)|45|346|347|1. Value must b Source Location List (VVL)
2. Value must be 2 characters
3. Mandatory

CIP114|CIP.002.114|TOT-MEDICAID-PAID-AMT|Total Medicaid Paid Amount|Conditional|The amount paid by Medicaid/CHIP or the managed care plan on this claim or adjustment at th 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 netwo provider, report the total amount that the sub-capitated entity paid the provider for the se 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, re a null value in this field.
|N/A|CIP00002|CLAIM-HEADER-RECORD-IP|S9(11)V99|54|417|429|1. Value must be betwee 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 reporte must equal Total Medicaid Paid Amount
5. When Payment Level Indicator equals '2', value must equal the sum of line level Medica Paid Amounts.
6. Conditional
7. Value must not be greater than Total Allowed Amount (CIP.002.113)

CIP126|CIP.002.126|FUNDING-CODE|Funding Code|Conditional|A code to indicate the sourc
non-federal share funds.
|FUNDING-CODE|CIP00002|CLAIM-HEADER-RECORD-IP|X(2)|62|487|488|1. Value must be in
Funding Code List (VVL)
2. Value must be 1 character
3. Value must be populated if TYPE-OF-CLAIM equals ‘3', ‘C’, ‘W’, or '6’
4. Conditional

CIP127|CIP.002.127|FUNDING-SOURCE-NONFEDERAL-SHARE|Funding Source Non-Federal
Share|Conditional|A code to indicate the type of non-federal share used by the state to fina
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)|63|489
1. Value must be in Funding Source Non-Federal Share List (VVL)
2. Value must be 2 characters
3. Value must be populated if TYPE-OF-CLAIM equals ‘3', ‘C’, ‘W’, or '6’
4. 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 combin
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)|71|527|533|1. Value m
be a positive integer
2. Value must be between 0:99999999999 (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 d
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, 08
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 li
on the claim.|N/A|CIP00002|CLAIM-HEADER-RECORD-IP|9(4)|72|534|537|1. Value must be a
positive integer
2. Value must be between 0:9999 (inclusive)
3. Value must not include commas or other non-numeric characters
4. 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

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 He
Home care model to provide services for the beneficiary on the claim. Health home provid
provide service for patients with chronic illnesses. 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
the health home model.|HEALTH-HOME-PROV-IND|CIP00002|CLAIM-HEADER-RECORD-IP|X(
111|818|818|1. Value must be in Health Home Provider Indicator List (VVL)
2. Value must be 1 character
3. Value must be in [0, 1] or not populated
4. If there is an associated Health Home Entity Name value, then value must be "1"
5. Value must be 1 character
6. 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, ful
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)|113|821|840|1. Value must be associated with
populated Waiver Type
2. Value must be 20 characters or less
3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associated Cl
Waiver Type value must be 01 or in [21-30]
4. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation follow
by a period (.), the associated Claim Waiver Type value must be in [02-20, 32, 33]
5. Conditional

CIP179|CIP.002.179|BILLING-PROV-NUM|Billing Provider Number|Conditional|A unique identification number assigned by the state to a provider or managed care plan. This data element should represent the entity billing for the service. For encounter records, if associ Type of Claim value equals 3, C, or W, then value must be the state identifier of the provid entity (billing or reporting) to the managed care plan.|N/A|CIP00002|CLAIM-HEADER-RECOI IP|X(30)|114|841|870|1. Value must be 30 characters or less.
2. Conditional
3. When Type of Claim not in ['3','C','W'] then value may match (PRV.002.019) Submitting Provider ID or
4. When Type of Claim not in ['3','C','W'] then value may match (PRV.005.081) Provider Identifier where the Provider Identifier.
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|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 b admitting provider except for Long Term Care.|N/A|CIP00002|CLAIM-HEADER-RECORD-IP|X 115|871|880|1. Value must be 10 digits, consisting of 9 numeric digits followed by one che digit calculated using the Luhn formula (algorithm)
2. Value must have an associated Provider Identifier Type equal to '2'
3. Conditional
4. When populated, value must match Provider Identifier (PRV.005.081) and Facility Group Individual Code (PRV.002.028) must equal '01'

CIP184|CIP.002.184|ADMITTING-PROV-NPI-NUM|Admitting Provider NPI Number|Conditiona National Provider ID (NPI) of the doctor responsible for admitting a patient to a hospital or inpatient health facility.|N/A|CIP00002|CLAIM-HEADER-RECORD-IP|X(10)|119|897|906|1. Va must be 10 digits, consisting of 9 numeric digits followed by one check digit calculated usi the Luhn formula (algorithm)
2. Conditional
3. Value must have an associated Provider Identifier Type equal to '2'

CIP190|CIP.002.190|REFERRING-PROV-NPI-NUM|Referring Provider NPI Number|Conditional National Provider ID (NPI) of the provider who recommended the servicing provider to the patient.|N/A|CIP00002|CLAIM-HEADER-RECORD-IP|X(10)|125|983|992|1. Value must be 10 digits, consisting of 9 numeric digits followed by one check digit calculated using the Luhn formula (algorithm)
2. Value must have an associated Provider Identifier Type equal to '2'
3. Conditional

CIP203|CIP.002.203|SPLIT-CLAIM-IND|Split Claim Indicator|Conditional|An indicator that der
that claims in excess of a pre-determined number of claim lines (threshold determined by
individual state) will be split during processing.|SPLIT-CLAIM-IND|CIP00002|CLAIM-HEADER-
RECORD-IP|X(1)|133|1065|1065|1. Value must be 1 character
2. Value must be in [0, 1] or not populated
3. Value must be in Split Claim Indicator List (VVL).
4. Value must be 1 character
5. Conditional

CIP221|CIP.002.221|HEALTH-HOME-PROVIDER-NPI|Health Home Provider NPI Number|
Conditional|The National Provider ID (NPI) of the health home provider.|N/A|CIP00002|CLAI
HEADER-RECORD-IP|X(10)|149|1237|1246|1. Value must be 10 digits, consisting of 9 nume
digits followed by one check digit calculated using the Luhn formula (algorithm)
2. Value must have an associated Provider Identifier Type equal to '2'
3. Conditional

CIP298|CIP.002.298|BILLING-PROV-ADDR-LINE-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

CIP299|CIP.002.299|BILLING-PROV-ADDR-LINE-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

CIP300|CIP.002.300|BILLING-PROV-ADDR-CITY-NAME|Billing Provider Address City Name|
Mandatory|Billing provider address city name from X12 837I loop 2010AA.|N/A|CIP00002|C
HEADER-RECORD-IP|X(28)|163|1490|1517|1. Value must not be more than 28 characters lo
2. Mandatory

CIP301|CIP.002.301|BILLING-PROV-ADDR-STATE-CODE|Billing Provider Address State Code|
Mandatory|Billing provider address state code from X12 837I loop 2010AA.|N/A|CIP00002|
CLAIM-HEADER-RECORD-IP|X(2)|164|1518|1519|1. Value must not be more than 2 characte
2. Value must be in State Code list (VVL)
3. Mandatory

CIP302|CIP.002.302|BILLING-PROV-ADDR-ZIP-CODE|Billing Provider Address ZIP Code|
Mandatory|Billing provider address ZIP code from X12 837I loop 2010AA.|N/A|CIP00002|CL
HEADER-RECORD-IP|X(9)|165|1520|1528|1. Value must contain a string of either 5 or 9 nu
values
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 cont
sting of 10 numeric values.
2. Value must be in NPPES (external reference).
3. Conditional

CIP304|CIP.002.304|SERVICE-FACILITY-LOCATION-ADDR-LINE-1|Service Facility Location
Address Line 1|Conditional|Service facility location address line 1 from X12 837I loop 2310
N/A|CIP00002|CLAIM-HEADER-RECORD-IP|X(60)|167|1539|1598|1. Value must not be more
60 characters long.
2. Conditional

CIP305|CIP.002.305|SERVICE-FACILITY-LOCATION-ADDR-LINE-2|Service Facility Location
Address Line 2|Conditional|Service facility location address line 2 from X12 837I loop 2310
N/A|CIP00002|CLAIM-HEADER-RECORD-IP|X(60)|168|1599|1658|1. Value must not be more
60 characters long.
2. Conditional

CIP306|CIP.002.306|SERVICE-FACILITY-LOCATION-ADDR-CITY-NAME|Service Facility Locatio
Address City Name|Conditional|Service facility location address city name from X12 837I lo
2310E.|N/A|CIP00002|CLAIM-HEADER-RECORD-IP|X(28)|169|1659|1686|1. Value must not b
more than 28 characters long.
2. Conditional

CIP307|CIP.002.307|SERVICE-FACILITY-LOCATION-ADDR-STATE-CODE|Service Facility Locat
Address State Code|Conditional|Service facility location address state code from X12 837I
2310E.|N/A|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-ADDR-ZIP-CODE|Service Facility Location
Address ZIP Code|Conditional|Service facility location address ZIP code from X12 837I loop
2310E.|N/A|CIP00002|CLAIM-HEADER-RECORD-IP|X(9)|171|1689|1697|1. Value must contai
string of either 5 or 9 numeric values.
2. Value must be in ZIP Code list (VVL).
3. Conditional

CIP234|CIP.003.234|MSIS-IDENTIFICATION-NUM|MSIS Identification Number|Mandatory|A st
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 da
distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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-blog/entry/4757
|N/A|CIP00003|CLAIM-LINE-RECORD-IP|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less.

CIP236|CIP.003.236|ICN-ADJ|Adjustment ICN|Conditional|A unique claim number assigned b
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 0, then value must not be populated
4. Conditional

CIP254|CIP.003.254|MEDICAID-PAID-AMT|Medicaid Paid Amount|Conditional|The amount pa
by Medicaid/CHIP agency or the managed care plan on this claim or adjustment at the clai
detail level.
For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated netwo
provider, report the amount that the sub-capitated entity paid the provider at the claim lin
detail level. Report a null value in this field if the provider is a sub-capitated network provi
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, re
a null value in this field.
|N/A|CIP00003|CLAIM-LINE-RECORD-IP|S9(11)V99|20|231|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

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|CIP00003|CLAIM-LINE-RECORD-IP|X(3)|23|259|261|1. Value must be 3
characters
2. Mandatory
3. Value must not equal '086' if Sex (ELG.002.023) equals 'M'
4. Value must be in ['001', '058', '060', '084', '086', '090', '091', '092', '093', '123', '132', '1
'136', '137']

CIP261|CIP.003.261|SERVICING-PROV-NPI-NUM|Servicing Provider NPI Number|Conditional|
NPI of the health care professional who delivers or completes a particular medical service
non-surgical
procedure. The Servicing Provider NPI Number is required when rendering provider is diffe
than the attending
provider and state or federal regulatory requirements call for a "combined claim" (i.e., a cl
that includes both facility
and professional components). Examples are Medicaid clinic bills or critical access hospita
claims.|N/A|CIP00003|CLAIM-LINE-RECORD-IP|X(10)|25|292|301|1. Value must be 10 digits,
consisting of 9 numeric digits followed by one check digit calculated using the Luhn formul
(algorithm)
2. Value must have an associated Provider Identifier Type equal to '2'
3. Conditional

CIP265|CIP.003.265|OPERATING-PROV-NPI-NUM|Operating Provider NPI Number|Conditiona
National Provider ID (NPI) of the provider who performed the surgical procedures on the beneficiary.|N/A|CIP00003|CLAIM-LINE-RECORD-IP|X(10)|28|306|315|1. Value must be 10 d
consisting of 9 numeric digits followed by one check digit calculated using the Luhn formul
(algorithm)
2. Value must have an associated Provider Identifier Type equal to '2'
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 [0, 1]
3. Mandatory

CIP315|CIP.003.315|MBESCBES-CATEGORY-OF-SERVICE|MBES or CBES Category of Service
Conditional|A code indicating the category of service for the paid claim. The category of se
is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM
21, 64.9 WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS) that states use to report
expenditures and request federal financial participation.|MBESCBES-CATEGORY-OF-SERVIC
(XIX), MBESCBES-CATEGORY-OF-SERVICE (XXI)|CIP00003|CLAIM-LINE-RECORD-IP|X(5)|41|4
485|1. Value must not be more than 5 characters
2. Value must be in MBES or CBES Category of Service Code List (VVL)
3. Value must be populated on all FFS claim lines with a paid amount greater than $0
4. Conditional

CIP316|CIP.003.316|MBESCBES-FORM|MBES or CBES Form|Conditional|The MBES or CBES f
to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, 64.9
WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS). This should be determined by th
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.|MBESCBE
FORM|CIP00003|CLAIM-LINE-RECORD-IP|X(50)|42|486|535|1. Value must be 50 characters
less
2. Value must be in MBES or CBES Form Code List (VVL)
3. Value must be populated on all FFS claim lines with a paid amount greater than $0
4. Conditional

CIP319|CIP.003.319|REFERRING-PROV-NPI-NUM|Referring Provider NPI Number|Conditional
National Provider ID (NPI) of the provider who recommended the servicing provider to the
patient.|N/A|CIP00003|CLAIM-LINE-RECORD-IP|X(10)|45|579|588|1. Value must be 10 digits
consisting of 9 numeric digits followed by one check digit calculated using the Luhn formul
(algorithm)
2. Value must have an associated Provider Identifier Type equal to '2'
3. Conditional

N/A

CIP322|CIP.004.322|RECORD-ID|Record ID|Mandatory|The Record ID represents the type o
segment being reported. The Record ID communicates how the contents of a given row of
should be interpreted depending on which segment type the Record ID represents. Each t
of segment collects different data elements so each segment type has a distinct layout. Th
first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th
segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).|N/A|CIP000
CLAIM-DX-IP|X(8)|1|1|8|1. Mandatory
2. Value must be 8 characters
3. Value must be in Record ID List (VVL)

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 receiv
STATE|CIP00004|CLAIM-DX-IP|X(2)|2|9|10|1. Value must be in State Code List (VVL)
2. Value must be 2 characters
3. Mandatory
4. Value must be the same as Submitting State (CIP.001.007)

CIP326|CIP.004.326|ICN-ADJ|Adjustment ICN|Conditional|A unique claim number assigned
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
2. Value must not contain a pipe or asterisk symbols
3. If associated Adjustment Indicator value is 0, then value must not be populated
4. Conditional

CIP327|CIP.004.327|ADJUSTMENT-IND|Adjustment Indicator|Mandatory|Indicates the type
adjustment record.|LINE-ADJUSTMENT-IND|CIP00004|CLAIM-DX-IP|X(1)|6|122|122|1. Value
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 [
4]
3. If associated Type of Claim value is '4, D, X', then value must be in [5, 6]
4. Value must be 1 character
5. Mandatory

CIP330|CIP.004.330|DIAGNOSIS-SEQUENCE-NUMBER|Diagnosis Sequence Number|Mandat
The order in which the diagnosis occurred on the provider's claim for a given type of diagn
code (e.g., an 837I claim can have up to 12 external cause of injury diagnosis codes and u
24 other diagnosis codes).|N/A|CIP00004|CLAIM-DX-IP|9(2)|9|132|133|1. Value must be
between 1 and 24
2. Mandatory

CLT006|CLT.001.006|FILE-NAME|File Name|Mandatory|A code to identify the subject area t
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 C
Plan Information,
Inpatient, Long-Term Care, Other, and Pharmacy Claim).|FILE-NAME|CLT00001|FILE-HEADE
RECORD-LT|X(8)|6|32|39|1. Value must equal 'CLAIM-LT'
2. Mandatory

CLT020|CLT.002.020|ICN-ADJ|Adjustment ICN|Conditional|A unique claim number assigned
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 0, then value must not be populated
4. Conditional

CLT022|CLT.002.022|MSIS-IDENTIFICATION-NUM|MSIS Identification Number|Mandatory|A s
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 da
distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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-blog/entry/4757
|N/A|CLT00002|CLAIM-HEADER-RECORD-LT|X(20)|7|134|153|1. Mandatory
2. Value must be 20 characters or less.
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|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. Value mu
be in Crossover Indicator List (VVL)
2. Value must be 1 character
3. Value must be in [0, 1] or not populated
4. If Crossover Indicator value is "1", the associated Dual Eligible Code (ELG.005.085) valu
must be in "01", "02", "04", "08", "09", or "10" for the same time period (by date of service
5. Value must be 1 character
6. Mandatory

CLT025|CLT.002.025|ADJUSTMENT-IND|Adjustment Indicator|Mandatory|Indicates the type
adjustment record.
|ADJUSTMENT-IND|CLT00002|CLAIM-HEADER-RECORD-LT|X(1)|10|156|156|1. Value must be
Adjustment Indicator List (VVL).
2. Value must be in [0, 1, 4].
3. Value must be 1 character.
4. Mandatory

CLT052|CLT.002.052|TYPE-OF-CLAIM|Type of Claim|Mandatory|A code to indicate what typ
payment is covered in this claim.
For sub-capitated encounters from a sub-capitated entity or sub-capitated network provide
report TYPE-OF-CLAIM = '3' for a Medicaid sub-capitated encounter record or “C” for an S-C
sub-capitated encounter record.
|TYPE-OF-CLAIM|CLT00002|CLAIM-HEADER-RECORD-LT|X(1)|20|212|212|1. Value must be i
Type of Claim List (VVL)
2. Value must be 1 character
3. Mandatory
4. When value equals 'Z', claim denied indicator must equal '0'

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 the claim header level, which is the sum of the amounts paid by Medicaid or the managed plan at the detail level for the claim.
For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated netwo provider, report the total amount that the sub-capitated entity paid the provider for the se 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, re a null value in this field.
|N/A|CLT00002|CLAIM-HEADER-RECORD-LT|S9(11)V99|33|294|306|1. Value must be betwe 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 reporte must equal Total Medicaid Paid Amount
5. When Payment Level Indicator equals '2', value must equal the sum of line level Medica Paid Amounts.
6. Conditional
7. Value must not be greater than Total Allowed Amount

CLT076|CLT.002.076|FUNDING-CODE|Funding Code|Conditional|A code to indicate the sou non-federal share funds.
|FUNDING-CODE|CLT00002|CLAIM-HEADER-RECORD-LT|X(2)|41|364|365|1. Value must be Funding Code List (VVL)
2. Value must be 1 character
3. Value must be populated if TYPE-OF-CLAIM equals ‘3', ‘C’, ‘W’, or '6’
4. 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/ CLT00002|CLAIM-HEADER-RECORD-LT|S9(5)|50|404|408|1. Value must be a positive intege
2. Value must be between 0:99999999999 (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 in [044, 048, 050], this field must be populated

CLT087|CLT.002.087|CLAIM-LINE-COUNT|Claim Line Count|Mandatory|The total number of on the claim.|N/A|CLT00002|CLAIM-HEADER-RECORD-LT|9(4)|51|409|412|1. Value must be positive integer
2. Value must be between 0:9999 (inclusive)
3. Value must not include commas or other non-numeric characters
4. 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

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 He Home care model to provide services for the beneficiary on the claim. Health home provid provide service for patients with chronic illnesses. 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 the health home model.|HEALTH-HOME-PROV-IND|CLT00002|CLAIM-HEADER-RECORD-LT|X 89|684|684|1. Value must be in Health Home Provider Indicator List (VVL)
2. Value must be 1 character
3. Value must be in [0, 1] or not populated
4. If there is an associated Health Home Entity Name value, then value must be "1"
5. Value must be 1 character
6. 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, ful 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)|91|687|706|1. Value must be associated with populated Waiver Type
2. Value must be 20 characters or less
3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associated Cl Waiver Type value must be 01 or in [21-30]
4. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation follow by a period (.), the associated Claim Waiver Type value must be in [02-20, 32, 33]
5. Conditional

CLT131|CLT.002.131|BILLING-PROV-NPI-NUM|Billing Provider NPI Number|Conditional|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 b admitting provider except for Long Term Care.|N/A|CLT00002|CLAIM-HEADER-RECORD-LT|X(10)|93|737|746|1. Value must be 10 digits, consisting of 9 numeric digits followed by one check digit calculated using the Luhn formula (algorithm)
2. Value must have an associated Provider Identifier Type equal to '2'
3. Conditional
4. When Type of Claim (CLT.002.052) not in ('3','C','W') then value must match Provider Identifier (PRV.002.081)

CLT136|CLT.002.136|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|CLT00002|CLAIM-HEADER-RECORD-LT|X(10)|98|793|802|1. Value must be 10 digits, consisting of 9 numeric digits followed by one check digit calculated using the Luhn formula (algorithm)
2. Value must have an associated Provider Identifier Type equal to '2'
3. Conditional

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 determ by the individual state) will be split during processing.|SPLIT-CLAIM-IND|CLT00002|CLAIM-HEADER-RECORD-LT|X(1)|106|875|875|1. Value must be 1 character
2. Value must be in [0, 1] or not populated
3. Value must be in Split Claim Indicator List (VVL).
4. Value must be 1 character
5. Conditional

CLT167|CLT.002.167|HEALTH-HOME-PROVIDER-NPI|Health Home Provider NPI Number|Conditional|The National Provider ID (NPI) of the health home provider.|N/A|CLT00002|CLAIM-HEADER-RECORD-LT|X(12)|121|1034|1045|1. Value must be 10 digits, consisting of 9 numeric digits followed by one check digit calculated using the Luhn formula (algorithm)
2. Value must have an associated Provider Identifier Type equal to '2'
3. Conditional

CLT174|CLT.002.174|ADMITTING-PROV-NPI-NUM|Admitting Provider NPI Number|Conditional|The National Provider ID (NPI) of the doctor responsible for admitting a patient to a hospital other inpatient health facility.|N/A|CLT00002|CLAIM-HEADER-RECORD-LT|X(10)|123|1058|1
1. Value must be 10 digits, consisting of 9 numeric digits followed by one check digit calculated using the Luhn formula (algorithm)
2. Value must have an associated Provider Identifier Type equal to '2'
3. Conditional

CLT244|CLT.002.244|BILLING-PROV-ADDR-LINE-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

CLT245|CLT.002.245|BILLING-PROV-ADDR-LINE-2|Billing Provider Address Line 2|Conditiona
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

CLT246|CLT.002.246|BILLING-PROV-ADDR-CITY-NAME|Billing Provider Address City Name|
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-ADDR-STATE-CODE|Billing Provider Address State Code
Mandatory|Billing provider address state code from X12 837I loop 2010AA.|N/A|CLT00002|
CLAIM-HEADER-RECORD-LT|X(2)|137|1332|1333|1. Value must not be more than 2 charact
2. Value must be in State Code list (VVL)
3. Mandatory

CLT248|CLT.002.248|BILLING-PROV-ADDR-ZIP-CODE|Billing Provider Address ZIP Code|
Mandatory|Billing provider address ZIP code from X12 837I loop 2010AA.|N/A|CLT00002|CL
HEADER-RECORD-LT|X(9)|138|1334|1342|1. Value must contain a string of either 5 or 9
numeric values
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 con
a sting of 10 numeric values.
2. Value must be in NPPES (external reference).
3. Conditional

CLT250|CLT.002.250|SERVICE-FACILITY-LOCATION-ADDR-LINE-1|Service Facility Location Address Line 1|Conditional|Service facility location address line 1 from X12 837I loop 2310 N/A|CLT00002|CLAIM-HEADER-RECORD-LT|X(60)|140|1353|1412|1. Value must not be mor than 60 characters long.
2. Conditional

CLT251|CLT.002.251|SERVICE-FACILITY-LOCATION-ADDR-LINE-2|Service Facility Location Address Line 2|Conditional|Service facility location address line 2 from X12 837I loop 2310 N/A|CLT00002|CLAIM-HEADER-RECORD-LT|X(60)|141|1413|1472|1. Value must not be mor than 60 characters long.
2. Conditional

CLT252|CLT.002.252|SERVICE-FACILITY-LOCATION-ADDR-CITY-NAME|Service Facility Locati Address City Name|Conditional|Service facility location address city name from X12 837I lo 2310E.|N/A|CLT00002|CLAIM-HEADER-RECORD-LT|X(28)|142|1473|1500|1. Value must not more than 28 characters long.
2. Conditional

CLT253|CLT.002.253|SERVICE-FACILITY-LOCATION-ADDR-STATE-CODE|Service Facility Loca Address State Code|Conditional|Service facility location address state code from X12 837I 2310E.|N/A|CLT00002|CLAIM-HEADER-RECORD-LT|X(2)|143|1501|1502|1. Value must not b more than 2 characters.
2. Value must be in State Code list (VVL).
3. Conditional

CLT254|CLT.002.254|SERVICE-FACILITY-LOCATION-ADDR-ZIP-CODE|Service Facility Locatio Address ZIP Code|Conditional|Service facility location address ZIP code from X12 837I loop 2310E.|N/A|CLT00002|CLAIM-HEADER-RECORD-LT|X(9)|144|1503|1511|1. Value must conta string of either 5 or 9 numeric values.
2. Value must be in ZIP Code list (VVL).
3. Conditional

CLT187|CLT.003.187|MSIS-IDENTIFICATION-NUM|MSIS Identification Number|Mandatory|A s
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 da
distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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-blog/entry/4757
|N/A|CLT00003|CLAIM-LINE-RECORD-LT|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less.

CLT189|CLT.003.189|ICN-ADJ|Adjustment ICN|Conditional|A unique claim number assigned
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 0, then value must not be populated
4. Conditional

CLT208|CLT.003.208|MEDICAID-PAID-AMT|Medicaid Paid Amount|Conditional|The amount p
by Medicaid/CHIP agency or the managed care plan on this claim or adjustment at the clai
detail level.
For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated netwo
provider, report the amount that the sub-capitated entity paid the provider at the claim lin
detail level. Report a null value in this field if the provider is a sub-capitated network provi
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, re
a null value in this field.
|N/A|CLT00003|CLAIM-LINE-RECORD-LT|S9(11)V99|22|257|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

CLT213|CLT.003.213|SERVICING-PROV-NPI-NUM|Servicing Provider NPI Number|Conditiona
NPI of the health care professional who delivers or completes a particular medical service
non-surgical procedure. The Servicing Provider NPI Number is required when rendering
provider is different than the attending provider and state or federal regulatory requireme
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-L
RECORD-LT|X(10)|27|318|327|1. Value must be 10 digits, consisting of 9 numeric digits
followed by one check digit calculated using the Luhn formula (algorithm)
2. Value must have an associated Provider Identifier Type equal to '2'
3. Conditional
4. When Type of Claim (CLT.002.052) not in ('3','C','W') then value must match Provider
Identifier (PRV.005.081)

CLT219|CLT.003.219|CATEGORY-FOR-FEDERAL-REIMBURSEMENT|Category for Federal
Reimbursement|Conditional|A code to indicate the Federal funding source for the payment
CATEGORY-FOR-FEDERAL-REIMBURSEMENT|CLT00003|CLAIM-LINE-RECORD-LT|X(2)|31|335
336|1. Value must be in Category for Federal Reimbursement List (VVL).
2. Value must be 2 characters.
3. (Federal Funding under Title XXI) if value equals '02', then the eligible's CHIP Code
(ELG.003.054) must be in ['2', '3'].
4. (Federal Funding under Title XIX) if value equals '01' then the eligible's CHIP Code
(ELG.003.054) must be '1'.
5. Conditional
6. If Type of Claim is in ['1','A','U'] and the Total Medicaid Paid Amount is populated on the
corresponding claim header, then value must be reported.

CLT233|CLT.003.233|ADJUDICATION-DATE|Adjudication Date|Mandatory|The date on which
payment status of the claim was finally adjudicated by the state. For Encounter Records (
of Claim = 3, C, W), use date the encounter was processed by the state.|N/A|CLT00003|CL
LINE-RECORD-LT|9(8)|36|378|385|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
or Sept 31st)
3. Value should be on or before End of Time Period value found in associated T-MSIS File
Header Record
4. Mandatory
5. Value should be on or after associated Admission Date value

CLT243|CLT.003.243|IHS-SERVICE-IND|IHS Service Indicator|Mandatory|To indicate Service
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 [0, 1]
3. Mandatory

CLT261|CLT.003.261|MBESCBES-CATEGORY-OF-SERVICE|MBES or CBES Category of Servic
Conditional|A code indicating the category of service for the paid claim. The category of se
is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM
21, 64.9 WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS) that states use to report
expenditures and request federal financial participation.|MBESCBES-CATEGORY-OF-SERVIC
(XIX), MBESCBES-CATEGORY-OF-SERVICE (XXI)|CLT00003|CLAIM-LINE-RECORD-LT|X(5)|41|
488|1. Value must not be more than 5 characters
2. Value must be in MBES or CBES Category of Service Code List (VVL)
3. Value must be populated on all FFS claim lines with a paid amount greater than $0
4. Conditional

CLT262|CLT.003.262|MBESCBES-FORM|MBES or CBES Form|Conditional|The MBES or CBES to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, 64.9 WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS). This should be determined by th 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.|MBESCBE FORM|CLT00003|CLAIM-LINE-RECORD-LT|X(50)|42|489|538|1. Value must be 50 characters less 2. Value must be in MBES or CBES Form Code List (VVL) 3. Value must be populated on all FFS claim lines with a paid amount greater than $0 4. Conditional
CLT265|CLT.003.265|REFERRING-PROV-NPI-NUM|Referring Provider NPI Number|Conditiona National Provider ID (NPI) of the provider who recommended the servicing provider to the patient.|N/A|CLT00003|CLAIM-LINE-RECORD-LT|X(10)|45|582|591|1. Value must be 10 digit consisting of 9 numeric digits followed by one check digit calculated using the Luhn formul (algorithm) 2. Value must have an associated Provider Identifier Type equal to '2' 3. Conditional
N/A
CLT268|CLT.004.268|RECORD-ID|Record ID|Mandatory|The Record ID represents the type segment being reported. The Record ID communicates how the contents of a given row of should be interpreted depending on which segment type the Record ID represents. Each t of segment collects different data elements so each segment type has a distinct layout. Th first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).|N/A|CLT00 CLAIM-DX-LT|X(8)|1|1|8|1. Mandatory 2. Value must be 8 characters 3. Value must be in Record ID List (VVL)

CLT272|CLT.004.272|ICN-ADJ|Adjustment ICN|Conditional|A unique claim number assigned
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
2. Value must not contain a pipe or asterisk symbols
3. If associated Adjustment Indicator value is 0, then value must not be populated
4. Conditional

CLT273|CLT.004.273|ADJUSTMENT-IND|Adjustment Indicator|Mandatory|Indicates the type
adjustment record.|LINE-ADJUSTMENT-IND|CLT00004|CLAIM-DX-LT|X(1)|6|122|122|1. 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 [
4]
3. If associated Type of Claim value is '4, D, X', then value must be in [5, 6]
4. Value must be 1 character
5. Mandatory

CLT276|CLT.004.276|DIAGNOSIS-SEQUENCE-NUMBER|Diagnosis Sequence Number|Manda
The order in which the diagnosis occurred on the provider's claim for a given type of diagn
code (e.g., an 837I claim can have up to 12 external cause of injury diagnosis codes and u
24 other diagnosis codes).|N/A|CLT00004|CLAIM-DX-LT|9(2)|9|132|133|1. Value must be
between 1 and 24
2. Mandatory

COT020|COT.002.020|ICN-ADJ|Adjustment ICN|Conditional|A unique claim number assigne
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 5
characters or less
2. Value must not contain a pipe or asterisk symbols
3. If associated Adjustment Indicator value is 0, then value must not be populated
4. Conditional

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident
MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity
data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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-blog/entry/4757
|N/A|COT00002|CLAIM-HEADER-RECORD-OT|X(20)|7|134|153|1. Mandatory
2. Value must be 20 characters or less.
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|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. Value m
be in Crossover Indicator List (VVL)
2. Value must be 1 character
3. Value must be in [0, 1] or not populated
4. If Crossover Indicator value is "1", the associated Dual Eligible Code (ELG.005.085) valu
must be in "01", "02", "04", "08", "09", or "10" for the same time period (by date of service
5. Value must be 1 character
6. Mandatory

COT025|COT.002.025|ADJUSTMENT-IND|Adjustment Indicator|Mandatory|Indicates the type
adjustment record.
|ADJUSTMENT-IND|COT00002|CLAIM-HEADER-RECORD-OT|X(1)|10|156|156|1. Value must b
Adjustment Indicator List (VVL).
2. Value must be in [0, 1, 4].
3. Value must be 1 character.
4. Mandatory

COT037|COT.002.037|TYPE-OF-CLAIM|Type of Claim|Mandatory|A code to indicate what typ
payment is covered in this claim.
For sub-capitated encounters from a sub-capitated entity or sub-capitated network provide
report TYPE-OF-CLAIM = '3' for a Medicaid sub-capitated encounter record or “C” for an S-C
sub-capitated encounter record.
For sub-capitation payments, report TYPE-OF-CLAIM = '6' or “F”.
|TYPE-OF-CLAIM|COT00002|CLAIM-HEADER-RECORD-OT|X(1)|16|192|192|1. Value must be
Type of Claim List (VVL)
2. Value must be 1 character
3. Mandatory
4. When value equals 'Z', claim denied indicator must equal '0'

COT041|COT.002.041|SOURCE-LOCATION|Source Location|Mandatory|The field denotes th
claims payment system from which the claim was extracted.
For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated netwo
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 t
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-capitation payments, report a SOURCE-LOCATION of '20', indicating the managed c
plan is the source of payment.
|SOURCE-LOCATION|COT00002|CLAIM-HEADER-RECORD-OT|X(2)|20|203|204|1. Value mus
in Source Location List (VVL)
2. Value must be 2 characters
3. Mandatory

COT048|COT.002.048|TOT-BILLED-AMT|Total Billed Amount|Conditional|The total amount b
for this claim at the claim header level as submitted by the provider. For encounter record
when Type of Claim value is in [3, C, W], then value must equal amount the provider billed
the managed care plan. For sub-capitated encounters from a sub-capitated entity that is n
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-capi
network provider. For sub-capitated encounters from a sub-capitated network provider, if t
sub-capitated network provider directly employs the provider that renders the service to th
enrollee, report a null value in this field.
|N/A|COT00002|CLAIM-HEADER-RECORD-OT|S9(11)V99|27|248|260|1. Value must be betwe
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

COT050|COT.002.050|TOT-MEDICAID-PAID-AMT|Total Medicaid Paid Amount|Conditional|Th
total amount paid by Medicaid/CHIP or the managed care plan on this claim or adjustment
the claim header level, which is the sum of the amounts paid by Medicaid or the managed
plan at the detail level for the claim.
For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated netwo
provider, report the total amount that the sub-capitated entity paid the provider for the se
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, re
a null value in this field.
For sub-capitation payments, this represents the amount paid by the managed care plan t
sub-capitated entity.
|N/A|COT00002|CLAIM-HEADER-RECORD-OT|S9(11)V99|29|274|286|1. Value must be betwe
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 reporte
must equal Total Medicaid Paid Amount
5. When Payment Level Indicator equals '2', value must equal the sum of line level Medica
Paid Amounts.
6. Conditional
7. Value must not be greater than Total Allowed Amount (COT.002.049)

COT057|COT.002.057|OTHER-INSURANCE-IND|Other Insurance Indicator|Conditional|The fi
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)|34|339|339|1. Value
be 1 character
2. Value must be in [0, 1] or not populated
3. Value must be in Other Insurance Indicator List (VVL)
4. Conditional

COT062|COT.002.062|FUNDING-CODE|Funding Code|Conditional|A code to indicate the sou
of non-federal share funds.
|FUNDING-CODE|COT00002|CLAIM-HEADER-RECORD-OT|X(2)|37|344|345|1. Value must be
Funding Code List (VVL)
2. Value must be 1 character
3. Value must be populated if TYPE-OF-CLAIM equals ‘3', ‘C’, ‘W’, or '6’
4. Conditional

COT063|COT.002.063|FUNDING-SOURCE-NONFEDERAL-SHARE|Funding Source Non-Federa
Share|Conditional|A code to indicate the type of non-federal share used by the state to fina
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)|38|3
347|1. Value must be in Funding Source Non-Federal Share List (VVL)
2. Value must be 2 characters
3. Value must be populated if TYPE-OF-CLAIM equals ‘3', ‘C’, ‘W’, or '6’
4. Conditional

COT066|COT.002.066|PLAN-ID-NUMBER|Plan ID Number|Conditional|A unique number assi
by the state which represents a distinct comprehensive managed care plan, prepaid healt
plan, primary care case management program, a program for all-inclusive care for the elde
entity, or other approved plans.
For sub-capitated encounters from a sub-capitated entity or sub-capitated network provide
report the PLAN-ID-NUMBER for the MCP (MCO, PIHP, or PAHP that has a contract with a sta
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, re
a null value in this field.
|N/A|COT00002|CLAIM-HEADER-RECORD-OT|X(12)|41|351|362|1. Value must be 12 charact
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 in [3, C, W] value must have a managed care enrollment (ELG.014)
the beneficiary where the Beginning DOS (CLT.002.048) occurs between the managed care
plan enrollment eff/end dates (ELG.014.197/198).
7. When Type of Claim in [3, C, W] value must have a managed care main record (MCR.00
the plan where the Beginning DOS (CLT.002.048) occurs between the managed care contr
eff/end dates (MCR.002.020/021).

COT070|COT.002.070|CLAIM-LINE-COUNT|Claim Line Count|Mandatory|The total number o
lines on the claim.|N/A|COT00002|CLAIM-HEADER-RECORD-OT|9(4)|44|366|369|1. Value m
be a positive integer
2. Value must be between 0:9999 (inclusive)
3. Value must not include commas or other non-numeric characters
4. 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

COT109|COT.002.109|HEALTH-HOME-PROV-IND|Health Home Provider Indicator|Conditiona
Indicates whether the claim is submitted by a provider or provider group enrolled in the He
Home care model to provide services for the beneficiary on the claim. Health home provid
provide service for patients with chronic illnesses. 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
the health home model.|HEALTH-HOME-PROV-IND|COT00002|CLAIM-HEADER-RECORD-OT|X
82|641|641|1. Value must be in Health Home Provider Indicator List (VVL)
2. Value must be 1 character
3. Value must be in [0, 1] or not populated
4. If there is an associated Health Home Entity Name value, then value must be "1"
5. Value must be 1 character
6. Conditional

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, ful
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)|84|644|663|1. Value must be associated with
populated Waiver Type
2. Value must be 20 characters or less
3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associated Cl
Waiver Type value must be 01 or in [21-30]
4. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation follow
by a period (.), the associated Claim Waiver Type value must be in [02-20, 32, 33]
5. Conditional

COT112|COT.002.112|BILLING-PROV-NUM|Billing Provider Number|Conditional|A unique identification number assigned by the state to a provider or managed care plan. This data element should represent the entity billing for the service. For encounter records, if associ Type of Claim value equals 3, C, or W, then value must be the state identifier of the provid entity (billing or reporting) to the managed care plan.|N/A|COT00002|CLAIM-HEADER-RECO OT|X(30)|85|664|693|1. Value must be 30 characters or less.
2. Conditional
3. When Type of Claim not in ['3','C','W'] then value may match (PRV.002.019) Submitting Provider ID or
4. When Type of Claim not in ['3','C','W'] then value may match (PRV.005.081) Provider Identifier where the Provider Identifier.
5. Must have an enrollment where the Ending Date of Service (COT.003.167) may be betw 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 betw Provider Identifier Effective Date (PRV.005.079) and Provider Identifier End Date (PRV.005.
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|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 l admitting provider except for Long Term Care.
For sub-capitation payments, report the national provider identifier (NPI) for the sub-capita entity if the provider has one.
|N/A|COT00002|CLAIM-HEADER-RECORD-OT|X(10)|86|694|703|1. Value must be 10 digits, consisting of 9 numeric digits followed by one check digit calculated using the Luhn formul (algorithm)
2. Value must have an associated Provider Identifier Type equal to '2'
3. Conditional
4. When Type of Claim (COT.002.037) not in ('3','C','W') then value must match Provider Identifier (PRV.002.081)

COT114|COT.002.114|BILLING-PROV-TAXONOMY|Billing Provider Taxonomy|Conditional|Th taxonomy code for the provider billing for the service.
|PROV-TAXONOMY|COT00002|CLAIM-HEADER-RECORD-OT|X(12)|87|704|715|1. Value must 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

COT118|COT.002.118|REFERRING-PROV-NPI-NUM|Referring Provider NPI Number|Condition
The National Provider ID (NPI) of the provider who recommended the servicing provider to
patient.|N/A|COT00002|CLAIM-HEADER-RECORD-OT|X(10)|91|750|759|1. Value must be 10
digits, consisting of 9 numeric digits followed by one check digit calculated using the Luhn
formula (algorithm)
2. Value must have an associated Provider Identifier Type equal to '2'
3. Conditional

COT146|COT.002.146|HEALTH-HOME-PROVIDER-NPI|Health Home Provider NPI Number|
Conditional|The National Provider ID (NPI) of the health home provider.|N/A|COT00002|CLA
HEADER-RECORD-OT|X(10)|110|969|978|1. Value must be 10 digits, consisting of 9 numeri
digits followed by one check digit calculated using the Luhn formula (algorithm)
2. Value must have an associated Provider Identifier Type equal to '2'
3. Conditional
4. When Type of Service (COT.003.186) equals '121', value must not be populated

COT236|COT.002.236|BILLING-PROV-ADDR-LINE-1|Billing Provider Address Line 1|Mandato
Billing provider address line 1 from X12 837I, 837P, and 837D loop 2010AA.|N/A|COT0000
CLAIM-HEADER-RECORD-OT|X(60)|118|1061|1120|1. Value must not be more than 60
characters long
2. Mandatory

COT237|COT.002.237|BILLING-PROV-ADDR-LINE-2|Billing Provider Address Line 2|Condition
Billing provider address line 2 from X12 837I, 837P, and 837D loop 2010AA.|N/A|COT0000
CLAIM-HEADER-RECORD-OT|X(60)|119|1121|1180|1. Value must not be more than 60
characters long
2. Conditional

COT238|COT.002.238|BILLING-PROV-ADDR-CITY-NAME|Billing Provider Address City Name|
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 n
more than 28 characters long
2. Mandatory

COT239|COT.002.239|BILLING-PROV-ADDR-STATE-CODE|Billing Provider Address State Cod
Mandatory|Billing provider address state code from X12 837I, 837P, and 837D loop 2010AA
N/A|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-ADDR-ZIP-CODE|Billing Provider Address ZIP Code|
Mandatory|Billing provider address ZIP code from X12 837I, 837P, and 837D loop 2010AA.|
COT00002|CLAIM-HEADER-RECORD-OT|X(9)|122|1211|1219|1. Value must contain a string
either 5 or 9 numeric values
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 2
or 837P and 837D loop 2310C.|N/A|COT00002|CLAIM-HEADER-RECORD-OT|X(10)|123|1220
1229|1. Value must contain a sting of 10 numeric values.
2. Value must be in NPPES (external reference).
3. Conditional

COT242|COT.002.242|SERVICE-FACILITY-LOCATION-ADDR-LINE-1|Service Facility Location
Address Line 1|Conditional|Service facility location address line 1 from X12 837I loop 2310
837P and 837D loop 2310C.|N/A|COT00002|CLAIM-HEADER-RECORD-OT|X(60)|124|1230|12
1. Value must not be more than 60 characters long.
2. Conditional

COT243|COT.002.243|SERVICE-FACILITY-LOCATION-ADDR-LINE-2|Service Facility Location
Address Line 2|Conditional|Service facility location address line 2 from X12 837I loop 2310
837P and 837D loop 2310C.|N/A|COT00002|CLAIM-HEADER-RECORD-OT|X(60)|125|1290|13
1. Value must not be more than 60 characters long.
2. Conditional

COT244|COT.002.244|SERVICE-FACILITY-LOCATION-ADDR-CITY-NAME|Service Facility Locat
Address City Name|Conditional|Service facility location address city name from X12 837I lo
2310E or 837P and 837D loop 2310C.|N/A|COT00002|CLAIM-HEADER-RECORD-OT|X(28)|12
1350|1377|1. Value must not be more than 28 characters long.
2. Conditional

COT245|COT.002.245|SERVICE-FACILITY-LOCATION-ADDR-STATE-CODE|Service Facility Loc
Address State Code|Conditional|Service facility location address state code from X12 837I
2310E or 837P and 837D loop 2310C.|N/A|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-ADDR-ZIP-CODE|Service Facility Locati
Address ZIP Code|Conditional|Service facility location address ZIP code from X12 837I loop
2310E or 837P and 837D loop 2310C.|N/A|COT00002|CLAIM-HEADER-RECORD-OT|X(9)|128
1380|1388|1. Value must contain a string of either 5 or 9 numeric values.
2. Value must be in ZIP Code list (VVL).
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,
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 u
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

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
header of their claim.|N/A|COT00002|CLAIM-HEADER-RECORD-OT|X(10)|133|1484|1493|1.
Value must be 10 digits, consisting of 9 numeric digits followed by one check digit calculat
using the Luhn formula (algorithm)
2. Value must have an associated Provider Identifier Type equal to '2'
3. Conditional

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
|N/A|COT00003|CLAIM-LINE-RECORD-OT|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less.

COT159|COT.003.159|ICN-ADJ|Adjustment ICN|Conditional|A unique claim number assigne 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 0, then value must not be populated
4. Conditional

COT169|COT.003.169|PROCEDURE-CODE|Procedure Code|Conditional|A field to capture th or HCPCS code that describes a service or good rendered by the provider to an enrollee on specified date of service.
|N/A|COT00003|CLAIM-LINE-RECORD-OT|X(8)|16|187|194|1. When populated, there must b corresponding Procedure Code Flag
2. If associated Procedure Code Flag List (VVL) value indicates an CPT-4 encoding '01', the value must be a valid CPT-4 procedure code
3. If associated Procedure Code Flag List (VVL) value indicates an 'Other' encoding '10-87', State must provide T-MSIS system with State-specific procedure code list, and value must valid State-specific procedure code
4. If associated Procedure Code Flag List (VVL) value indicates an HCPCS encoding '06', the value must be a valid HCPCS code
5. Value must be 8 characters or less
6. Value must be in Procedure Code List (VVL)
7. Conditional

COT172|COT.003.172|PROCEDURE-CODE-MOD-1|Procedure Code Modifier 1|Conditional|Th
procedure code modifier used with an associated procedure code. For example, some stat
use modifiers to indicate assistance in surgery or anesthesia services.|N/A|COT00003|CLAI
LINE-RECORD-OT|X(2)|19|205|206|1. Must be associated with a Procedure Code
2. Value must be 2 characters
3. Value must be in Procedure Code Mod List (VVL)
4. Conditional

COT178|COT.003.178|MEDICAID-PAID-AMT|Medicaid Paid Amount|Conditional|The amount
by Medicaid/CHIP agency or the managed care plan on this claim or adjustment at the clai
detail level.
For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated netwo
provider, report the amount that the sub-capitated entity paid the provider at the claim lin
detail level. Report a null value in this field if the provider is a sub-capitated network provi
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, re
a null value in this field.
|N/A|COT00003|CLAIM-LINE-RECORD-OT|S9(11)V99|24|259|271|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

COT186|COT.003.186|TYPE-OF-SERVICE|Type of Service|Mandatory|A code to categorize th
services provided to a Medicaid or CHIP enrollee.
|TYPE-OF-SERVICE|COT00003|CLAIM-LINE-RECORD-OT|X(3)|29|320|322|1. Value must be 3
characters.
2. Mandatory
3. Value must be in ['002', '003', '004', '005', '006', '007', '008', '010', '011', '012', '013', '0
'015', '016', '017', '018', '019', '020', '021', '022', '023', '024', '025', '026', '027', '028', '029
'030', '031', '032', '035', '036', '037', '038', '039', '040', '041', '042', '043', '049', '050', '051
'052', '053', '054', '055', '056', '057', '058', '060', '061', '062', '063', '064', '065', '066', '067
'068', '069', '070', '071', '072', '073', '074', '075', '076', '077', '078', '079', '080', '081', '082
'083', '084', '085', '086', '087', '088', '089', '115','127', '136', '137', '144', '145', '147'].
4. Value must be 3 characters.
5. When value is not in ['025','085'], Sex (ELG.002.023) equals 'M'.

COT190|COT.003.190|SERVICING-PROV-NPI-NUM|Servicing Provider NPI Number|Conditiona
The NPI of the health care professional who delivers or completes a particular medical serv
or non-surgical procedure. The SERVICING-PROV-NPI-NUM is required when rendering prov
is different than the attending provider and state or federal regulatory requirements call fo
"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-L
RECORD-OT|X(10)|33|359|368|1. Value must be 10 digits, consisting of 9 numeric digits
followed by one check digit calculated using the Luhn formula (algorithm)
2. Value must have an associated Provider Identifier Type equal to '2'
3. Conditional
4. When Type of Claim (COT.002.037) not in ('3','C','W') then value must match Provider
Identifier (PRV.005.081)

COT203|COT.003.203|ORIGINATION-ZIP-CODE|Origination ZIP Code|Conditional|The zip cod
the origination city 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.|N/A|COT00003|CLAI
LINE-RECORD-OT|X(9)|46|545|553|1. Value may only be 5 digits (0-9) (Example: 91320) or
digits (0-9) (Example: 913200011)
2. Conditional

COT208|COT.003.208|DESTINATION-ZIP-CODE|Destination ZIP Code|Conditional|The zip co
the destination city to which a patient is transported either from home or long term care fa
to a health care provider for healthcare services or vice versa. For transportation claims or
Required if state has captured this information, otherwise it is conditional.|N/A|COT00003|
CLAIM-LINE-RECORD-OT|X(9)|51|704|712|1. Value may only be 5 digits (0-9) (Example: 913
or 9 digits (0-9) (Example: 913200011)
2. Conditional

COT210|COT.003.210|CATEGORY-FOR-FEDERAL-REIMBURSEMENT|Category for Federal
Reimbursement|Conditional|A code to indicate the Federal funding source for the payment
CATEGORY-FOR-FEDERAL-REIMBURSEMENT|COT00003|CLAIM-LINE-RECORD-OT|X(2)|52|71
714|1. Value must be in Category for Federal Reimbursement List (VVL).
2. Value must be 2 characters.
3. (Federal Funding under Title XXI) if value equals '02', then the eligible's CHIP Code
(ELG.003.054) must be in ['2', '3'].
4. (Federal Funding under Title XIX) if value equals '01' then the eligible's CHIP Code
(ELG.003.054) must be '1'.
5. Conditional
6. If Type of Claim is in ['1','A','U'] and the Total Medicaid Paid Amount is populated on the
corresponding claim header, then value must be reported.

COT218|COT.003.218|PROCEDURE-CODE-MOD-3|Procedure Code Modifier 3|Conditional|Th
procedure code modifier used with an associated procedure code. For example, some stat
use modifiers to indicate assistance in surgery or anesthesia services.|N/A|COT00003|CLAI
LINE-RECORD-OT|X(2)|56|742|743|1. Must be associated with a Procedure Code
2. Value must be 2 characters
3. Value must be in Procedure Code Mod List (VVL)
4. Conditional

COT219|COT.003.219|PROCEDURE-CODE-MOD-4|Procedure Code Modifier 4|Conditional|Th
procedure code modifier used with an associated procedure code. For example, some stat
use modifiers to indicate assistance in surgery or anesthesia services.|N/A|COT00003|CLAI
LINE-RECORD-OT|X(2)|57|744|745|1. Must be associated with a Procedure Code
2. Value must be 2 characters
3. Value must be in Procedure Code Mod List (VVL)
4. Conditional

COT227|COT.003.227|PROCEDURE-CODE-MOD-2|Procedure Code Modifier 2|Conditional|Th
procedure code modifier used with an associated procedure code. For example, some stat
use modifiers to indicate assistance in surgery or anesthesia services.|N/A|COT00003|CLAI
LINE-RECORD-OT|X(2)|55|740|741|1. Must be associated with a Procedure Code
2. Value must be 2 characters
3. Value must be in Procedure Code Mod List (VVL)
4. Conditional

COT234|COT.003.234|IHS-SERVICE-IND|IHS Service Indicator|Mandatory|To indicate Servic
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 [0, 1]
3. Mandatory

COT256|COT.003.256|MBESCBES-CATEGORY-OF-SERVICE|MBES or CBES Category of Servi
Conditional|A code indicating the category of service for the paid claim. The category of se
is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM
21, 64.9 WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS) that states use to report
expenditures and request federal financial participation.|MBESCBES-CATEGORY-OF-SERVIC
(XIX), MBESCBES-CATEGORY-OF-SERVICE (XXI)|COT00003|CLAIM-LINE-RECORD-OT|X(5)|69
884|1. Value must not be more than 5 characters
2. Value must be in MBES or CBES Category of Service Code List (VVL)
3. Value must be populated on all FFS claim lines with a paid amount greater than $0
4. Conditional

COT257|COT.003.257|MBESCBES-FORM|MBES or CBES Form|Conditional|The MBES or CBES
form to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, 6
WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS). This should be determined by th
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.|MBESCBE
FORM|COT00003|CLAIM-LINE-RECORD-OT|X(50)|70|885|934|1. Value must be 50 character
less
2. Value must be in MBES or CBES Form Code List (VVL)
3. Value must be populated on all FFS claim lines with a paid amount greater than $0
4. Conditional

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)|71|935|944|1. Value must contain a sting of 10 numeric values.
2. Value must be in NPPES (external reference).
3. Conditional

COT259|COT.003.259|SERVICE-FACILITY-LOCATION-ADDR-LINE-1|Service Facility Location Address Line 1|Conditional|Service facility location address line 1 from X12 837P loop 2420 and 837D loop 2420D.|N/A|COT00003|CLAIM-LINE-RECORD-OT|X(60)|72|945|1004|1. Value must not be more than 60 characters long.
2. Conditional

COT260|COT.003.260|SERVICE-FACILITY-LOCATION-ADDR-LINE-2|Service Facility Location Address Line 2|Conditional|Service facility location address line 2 from X12 837P loop 2420 and 837D loop 2420D.|N/A|COT00003|CLAIM-LINE-RECORD-OT|X(60)|73|1005|1064|1. Valu must not be more than 60 characters long.
2. Conditional

COT261|COT.003.261|SERVICE-FACILITY-LOCATION-ADDR-CITY-NAME|Service Facility Locat Address City Name|Conditional|Service facility location address city name from X12 837P l 2420C and 837D loop 2420D.|N/A|COT00003|CLAIM-LINE-RECORD-OT|X(28)|74|1065|1092 Value must not be more than 28 characters long.
2. Conditional

COT262|COT.003.262|SERVICE-FACILITY-LOCATION-ADDR-STATE-CODE|Service Facility Loc Address State Code|Conditional|Service facility location address state code from X12 837P 2420C and 837D loop 2420D.|N/A|COT00003|CLAIM-LINE-RECORD-OT|X(2)|75|1093|1094|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-ADDR-ZIP-CODE|Service Facility Locati
Address ZIP Code|Conditional|Service facility location address ZIP code from X12 837P loop
2420C and 837D loop 2420D.|N/A|COT00003|CLAIM-LINE-RECORD-OT|X(9)|76|1095|1103|1
Value must contain a string of either 5 or 9 numeric values.
2. Value must be in ZIP Code list (VVL).
3. Conditional

COT266|COT.003.266|REFERRING-PROV-NUM-1|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,
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 u
the DEA ID for this data element.|N/A|COT00003|CLAIM-LINE-RECORD-OT|X(30)|79|1119|11
1. Value must be 30 characters or less
2. Conditional

COT267|COT.003.267|REFERRING-PROV-NPI-NUM-1|Referring Provider NPI Number|Conditi
The National Provider ID (NPI) of the provider who recommended the servicing provider to
patient.|N/A|COT00003|CLAIM-LINE-RECORD-OT|X(10)|80|1149|1158|1. Value must be 10 c
consisting of 9 numeric digits followed by one check digit calculated using the Luhn formul
(algorithm)
2. Value must have an associated Provider Identifier Type equal to '2'
3. Conditional

COT268|COT.003.268|REFERRING-PROV-NUM-2|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,
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 u
the DEA ID for this data element. 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(30)|81|11
1188|1. Value must be 30 characters or less
2. Conditional

COT269|COT.003.269|REFERRING-PROV-NPI-NUM-2|Referring Provider NPI Number|Conditi
The National Provider ID (NPI) of the provider who recommended the servicing provider to
patient. This is only applicable when a provider reports a second referral at the line/detail
their claim.|N/A|COT00003|CLAIM-LINE-RECORD-OT|X(10)|82|1189|1198|1. Value must be
digits, consisting of 9 numeric digits followed by one check digit calculated using the Luhn
formula (algorithm)
2. Value must have an associated Provider Identifier Type equal to '2'
3. Conditional

COT271|COT.003.271|ORDERING-PROV-NPI-NUM|Ordering Provider NPI Number|Conditiona
NPI of Ordering Provider represents the individual who requested the service or items bein
reported on this service line. Example include, but are not limited to, provider ordering
diagnostic tests and medical equipment or supplies.|N/A|COT00003|CLAIM-LINE-RECORD-C
X(10)|84|1229|1238|1. Value must be 10 digits, consisting of 9 numeric digits followed by
check digit calculated using the Luhn formula (algorithm)
2. Value must have an associated Provider Identifier Type equal to '2'
3. Conditional

N/A

COT274|COT.004.274|RECORD-ID|Record ID|Mandatory|The Record ID represents the type
segment being reported. The Record ID communicates how the contents of a given row of
should be interpreted depending on which segment type the Record ID represents. Each t
of segment collects different data elements so each segment type has a distinct layout. Th
first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th
segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).|N/A|COT0
CLAIM-DX-OT|X(8)|1|1|8|1. Mandatory
2. Value must be 8 characters
3. Value must be in Record ID List (VVL)

COT278|COT.004.278|ICN-ADJ|Adjustment ICN|Conditional|A unique claim number assigne
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 o
2. Value must not contain a pipe or asterisk symbols
3. Conditional

COT279|COT.004.279|ADJUSTMENT-IND|Adjustment Indicator|Mandatory|Indicates the type
adjustment record.|LINE-ADJUSTMENT-IND|COT00004|CLAIM-DX-OT|X(1)|6|122|122|1. Valu
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 [
4]
3. If associated Type of Claim value is '4, D, X', then value must be in [5, 6]
4. Value must be 1 character
5. Mandatory

COT282|COT.004.282|DIAGNOSIS-SEQUENCE-NUMBER|Diagnosis Sequence Number|Manda
The order in which the diagnosis occurred on the provider's claim for a given type of diagn
code (e.g., an 837P claim can have up to 12 external cause of injury diagnosis codes and u
24 other diagnosis codes).|N/A|COT00004|CLAIM-DX-OT|9(2)|9|132|133|1. Value must be
between 1 and 24
2. Mandatory

CRX002|CRX.001.002|DATA-DICTIONARY-VERSION|Data Dictionary Version|Mandatory|A da
element to capture the version of the T-MSIS data dictionary that was used to build the file
the version number specified on the Cover Sheet of the data dictionary".|DATA-DICTIONAR
VERSION|CRX00001|FILE-HEADER-RECORD-RX|X(10)|2|9|18|1. Value must be 10 character
less
2. Value must not include the pipe ("|") symbol
3. Mandatory

CRX006|CRX.001.006|FILE-NAME|File Name|Mandatory|A code to identify the subject area
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 C
Plan Information,
Inpatient, Long-Term Care, Other, and Pharmacy Claim).|FILE-NAME|CRX00001|FILE-HEADE
RECORD-RX|X(8)|6|32|39|1. Value must equal 'CLAIM-RX'
2. Mandatory

CRX020|CRX.002.020|ICN-ADJ|Adjustment ICN|Conditional|A unique claim number assigned
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 5
characters or less
2. Value must not contain a pipe or asterisk symbols
3. If associated Adjustment Indicator value is 0, then value must not be populated
4. Conditional

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident
MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity
data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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-blog/entry/4757
|N/A|CRX00002|CLAIM-HEADER-RECORD-RX|X(20)|7|134|153|1. Mandatory
2. Value must be 20 characters or less
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|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. Value m
be in Crossover Indicator List (VVL)
2. Value must be 1 character
3. Value must be in [0, 1] or not populated
4. If Crossover Indicator value is "1", the associated Dual Eligible Code (ELG.005.085) valu
must be in "01", "02", "04", "08", "09", or "10" for the same time period (by date of service
5. Value must be 1 character
6. Mandatory

CRX025|CRX.002.025|ADJUSTMENT-IND|Adjustment Indicator|Mandatory|Indicates the type
adjustment record.
|ADJUSTMENT-IND|CRX00002|CLAIM-HEADER-RECORD-RX|X(1)|10|156|156|1. Value must b
Adjustment Indicator List (VVL).
2. Value must be in [0, 1, 4].
3. Value must be 1 character.
4. Mandatory

CRX029|CRX.002.029|TYPE-OF-CLAIM|Type of Claim|Mandatory|A code to indicate what typ
payment is covered in this claim.
For sub-capitated encounters from a sub-capitated entity or sub-capitated network provide
report TYPE-OF-CLAIM = '3' for a Medicaid sub-capitated encounter record or “C” for an S-C
sub-capitated encounter record.
|TYPE-OF-CLAIM|CRX00002|CLAIM-HEADER-RECORD-RX|X(1)|14|176|176|1. Value must be
Type of Claim List (VVL)
2. Value must be 1 character
3. Mandatory
4. When value equals 'Z', claim denied indicator must equal '0'

CRX032|CRX.002.032|SOURCE-LOCATION|Source Location|Mandatory|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 netwo
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 t
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. Value must
in Source Location List (VVL)
2. Value must be 2 characters
3. Mandatory

CRX041|CRX.002.041|TOT-MEDICAID-PAID-AMT|Total Medicaid Paid Amount|Conditional|Th
total amount paid by Medicaid/CHIP or the managed care plan on this claim or adjustment
the claim header level, which is the sum of the amounts paid by Medicaid or the managed
plan at the detail level for the claim.
For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated netwo
provider, report the total amount that the sub-capitated entity paid the provider for the se
Report a null value in this field if the provider is a sub-capitated network provider.
For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated netwo
provider, report the total amount that the sub-capitated entity paid the provider for the se
Report a null value in this field if the provider is a sub-capitated network provider.

|N/A|CRX00002|CLAIM-HEADER-RECORD-RX|S9(11)V99|26|254|266|1. Value must be betwe
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 reporte
must equal Total Medicaid Paid Amount
5. When Payment Level Indicator equals '2', value must equal the sum of line level Medica
Paid Amounts.
6. Conditional

CRX048|CRX.002.048|OTHER-INSURANCE-IND|Other Insurance Indicator|Conditional|The fi
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)|31|319|319|1. Value
be 1 character
2. Value must be in [0, 1] or not populated
3. Value must be in Other Insurance Indicator List (VVL)
4. Conditional

CRX053|CRX.002.053|FUNDING-CODE|Funding Code|Conditional|A code to indicate the sou
of non-federal share funds.
|FUNDING-CODE|CRX00002|CLAIM-HEADER-RECORD-RX|X(2)|34|324|325|1. Value must be
Funding Code List (VVL)
2. Value must be 1 character
3. Value must be populated if TYPE-OF-CLAIM equals ‘3', ‘C’, ‘W’, or '6’
4. Conditional

CRX054|CRX.002.054|FUNDING-SOURCE-NONFEDERAL-SHARE|Funding Source Non-Federa
Share|Conditional|A code to indicate the type of non-federal share used by the state to fina
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)|35|3
327|1. Value must be in Funding Source Non-Federal Share List (VVL)
2. Value must be 2 characters
3. Value must be populated if TYPE-OF-CLAIM equals ‘3', ‘C’, ‘W’, or '6’
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)|40|345|348|1. Value m
be a positive integer
2. Value must be between 0:9999 (inclusive)
3. Value must not include commas or other non-numeric characters
4. 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

CRX067|CRX.002.067|HEALTH-HOME-PROV-IND|Health Home Provider Indicator|Conditiona
Indicates whether the claim is submitted by a provider or provider group enrolled in the He
Home care model to provide services for the beneficiary on the claim. Health home provid
provide service for patients with chronic illnesses. 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
the health home model.|HEALTH-HOME-PROV-IND|CRX00002|CLAIM-HEADER-RECORD-RX|X
47|439|439|1. Value must be in Health Home Provider Indicator List (VVL)
2. Value must be 1 character
3. Value must be in [0, 1] or not populated
4. If there is an associated Health Home Entity Name value, then value must be "1"
5. Value must be 1 character
6. Conditional

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, ful 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)|49|442|461|1. Value must be associated with populated Waiver Type
2. Value must be 20 characters or less
3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associated Cl Waiver Type value must be 01 or in [21-30]
4. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation follow by a period (.), the associated Claim Waiver Type value must be in [02-20, 32, 33]
5. Conditional

CRX070|CRX.002.070|BILLING-PROV-NUM|Billing Provider Number|Conditional|A unique identification number assigned by the state to a provider or managed care plan. This data element should represent the entity billing for the service. For encounter records, if associ Type of Claim value equals 3, C, or W, then value must be the state identifier of the provid entity (billing or reporting) to the managed care plan.|N/A|CRX00002|CLAIM-HEADER-RECO RX|X(30)|50|462|491|1. Value must be 30 characters or less.
2. Conditional
3. When Type of Claim not in ('3','C','W') then value may match (PRV.002.019) Submitting Provider ID or
4. When Type of Claim not in ('3','C','W') then value may match (PRV.005.081) Provider Identifier where the Provider Identifier.
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).

CRX071|CRX.002.071|BILLING-PROV-NPI-NUM|Billing Provider NPI Number|Conditional|The National Provider ID (NPI) of the billing provider responsible for billing for the service on th 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)|51|492|501|1. Value must be 10 digits, consisting of 9 numeric digits followed by on check digit calculated using the Luhn formula (algorithm)
2. Value must have an associated Provider Identifier Type equal to '2'
3. Conditional
4. When Type of Claim not in ('3','C','W') then value must match Provider Identifier (PRV.002.081)

CRX075|CRX.002.075|PRESCRIBING-PROV-NPI-NUM|Prescribing Provider NPI Number| Mandatory|The National Provider ID (NPI) of the provider who prescribed a medication to a patient.|N/A|CRX00002|CLAIM-HEADER-RECORD-RX|X(10)|55|546|555|1. Value must be 10 digits, consisting of 9 numeric digits followed by one check digit calculated using the Luhn formula (algorithm)
2. Value must have an associated Provider Identifier Type equal to '2'
3. Mandatory

CRX102|CRX.002.102|DISPENSING-PRESCRIPTION-DRUG-PROV-NPI|Dispensing Prescription Drug Provider NPI Number|Mandatory|The National Provider ID (NPI) of the provider respon for dispensing the prescription drug.|N/A|CRX00002|CLAIM-HEADER-RECORD-RX|X(10)|75|7 782|1. Value must be 10 digits, consisting of 9 numeric digits followed by one check digit calculated using the Luhn formula (algorithm)
2. Value must have an associated Provider Identifier Type equal to '2'
3. When Type of Claim not in ('3','C','W') then value must match Provider Identifier (PRV.005.081)
4. Mandatory

CRX104|CRX.002.104|HEALTH-HOME-PROVIDER-NPI|Health Home Provider NPI Number| Conditional|The National Provider ID (NPI) of the health home provider.|N/A|CRX00002|CLA HEADER-RECORD-RX|X(10)|76|783|792|1. Value must be 10 digits, consisting of 9 numeric digits followed by one check digit calculated using the Luhn formula (algorithm)
2. Value must have an associated Provider Identifier Type equal to '2'
3. Conditional

CRX162|CRX.002.162|PRESCRIPTION-ORIGIN-CODE|Prescription Origin Code|Conditional|Ho
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 1:4
3. Conditional

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident
MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity
data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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-blog/entry/4757
|N/A|CRX00003|CLAIM-LINE-RECORD-RX|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less.

CRX113|CRX.003.113|ICN-ADJ|Adjustment ICN|Conditional|A unique claim number assigned
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 0, then value must not be populated
4. Conditional

CRX125|CRX.003.125|MEDICAID-PAID-AMT|Medicaid Paid Amount|Conditional|The amount
by Medicaid/CHIP agency or the managed care plan on this claim or adjustment at the clai
detail level.
For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated netwo
provider, report the amount that the sub-capitated entity paid the provider at the claim lin
detail level. Report a null value in this field if the provider is a sub-capitated network provi
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, re
a null value in this field.
|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

CRX132|CRX.003.132|PRESCRIPTION-QUANTITY-ACTUAL|Prescription Quantity Actual|
Mandatory|The quantity of a drug that is dispensed for a prescription as reported by Natio
Drug Code on the claim line. For use with CLAIMOT and CLAIMRX claims. For CLAIMIP and
CLAIMLT claims/encounter records, use the Revenue Center Quantity Actual field.|N/A|
CRX00003|CLAIM-LINE-RECORD-RX|S9(9)V(9)|24|308|325|1. Value may include up to 9 dig
to the left of the decimal point, and 9 digits to the right e.g. 123456789.123456789
2. Mandatory
3. When populated, corresponding Unit of Measure must be populated

CRX133|CRX.003.133|UNIT-OF-MEASURE|Unit of Measure|Conditional|A code to indicate th
basis by which the quantity of the drug or supply is expressed.|UNIT-OF-MEASURE|CRX000
CLAIM-LINE-RECORD-RX|X(2)|25|326|327|1. Value must be in NDC Unit of Measure List (VV
2. Value must be 2 characters
3. Conditional

CRX134|CRX.003.134|TYPE-OF-SERVICE|Type of Service|Mandatory|A code to categorize th
services provided to a Medicaid or CHIP enrollee.
|TYPE-OF-SERVICE|CRX00003|CLAIM-LINE-RECORD-RX|X(3)|26|328|330|1. Value must be 3
characters
2. Mandatory
3. Value must be in ['011', '018', '033', '034', '036', '085', '089', '127', '131', '136', '137', '14

CRX149|CRX.003.149|CATEGORY-FOR-FEDERAL-REIMBURSEMENT|Category for Federal Reimbursement|Conditional|A code to indicate the Federal funding source for the payment
CATEGORY-FOR-FEDERAL-REIMBURSEMENT|CRX00003|CLAIM-LINE-RECORD-RX|X(2)|39|38
388|1. Value must be in Category for Federal Reimbursement List (VVL).
2. Value must be 2 characters.
3. (Federal Funding under Title XXI) if value equals '02', then the eligible's CHIP Code (ELG.003.054) must be in ['2', '3'].
4. (Federal Funding under Title XIX) if value equals '01' then the eligible's CHIP Code (ELG.003.054) must be '1'.
5. Conditional
6. If Type of Claim is in ['1','A','U'] and the Total Medicaid Paid Amount is populated on the corresponding claim header, then value must be reported.

CRX172|CRX.003.172|IHS-SERVICE-IND|IHS Service Indicator|Mandatory|To indicate Servic
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 [0, 1]
3. Mandatory

CRX180|CRX.003.180|MBESCBES-CATEGORY-OF-SERVICE|MBES or CBES Category of Servi
Conditional|A code indicating the category of service for the paid claim. The category of se
is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM
21, 64.9 WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS) that states use to report
expenditures and request federal financial participation.|MBESCBES-CATEGORY-OF-SERVIC
(XIX), MBESCBES-CATEGORY-OF-SERVICE (XXI)|CRX00003|CLAIM-LINE-RECORD-RX|X(5)|51
577|1. Value must not be more than 5 characters
2. Value must be in MBES or CBES Category of Service Code List (VVL)
3. Value must be populated on all FFS claim lines with a paid amount greater than $0
4. Conditional

CRX181|CRX.003.181|MBESCBES-FORM|MBES or CBES Form|Conditional|The MBES or CBES
form to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, 6
WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS). This should be determined by th
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.|MBESCBE
FORM|CRX00003|CLAIM-LINE-RECORD-RX|X(50)|52|578|627|1. Value must be 50 character
less
2. Value must be in MBES or CBES Form Code List (VVL)
3. Value must be populated on all FFS claim lines with a paid amount greater than $0
4. Conditional

CRX183|CRX.003.183|PROCEDURE-CODE-MODIFIER-1|Procedure Code Modifier 1|Condition
The first modifier associated with the procedure code (or if procedure code is missing, ther
modifier may be associated with an NDC or Unique Device Identifier).|N/A|CRX00003|CLAIM
LINE-RECORD-RX|X(2)|54|634|635|1. Value must be 2 characters.
2. Conditional

CRX184|CRX.003.184|PROCEDURE-CODE-MODIFIER-2|Procedure Code Modifier 2|Condition
The second modifier associated with the procedure code (or if procedure code is missing, t
the modifier may be associated with an NDC or Unique Device Identifier).|N/A|CRX00003|
CLAIM-LINE-RECORD-RX|X(2)|55|636|637|1. Value must be 2 characters.
2. Conditional

CRX185|CRX.003.185|PROCEDURE-CODE-MODIFIER-3|Procedure Code Modifier 3|Condition
The third modifier associated with the procedure code (or if procedure code is missing, the
modifier may be associated with an NDC or Unique Device Identifier).|N/A|CRX00003|CLAIM
LINE-RECORD-RX|X(2)|56|638|639|1. Value must be 2 characters.
2. Conditional

CRX186|CRX.003.186|PROCEDURE-CODE-MODIFIER-4|Procedure Code Modifier 4|Condition
The fourth modifier associated with the procedure code (or if procedure code is missing, th
the modifier may be associated with an NDC or Unique Device Identifier).|N/A|CRX00003|
CLAIM-LINE-RECORD-RX|X(2)|57|640|641|1. Value must be 2 characters.
2. Conditional

CRX187|CRX.003.187|PROCEDURE-CODE-MODIFIER-5|Procedure Code Modifier 5|Condition
The fifth modifier associated with the procedure code (or if procedure code is missing, ther
modifier may be associated with an NDC or Unique Device Identifier).|N/A|CRX00003|CLAIM
LINE-RECORD-RX|X(2)|58|642|643|1. Value must be 2 characters.
2. Conditional

CRX188|CRX.003.188|PROCEDURE-CODE-MODIFIER-6|Procedure Code Modifier 6|Condition
The sixth modifier associated with the procedure code (or if procedure code is missing, the
the modifier may be associated with an NDC or Unique Device Identifier).|N/A|CRX00003|
CLAIM-LINE-RECORD-RX|X(2)|59|644|645|1. Value must be 2 characters.
2. Conditional

CRX189|CRX.003.189|PROCEDURE-CODE-MODIFIER-7|Procedure Code Modifier 7|Condition
The seventh modifier associated with the procedure code (or if procedure code is missing,
the modifier may be associated with an NDC or Unique Device Identifier).|N/A|CRX00003|
CLAIM-LINE-RECORD-RX|X(2)|60|646|647|1. Value must be 2 characters.
2. Conditional

CRX190|CRX.003.190|PROCEDURE-CODE-MODIFIER-8|Procedure Code Modifier 8|Condition
The eighth modifier associated with the procedure code (or if procedure code is missing, th
the modifier may be associated with an NDC or Unique Device Identifier).|N/A|CRX00003|
CLAIM-LINE-RECORD-RX|X(2)|61|648|649|1. Value must be 2 characters.
2. Conditional

CRX191|CRX.003.191|PROCEDURE-CODE-MODIFIER-9|Procedure Code Modifier 9|Condition
The ninth modifier associated with the procedure code (or if procedure code is missing, the
the modifier may be associated with an NDC or Unique Device Identifier).|N/A|CRX00003|
CLAIM-LINE-RECORD-RX|X(2)|62|650|651|1. Value must be 2 characters
2. Conditional

CRX192|CRX.003.192|PROCEDURE-CODE-MODIFIER-10|Procedure Code Modifier 10|Condit
The tenth modifier associated with the procedure code (or if procedure code is missing, the
the modifier may be associated with an NDC or Unique Device Identifier).|N/A|CRX00003|
CLAIM-LINE-RECORD-RX|X(2)|63|652|653|1. Value must be 2 characters.
2. Conditional

N/A
CRX196|CRX.004.196|RECORD-ID|Record ID|Mandatory|The Record ID represents the type segment being reported. The Record ID communicates how the contents of a given row of should be interpreted depending on which segment type the Record ID represents. Each t of segment collects different data elements so each segment type has a distinct layout. Th first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).|N/A|CRX00 CLAIM-DX-RX|X(8)|1|1|8|1. Mandatory 2. Value must be 8 characters 3. Value must be in Record ID List (VVL)
CRX200|CRX.004.200|ICN-ADJ|Adjustment ICN|Conditional|A unique claim number assigned 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 o 2. Value must not contain a pipe or asterisk symbols 3. If associated Adjustment Indicator value is 0, then value must not be populated 4. Conditional
CRX201|CRX.004.201|ADJUSTMENT-IND|Adjustment Indicator|Mandatory|Indicates the type adjustment record.|LINE-ADJUSTMENT-IND|CRX00004|CLAIM-DX-RX|X(1)|6|122|122|1. Valu 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 [4] 3. If associated Type of Claim value is '4, D, X', then value must be in [5, 6] 4. Value must be 1 character 5. Mandatory

CRX204|CRX.004.204|DIAGNOSIS-SEQUENCE-NUMBER|Diagnosis Sequence Number|Manda
The order in which the diagnosis occurred on the provider's claim for a given type of diagn
code (e.g., an NCPDP claim can have up to 5 diagnosis codes).|N/A|CRX00004|CLAIM-DX-R
9(2)|9|132|133|1. Value must be between 1 and 24
2. Mandatory

ELG002|ELG.001.002|DATA-DICTIONARY-VERSION|Data Dictionary Version|Mandatory|A da
element to capture the version of the T-MSIS data dictionary that was used to build the file
the version number specified on the Cover Sheet of the data dictionary".|DATA-DICTIONAR
VERSION|ELG00001|FILE-HEADER-RECORD-ELIGIBILITY|X(10)|2|9|18|1. Value must be 10
characters or less
2. Value must not include the pipe ("|") symbol
3. 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 ed
rejects.|SUBMISSION-TRANSACTION-TYPE|ELG00001|FILE-HEADER-RECORD-ELIGIBILITY|X(1
19|19|1. Value must be in Submission Transaction Type List (VVL)
2. Value must be 1 character
3. Mandatory

ELG006|ELG.001.006|FILE-NAME|File Name|Mandatory|A code to identify the subject area t
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 C
Plan Information,
Inpatient, Long-Term Care, Other, and Pharmacy Claim).|FILE-NAME|ELG00001|FILE-HEADE
RECORD-ELIGIBILITY|X(8)|6|32|39|1. Value must equal 'ELIGIBLE'
2. 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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident
MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity
data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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-blog/entry/4757
|N/A|ELG00002|PRIMARY-DEMOGRAPHICS-ELIGIBILITY|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
|N/A|ELG00003|VARIABLE-DEMOGRAPHICS-ELIGIBILITY|X(20)|4|22|41|1. Mandatory
2. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individua SSN
3. Value must be 20 characters or less

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. Value must be 1 character
2. Value must be in [0, 1] or not populated
3. Value must be in Veteran Indicator List (VVL)
4. Value must be 1 character
5. Conditional
6. Value must be populated when Immigration Status (ELG.003.042) is in ['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. Va must be 1 character
2. Value must be in [0, 1, 2] or not populated
3. Value must be in Citizenship Indicator List (VVL)
4. If value is coded as '0', then associated Immigration Status (ELG.003.042) value must be [1, 2, 3]
5. If value is coded as '1', then associated Immigration Status (ELG.003.042) value must eq '8'
6. Value must be 1 character
7. Mandatory

ELG044|ELG.003.044|IMMIGRATION-STATUS-FIVE-YEAR-BAR-END-DATE|Immigration Status
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 199
(PRWORA) provides that certain immigrants who enter the United States on or after Augus
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 cou
with a status as a "qualified alien."|N/A|ELG00003|VARIABLE-DEMOGRAPHICS-ELIGIBILITY|9
15|111|118|1. Conditional
2. (U.S. Citizen) value should not be populated when Immigration Status (ELG.003.042) eq
'8'

ELG269|ELG.003.269|ELIGIBLE-FEDERAL-POVERTY-LEVEL-PERCENTAGE|Eligibile Federal Po
Level Percentage|Conditional|This data element provides the beneficiary's or their househo
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 wa
assessed using multiple methodologies (MAGI and Non-MAGI), report the income that appl
their primary eligibility group.
A beneficiary’s income is applicable unless it is not required by the eligibility group for whi
they were determined eligible. For example, the eligibility groups for children with adoptio
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
Additionally, for individuals receiving SSI, states with section 1634 agreements with the So
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 0 and 400 inclusively
2. Conditional

ELG273|ELG.003.273|APPLICATION-SIGNATURE-DATE|Application Signature Date|Condition
The date that a beneficiary signed their Medicaid or CHIP application. If the beneficiary wa
deemed eligible via an administrative determination then a signature may not be
applicable/available. |N/A|ELG00003|VARIABLE-DEMOGRAPHICS-ELIGIBILITY|9(8)|26|170|17
Value must be a valid date
2. Conditional
3. Value must be less than the VARIABLE-DEMOGRAPHIC-ELEMENT-END-DATE

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
|N/A|ELG00004|ELIGIBLE-CONTACT-INFORMATION|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

ELG071|ELG.004.071|ELIGIBLE-ZIP-CODE|Eligible ZIP Code|Mandatory|U.S. ZIP Code compo of an address associated with a given entity (e.g. person, organization, agency, etc.)|N/A| ELG00004|ELIGIBLE-CONTACT-INFORMATION|X(9)|11|254|262|1. Value may only be 5 digit 9) (Example: 91320) or 9 digits (0-9) (Example: 913200011)
2. 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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
|N/A|ELG00005|ELIGIBILITY-DETERMINANTS|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

ELG089|ELG.005.089|SSDI-IND|SSDI Indicator|Conditional|A flag indicating if the individual enrolled in Social Security Disability Insurance (SSDI) administered via the Social Security Administration (SSA).|SSDI-IND|ELG00005|ELIGIBILITY-DETERMINANTS|X(1)|10|62|62|1. Va must be 1 character
2. Value must be in [0, 1] or not populated
3. Value must be in SSDI Indicator List (VVL)
4. Value must be 1 character
5. 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)|11|63|63|1. Valu must be 1 character
2. Value must be in [0, 1] or not populated
3. Value must be in SSI Indicator List (VVL)
4. Value must be 1 character
5. Conditional
6. Value must equal '0' when SSI status (ELG.005.092) equals '000' or '003' or is not popul
7. Value must equal '1' when SSI status (ELG.005.092) equals '001' or '002'

ELG094|ELG.005.094|CONCEPTION-TO-BIRTH-IND|Conception To Birth Indicator|Conditiona flag to identify children eligible through the conception to birth option, which is available o through a separate State CHIP Program.|CONCEPTION-TO-BIRTH-IND|ELG00005|ELIGIBILIT DETERMINANTS|X(1)|15|76|76|1. Value must be in Conception to Birth Indicator List (VVL)
2. Value must be 1 character
3. Value must be in [0, 1] or not populated
4. If the value is equal to "1", then the Eligibility Group (ELG.005.087) must equal "64"
5. If the value is equal to "1", then any associated claims must indicate the Program Type '14' (State Plan CHIP)
6. If the value is equal to "1", then CHIP Code (ELG.003.054) must equal "3" (Individual wa Medicaid Expansion CHIP eligible, but was included in a separate title XXI CHIP Program)
7. Value must be 1 character
8. Conditional

ELG274|ELG.005.274|ELIGIBILITY-REDETERMINTATION-DATE|Eligibility Redetermination Da Conditional|The date by which a person's Medicaid or CHIP eligibility must be redetermine 1915(i)(1)(I), 42 CFR 435.916, 435.926, any other applicable regulations, or waiver of thes regulations. This is effectively the "expiration date" of the eligibility characteristics with wh 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 21|97|104|1. Value must be a valid date
2. Conditional
3. Value must be greater than the ELIGIBILITY-DETERMINANTS-EFF-DATE

ELG277|ELG.005.277|CONTINUOUS-ELIGIBILITY-CODE|Continuous Eligibility Code|Condition code to identify the authority used to provide continuous eligibility during the period of coverage|CONTINUOUS-ELIGIBILITY-CODE|ELG00005|ELIGIBILITY-DETERMINANTS|X(3)|24|1 160|1. Value must not be more than 3 characters
2. Value must be in Continuous Eligibility Code List (VVL)
3. Conditional

ELG281|ELG.005.281|ELIGIBILITY-TERMINATION-REASON-OTHER-TYPE-TEXT|Eligibility Termination Reason Other Type Text|Conditional|Value must be populated with a state-spe 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 less
2. Value must not be populated when Eligibility Termination Reason = 22 (Other)
3. Value must be populated when Eligibility Termination Reason <> 22 (Other)
3. Conditional

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
|N/A|ELG00006|HEALTH-HOME-SPA-PARTICIPATION-INFORMATION|X(20)|4|22|41|1. Mandat
2. Value must be 20 characters or less

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
|N/A|ELG00007|HEALTH-HOME-SPA-PROVIDERS|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
|N/A|ELG00008|HEALTH-HOME-CHRONIC-CONDITIONS|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
|N/A|ELG00009|LOCK-IN-INFORMATION|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

ELG270|ELG.009.270|LOCKED-IN-SRVCS|Locked In Services|Conditional|The type(s) of serv 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. Must be a 3 digit value from the Type-of-Service valid value list

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
|N/A|ELG00010|MFP-INFORMATION|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
|N/A|ELG00011|STATE-PLAN-OPTION-PARTICIPATION|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
|N/A|ELG00012|WAIVER-PARTICIPATION|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

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, ful 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. Value must be associated with a popu Waiver Type
2. Value must be 20 characters or less
3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associated Cl Waiver Type value must be 01 or in [21-30]
4. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation follow by a period (.), the associated Claim Waiver Type value must be in [02-20, 32, 33]
5. Value must have a corresponding value in Waiver Type (ELG.012.173)
6. 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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757 |N/A|ELG00013|LTSS-PARTICIPATION|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident
MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity
data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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-blog/entry/4757
|N/A|ELG00014|MANAGED-CARE-PARTICIPATION|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

ELG192|ELG.014.192|MANAGED-CARE-PLAN-ID|Managed Care Plan ID|Mandatory|The man
care plan identification number under which the eligible individual is enrolled.
See T-MSIS Guidance Document, "CMS Guidance: Best Practice for Reporting Managed-Car
Plan-ID in the Eligible File".
https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/4756

See T-MSIS Guidance Document, "CMS Guidance: Preliminary guidance for Primary Care Ca
Management Reporting".
https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/5289
N/A|ELG00014|MANAGED-CARE-PARTICIPATION|X(12)|5|42|53|1. Value must not contain a
or asterisk symbol
2. Value must be 12 characters or less
3. Value reported must match the value reported on State Plan Identification Number
(MCR.002.019)
4. Mandatory

ELG193|ELG.014.193|MANAGED-CARE-PLAN-TYPE|Managed Care Plan Type|Mandatory|A m
of health care delivery organized to provide a defined set of services.
See T-MSIS Guidance Document, "CMS Guidance: Best Practice for Reporting Non-Emerger
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/tmsis-blog/entry/4754
See T-MSIS Guidance Document, "CMS Guidance: Best Practice for Reporting Managed Car
Plan Type in the T-MSIS Managed Care File"
https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/4756
MANAGED-CARE-PLAN-TYPE|ELG00014|MANAGED-CARE-PARTICIPATION|X(2)|6|54|55|1. Va
must be in Managed Care Plan Type List (VVL)
2. Value must be 2 characters
3. Mandatory
4. Value must not be populated when Managed Care Plan ID (ELG.014.192) is not populate
5. Value must equal the Managed Care Plan Type (MCR.002.024) associated with the State
Identification Number (MCR.002.018)

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident
MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity
data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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-blog/entry/4757
|N/A|ELG00015|ETHNICITY-INFORMATION|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
|N/A|ELG00016|RACE-INFORMATION|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
|N/A|ELG00017|DISABILITY-INFORMATION|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
|N/A|ELG00018|1115A-DEMONSTRATION-INFORMATION|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
|N/A|ELG00020|HCBS-CHRONIC-CONDITIONS-NON-HEALTH-HOME|X(20)|4|22|41|1. Mandat
2. Value must be 20 characters or less

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
|N/A|ELG00021|ENROLLMENT-TIME-SPAN-SEGMENT|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
|N/A|ELG00022|ELG-IDENTIFIERS|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

N/A
N/A
N/A
N/A

N/A
N/A
N/A
N/A

N/A
N/A
N/A
N/A
N/A

FTX002|FTX.001.002|DATA-DICTIONARY-VERSION|Data Dictionary Version|Mandatory|A da
element to capture the version of the T-MSIS data dictionary that was used to build the file
the version number specified on the Cover Sheet of the data dictionary".|N/A|FTX00001|FIL
HEADER-RECORD-FTX|X(10)|2|9|18|1. Value must be 10 characters or less
2. Value must not include the pipe ("|") symbol
3. Mandatory

FTX006|FTX.001.006|FILE-NAME|File Name|Mandatory|A code to identify the subject area t
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 C
Plan Information,
Inpatient, Long-Term Care, Other, and Pharmacy Claim).|FILE-NAME|FTX00001|FILE-HEADE
RECORD-FTX|X(8)|6|32|39|1. Value must equal 'FINTRANS'
2. Mandatory

FTX020|FTX.002.020|ICN-ORIG|ICN Orig|Conditional|A unique item control number assigne
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
2. Value must not contain a pipe or asterisk symbols
3. If UNIQUE-TRANSACTION-ID is populated, ICN-ORIG must not be populated
4. Conditional

FTX021|FTX.002.021|ICN-ADJ|ICN Adj|Conditional|A unique claim/transaction number assig
by the state’s payment system that identifies the adjustment claim/transaction for an orig
item control number.|N/A|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(50)|5|72|121|1. Valu
must be 50 characters or less
2. Value must not contain a pipe or asterisk symbols
3. If UNIQUE-TRANSACTION-ID is populated, ICN-ADJ must not be populated
4. Conditional

FTX022|FTX.002.022|UNIQUE-TRANSACTION-ID|Unique Transaction ID|Conditional|For
transactions that are not assigned an ICN-ORIG or ICN-ADJ in the MMIS, this unique transac
ID distinguishes this transaction from all other transactions in T-MSIS.|N/A|FTX00002|
INDIVIDUAL-CAPITATION-PMPM|X(50)|6|122|171|1. Value must be 50 characters or less
2. If ICN-ORIG or ICN-ADJ are populated, UNIQUE-TRANSACTION-ID must not be populated
3. Conditional

FTX023|FTX.002.023|ADJUSTMENT-IND|Adjustment Ind|Conditional|Indicates the type of adjustment record.|ADJUSTMENT-IND|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(1)|7|172
1. Value must be 1 character
2. Value must be in ADJUSTMENT-IND list (VVL)
3. If UNIQUE-TRANSACTION-ID is populated, ADJUSTMENT-IND must not be populated
4. Conditional

FTX026|FTX.002.026|CHECK-EFF-DATE|Check Eff Date|Conditional|The date a check is issu 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)|10|194|201|1. Value must be 8 digits in the "CCYYMMDD"
2. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April or Sept 31st)
3. Must have an associated Check Number
4. Conditional

FTX028|FTX.002.028|PAYER-ID|Payer ID|Mandatory|This is the identifier that corresponds w the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking th action of either making a payment or taking a recoupment, as opposed to the payee who i object of the transaction. The payer is the entity that is either making a payment or recoup a payment from another entity or individual. The payee is the individual or entity that is ei 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)|12|217|246|1. Value must be 30 characters or less
2. If PAYER-ID-TYPE = '01' then PAYER-ID = SUBMITTING-STATE (FTX00001)
3. If PAYER-ID-TYPE = '02' then PAYER-ID = STATE-PLAN-ID-NUM (MCR00002)
4. If PAYER-ID-TYPE = '04' then PAYER-ID = SUBMITTING-STATE-PROV-ID (PRV00002)
5. Mandatory

FTX029|FTX.002.029|PAYER-ID-TYPE|Payer ID Type|Mandatory|This is a qualifier that indica what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted a submitting state code.|PAYER-ID-TYPE|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(2)|13|24 248|1. Value must be 2 characters
2. Value must be in PAYER-ID-TYPE list (VVL)
3. Mandatory

FTX033|FTX.002.033|PAYEE-ID|Payee ID|Mandatory|This is the identifier that corresponds w
the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or ent
that is either receiving a payment or having a previous payment recouped. The payee is th
object of the transaction, as opposed to the payer who is the subject taking the action of e
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)|17|451|480|1. Value must be 30 characters or less
2. If PAYEE-ID-TYPE = '01' then PAYEE-ID = SUBMITTING-STATE (FTX00001)
3. If PAYEE-ID-TYPE = '02' then PAYEE-ID = STATE-PLAN-ID-NUM (MCR00002)
4. If PAYEE-ID-TYPE = '04' or '05' then PAYEE-ID = SUBMITTING-STATE-PROV-ID (PRV0002)
6. If PAYEE-ID-TYPE = '06' then PAYEE-ID = PROV-IDENTIFIER where PROV-IDENTIFIER-TYPE
(PRV00005)
7. If PAYEE-ID-TYPE = '07' then PAYEE-ID = INSURANCE-CARRIER-ID-NUM (TPL00006)
8. If PAYER-ID-TYPE = '08' then PAYEE-ID = MSIS-IDENTIFICATION-NUM (ELG00002)
9. Mandatory

FTX034|FTX.002.034|PAYEE-ID-TYPE |Payee ID Type|Mandatory|This is a qualifier that indic
what type of ID the payee ID is. For example, if the payee ID represents a provider ID, ther
payee ID type will indicate that the payee ID should be interpreted as a provider ID.|PAYEE
TYPE |FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(2)|18|481|482|1. Value must be 2 chara
2. Value must be in PAYEE-ID-TYPE list (VVL)
3. Mandatory

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 th individual or entity that is either receiving a payment or having a previous payment recou The payee is the object of the transaction, as opposed to the payer who is the subject taki 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)|22|685|714|1. Value must be 12 character less
2. Mandatory

FTX039|FTX.002.039|PAYEE-TAX-ID-TYPE|Payee Tax ID Type|Mandatory|This is a qualifier t indicates what type of tax ID the payee tax ID is. For example, if the payee tax ID represer SSN, then the payee tax ID type will indicate that the payee tax ID should be interpreted a SSN.|PAYEE-TAX-ID-TYPE|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(2)|23|715|716|1. Valu 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 PAYE TAX-ID-TYPE was reported with a payee tax ID type of "Other".|N/A|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(100)|24|717|816|1. Value must be 100 characters or less
2. PAYEE-TAX-ID-TYPE must = '95'
3. Conditional

FTX042|FTX.002.042|MSIS-IDENTIFICATION-NUM|MSIS Identification Number|Mandatory|A s
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 da
distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for informatio
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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-blog/entry/4757
N/A|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(20)|26|917|936|1. Value must be 20 chara
or less
2. Mandatory

FTX045|FTX.002.045|CATEGORY-FOR-FEDERAL-REIMBURSEMENT|Category For Federal
Reimbursement|Conditional|A code to indicate the Federal funding source for the payment
CATEGORY-FOR-FEDERAL-REIMBURSEMENT|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(2)
953|954|1. Value must be 2 characters
2. Value must be in CATEGORY-OF-FEDERAL-REIMBURSEMENT list (VVL)
3. Value must be populated if SUBCAPITATION-IND = '01'
4. Conditional

FTX046|FTX.002.046|MBESCBES-CATEGORY-OF-SERVICE|MBES or CBES Category of Servic
Conditional|A code indicating the category of service for the paid claim. The category of se
is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM
21, 64.9 WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS) that states use to report
expenditures and request federal financial participation.|MBESCBES-CATEGORY-OF-SERVIC
(XIX), MBESCBES-CATEGORY-OF-SERVICE (XXI)|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X
30|955|959|1. Value must be in XIX-MBESCBES-CATEGORY-OF-SERVICE or XXI-MBESCBES-
CATEGORY-OF-SERVICE lists (VVLs)
2. Value must be 5 characters or less
3. Value must be populated if SUBCAPITATION-IND = '01'
4. Conditional

FTX047|FTX.002.047|MBESCBES-FORM|MBES or CBES Form|Conditional|The MBES or CBES
to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, 64.9
WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS). This should be determined by th
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.|MBESCBE
FORM|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(50)|31|960|1009|1. Value must be 50
characters or less
2. Value must be in MBES or CBES Form list (VVL)
3. Value must be populated if SUBCAPITATION-IND = '01'
4. Conditional

FTX048|FTX.002.048|MBESCBES-FORM-GROUP|MBES or CBES Form Group|Conditional|Indi
group of MBES/CBES forms that this payment applies to.|MBESCBES-FORM-GROUP|FTX000
INDIVIDUAL-CAPITATION-PMPM|X(1)|32|1010|1010|1. Value must be one character
2. Value must be in MBESCBES-FORM-GROUP list (VVL)
3. Value must be populated if SUBCAPITATION-IND = '01'
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 wa
ID number assigned during the state submission and CMS approval process. Waiver IDs sh
actually only be the "core" part of the waiver IDs, without including suffixes for renewals o
amendments.|N/A|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(20)|33|1011|1030|1. Value
be associated with a populated WAIVER-TYPE
2. Value must be 20 characters or less
3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associated Cl
Waiver Type value must be 01 or in [21-30]
4. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation follow
by a period (.), the associated Claim Waiver Type value must be in [02-20, 32, 33]
5. Value must match Eligible Waiver ID (ELG.012.172) for the enrollee for the same time p
6. Conditional

FTX051|FTX.002.051|FUNDING-CODE|Funding Code|Conditional|A code to indicate the sou
non-federal share funds.
|FUNDING-CODE|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(2)|35|1033|1034|1. Value mu
in FUNDING-CODE list (VVL)
2. Value must be 2 character
3. Value must be populated if SUBCAPITATION-IND = '01'
4. Conditional

FTX055|FTX.002.055|SPA-NUMBER|SPA Number|Conditional|State plan amendment (SPA) I
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 th
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 optional entry for specific SPA types|N/A|FTX00002|INDIVIDUAL-CAPITATION-PM
X(15)|39|1040|1054|1. Value must be 15 characters or less
2. Conditional

FTX064|FTX.003.064|RECORD-ID|Record ID|Mandatory|The Record ID represents the type o
segment being reported. The Record ID communicates how the contents of a given row of
should be interpreted depending on which segment type the Record ID represents. Each t
of segment collects different data elements so each segment type has a distinct layout. Th
first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th
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 b
exactly 8 characters
2. Value must be in RECORD-ID list (VVL)
3. Value must equal "FTX00003"
4. Mandatory

FTX067|FTX.003.067|ICN-ORIG|ICN Orig|Conditional|A unique item control number assigne
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 mu
50 characters or less
2. Value must not contain a pipe or asterisk symbols
3. If UNIQUE-TRANSACTION-ID is populated, ICN-ORIG must not be populated
4. Conditional

FTX068|FTX.003.068|ICN-ADJ|ICN Adj|Conditional|A unique claim/transaction number assig
by the state’s payment system that identifies the adjustment claim/transaction for an orig
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 UNIQUE-TRANSACTION-ID is populated, ICN-ADJ must not be populated
4. Conditional

FTX069|FTX.003.069|UNIQUE-TRANSACTION-ID|Unique Transaction ID|Conditional|For transactions that are not assigned an ICN-ORIG or ICN-ADJ in the MMIS, this unique transac ID distinguishes this transaction from all other transactions in T-MSIS.|N/A|FTX00003| INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT|X(50)|6|122|171|1. Value must be 50 characters or less
2. If ICN-ORIG or ICN-ADJ are populated, UNIQUE-TRANSACTION-ID must not be populated
3. Conditional

FTX070|FTX.003.070|ADJUSTMENT-IND|Adjustment Ind|Conditional|Indicates the type of adjustment record.|ADJUSTMENT-IND|FTX00003|INDIVIDUAL-HEALTH-INSURANCE-PREMIUM PAYMENT|X(1)|7|172|172|1. Value must be 1 character
2. Value must be in ADJUSTMENT-IND list (VVL)
3. If UNIQUE-TRANSACTION-ID is populated, ADJUSTMENT-IND must not be populated
4. Conditional

FTX075|FTX.003.075|PAYER-ID|Payer ID|Mandatory|This is the identifier that corresponds w the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking th action of either making a payment or taking a recoupment, as opposed to the payee who i object of the transaction. The payer is the entity that is either making a payment or recoup a payment from another entity or individual. The payee is the individual or entity that is ei 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)|12|217|246|1. Value must be 30 characters less
2. If PAYER-ID-TYPE = '01' then PAYER-ID = SUBMITTING-STATE (FTX00001)
3. Mandatory

FTX076|FTX.003.076|PAYER-ID-TYPE|Payer ID Type|Mandatory|This is a qualifier that indica what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted a submitting state code.|PAYER-ID-TYPE|FTX00003|INDIVIDUAL-HEALTH-INSURANCE-PREMIU PAYMENT|X(2)|13|247|248|1. Value must be 2 characters
2. Value must be in PAYER-ID-TYPE list (VVL)
3. Mandatory

FTX078|FTX.003.078|PAYEE-ID|Payee ID|Mandatory|This is the identifier that corresponds w
the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or ent
that is either receiving a payment or having a previous payment recouped. The payee is th
object of the transaction, as opposed to the payer who is the subject taking the action of e
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)|15|349|378|1. Value must be 30 characters
less
2. If PAYEE-ID-TYPE = '01' then PAYEE-ID = SUBMITTING-STATE (FTX00001)
3. If PAYEE-ID-TYPE = '02' then PAYEE-ID = STATE-PLAN-ID-NUM (MCR00002)
4. If PAYEE-ID-TYPE = '04' or '05' then PAYEE-ID = SUBMITTING-STATE-PROV-ID (PRV0002)
6. If PAYEE-ID-TYPE = '06' then PAYEE-ID = PROV-IDENTIFIER where PROV-IDENTIFIER-TYPE
(PRV00005)
7. If PAYEE-ID-TYPE = '07' then PAYEE-ID = INSURANCE-CARRIER-ID-NUM (TPL00006)
8. If PAYER-ID-TYPE = '08' then PAYEE-ID = MSIS-IDENTIFICATION-NUM (ELG00002)
9. Mandatory

FTX079|FTX.003.079|PAYEE-ID-TYPE |Payee ID Type|Mandatory|This is a qualifier that indic
what type of ID the payee ID is. For example, if the payee ID represents a provider ID, then
payee ID type will indicate that the payee ID should be interpreted as a provider ID.|PAYEE
TYPE |FTX00003|INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT|X(2)|16|379|380|1. V
must be 2 characters
2. Value must be in PAYEE-ID-TYPE list (VVL)
3. Mandatory

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 th individual or entity that is either receiving a payment or having a previous payment recou The payee is the object of the transaction, as opposed to the payer who is the subject taki 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)|18|481|510|1. Value must be 12 characters or less
2. Mandatory

FTX084|FTX.003.084|INSURANCE-CARRIER-ID-NUM|Insurance Carrier ID Num|Mandatory| The state-assigned identification number of the Third Party Liability (TPL) Entity.|N/A|FTX0 INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT|X(12)|21|613|624|1. Value must be 1 characters or less
2. Value must not contain a pipe or asterisk symbols
3. Mandatory

FTX085|FTX.003.085|INSURANCE-PLAN-ID|Insurance Plan ID|Conditional|The ID number iss 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)|22|625|644|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 s
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 da
distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for informatio
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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-blog/entry/4757
N/A|FTX00003|INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT|X(20)|23|645|664|1. V
must be 20 characters or less
2. Mandatory

FTX087|FTX.003.087|MEMBER-ID|Member ID|Conditional|Member identification number as
appears on the card issued by the TPL insurance carrier.|N/A|FTX00003|INDIVIDUAL-HEALT
INSURANCE-PREMIUM-PAYMENT|X(20)|24|665|684|1. Value must be 20 characters or less
2. Conditional

FTX091|FTX.003.091|MBESCBES-CATEGORY-OF-SERVICE|MBES or CBES Category of Servic
Mandatory|A code indicating the category of service for the paid claim. The category of se
is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM
21, 64.9 WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS) that states use to report
expenditures and request federal financial participation.|MBESCBES-CATEGORY-OF-SERVIC
(XIX), MBESCBES-CATEGORY-OF-SERVICE (XXI)|FTX00003|INDIVIDUAL-HEALTH-INSURANCE
PREMIUM-PAYMENT|X(5)|28|703|707|1. Value must be in XIX-MBESCBES-CATEGORY-OF-
SERVICE or XXI-MBESCBES-CATEGORY-OF-SERVICE lists (VVLs)
2. Value must be 5 characters or less
3. Mandatory

FTX092|FTX.003.092|MBESCBES-FORM|MBES or CBES Form|Mandatory|The MBES or CBES
to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, 64.9
WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS). This should be determined by th
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.|MBESCBE
FORM|FTX00003|INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT|X(50)|29|708|757|1.
Value must be 50 characters or less
2. Value must be in MBES or CBES Form 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 wa ID number assigned during the state submission and CMS approval process. Waiver IDs sh actually only be the "core" part of the waiver IDs, without including suffixes for renewals o amendments.|N/A|FTX00003|INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT|X(20)|3 759|778|1. Value must be associated with a populated WAIVER-TYPE
2. Value must be 20 characters or less
3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associated Cl Waiver Type value must be 01 or in [21-30]
4. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation follow by a period (.), the associated Claim Waiver Type value must be in [02-20, 32, 33]
5. Value must match Eligible Waiver ID (ELG.012.172) for the enrollee for the same time p
6. Conditional

FTX099|FTX.003.099|SPA-NUMBER|SPA Number|Conditional|State plan amendment (SPA) I 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 th 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 optional entry for specific SPA types|N/A|FTX00003|INDIVIDUAL-HEALTH-INSURA PREMIUM-PAYMENT|X(15)|36|787|801|1. Value must be 15 characters or less
2. Conditional

FTX105|FTX.004.105|RECORD-ID|Record ID|Mandatory|The Record ID represents the type o segment being reported. The Record ID communicates how the contents of a given row of should be interpreted depending on which segment type the Record ID represents. Each t of segment collects different data elements so each segment type has a distinct layout. Th first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th 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 exactly 8 characters
2. Value must be in RECORD-ID list (VVL)
3. Value must equal "FTX00004"
4. Mandatory

FTX108|FTX.004.108|ICN-ORIG|ICN Orig|Conditional|A unique item control number assigne 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. If UNIQUE-TRANSACTION-ID is populated, ICN-ORIG must not be populated 4. Conditional
FTX109|FTX.004.109|ICN-ADJ|ICN Adj|Conditional|A unique claim/transaction number assig by the state’s payment system that identifies the adjustment claim/transaction for an orig item control number.|N/A|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X(50)|5|72|12 Value must be 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If UNIQUE-TRANSACTION-ID is populated, ICN-ADJ must not be populated 4. Conditional
FTX110|FTX.004.110|UNIQUE-TRANSACTION-ID|Unique Transaction ID|Conditional|For transactions that are not assigned an ICN-ORIG or ICN-ADJ in the MMIS, this unique transac ID distinguishes this transaction from all other transactions in T-MSIS.|N/A|FTX00004|GROU INSURANCE-PREMIUM-PAYMENT|X(50)|6|122|171|1. Value must be 50 characters or less 2. If ICN-ORIG or ICN-ADJ are populated, UNIQUE-TRANSACTION-ID must not be populated 3. Conditional
FTX111|FTX.004.111|ADJUSTMENT-IND|Adjustment Ind|Conditional|Indicates the type of adjustment record.|ADJUSTMENT-IND|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X 172|172|1. Value must be 1 character 2. Value must be in ADJUSTMENT-IND list (VVL) 3. If UNIQUE-TRANSACTION-ID is populated, ADJUSTMENT-IND must not be populated 4. Conditional

FTX116|FTX.004.116|PAYER-ID|Payer ID|Mandatory|This is the identifier that corresponds w
the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking th
action of either making a payment or taking a recoupment, as opposed to the payee who i
object of the transaction. The payer is the entity that is either making a payment or recoup
a payment from another entity or individual. The payee is the individual or entity that is ei
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)|12|217|246|1. Value must be 30 characters or less
2. If PAYER-ID-TYPE = '01' then PAYER-ID = SUBMITTING-STATE (FTX00001)
3. Mandatory

FTX117|FTX.004.117|PAYER-ID-TYPE|Payer ID Type|Mandatory|This is a qualifier that indica
what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid
CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted a
submitting state code.|PAYER-ID-TYPE|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X
13|247|248|1. Value must be 2 characters
2. Value must be in PAYER-ID-TYPE list (VVL)
3. Mandatory

FTX119|FTX.004.119|PAYEE-ID|Payee ID|Mandatory|This is the identifier that corresponds w
the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or ent
that is either receiving a payment or having a previous payment recouped. The payee is th
object of the transaction, as opposed to the payer who is the subject taking the action of e
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)|15|349|378|1. Value must be 30 characters or less
2. If PAYEE-ID-TYPE = '01' then PAYEE-ID = SUBMITTING-STATE (FTX00001)
3. If PAYEE-ID-TYPE = '02' then PAYEE-ID = STATE-PLAN-ID-NUM (MCR00002)
4. If PAYEE-ID-TYPE = '04' or '05' then PAYEE-ID = SUBMITTING-STATE-PROV-ID (PRV0002)
6. If PAYEE-ID-TYPE = '06' then PAYEE-ID = PROV-IDENTIFIER where PROV-IDENTIFIER-TYPE
(PRV00005)
7. If PAYEE-ID-TYPE = '07' then PAYEE-ID = INSURANCE-CARRIER-ID-NUM (TPL00006)
8. If PAYER-ID-TYPE = '08' then PAYEE-ID = MSIS-IDENTIFICATION-NUM (ELG00002)
9. Mandatory

FTX120|FTX.004.120|PAYEE-ID-TYPE |Payee ID Type|Mandatory|This is a qualifier that indic
what type of ID the payee ID is. For example, if the payee ID represents a provider ID, ther
payee ID type will indicate that the payee ID should be interpreted as a provider ID.|PAYEE
TYPE |FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X(2)|16|379|380|1. Value must be
characters
2. Value must be in PAYEE-ID-TYPE list (VVL)
3. Mandatory

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 th
individual or entity that is either receiving a payment or having a previous payment recou
The payee is the object of the transaction, as opposed to the payer who is the subject taki
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)|18|481|510|1. Value must be 12
characters or less
2. Mandatory

FTX123|FTX.004.123|PAYEE-TAX-ID-TYPE|Payee Tax ID Type|Mandatory|This is a qualifier t
indicates what type of tax ID the payee tax ID is. For example, if the payee tax ID represer
SSN, then the payee tax ID type will indicate that the payee tax ID should be interpreted a
SSN.|PAYEE-TAX-ID-TYPE|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X(2)|19|511|5
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 PAYE
TAX-ID-TYPE was reported with a payee tax ID type of "Other".|N/A|FTX00004|GROUP-
INSURANCE-PREMIUM-PAYMENT|X(100)|20|513|612|1. Value must be 100 characters or les
2. PAYEE-TAX-ID-TYPE must = '95'
3. Conditional

FTX125|FTX.004.125|INSURANCE-CARRIER-ID-NUM|Insurance Carrier ID Num|Mandatory|
The state-assigned identification number of the Third Party Liability (TPL) Entity.|N/A|FTX0
GROUP-INSURANCE-PREMIUM-PAYMENT|X(12)|21|613|624|1. Value must be 12 characters
less
2. Value must not contain a pipe or asterisk symbols
3. Mandatory

FTX126|FTX.004.126|INSURANCE-PLAN-ID|Insurance Plan ID|Conditional|The ID number iss
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)|22|625|644|1. Value must not contain a pipe
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 iden MSIS Identification Numbers are a unique “key” value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for informatio reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
N/A|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X(20)|23|645|664|1. Value must be characters or less
2. Conditional
3. If value is not populated, then SSN must be populated.

FTX128|FTX.004.128|SSN|SSN|Conditional|The eligible individual's social security number. 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, t MSIS Identification Number field should be populated |N/A|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X(9)|24|665|673|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 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 va must not equal MSIS Identification Number (ELG.002.019)

FTX129|FTX.004.129|MEMBER-ID|Member ID|Conditional|Member identification number as appears on the card issued by the TPL insurance carrier.|N/A|FTX00004|GROUP-INSURANC PREMIUM-PAYMENT|X(20)|25|674|693|1. Value must be 20 characters or less
2. Conditional

FTX131|FTX.004.131|POLICY-OWNER-CODE|Policy Owner Code|Conditional|This code ident
the relationship of the policy holder to the Medicaid/CHIP beneficiary.|POLICY-OWNER-COD
FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X(2)|27|710|711|1. Value must be 2
characters
2. Value must be in VVL
3. Conditional

FTX135|FTX.004.135|MBESCBES-CATEGORY-OF-SERVICE|MBES or CBES Category of Servic
Conditional|A code indicating the category of service for the paid claim. The category of se
is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM
21, 64.9 WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS) that states use to report
expenditures and request federal financial participation.|MBESCBES-CATEGORY-OF-SERVIC
(XIX), MBESCBES-CATEGORY-OF-SERVICE (XXI)|FTX00004|GROUP-INSURANCE-PREMIUM-
PAYMENT|X(5)|31|730|734|1. Value must be in XIX-MBESCBES-CATEGORY-OF-SERVICE or X
MBESCBES-CATEGORY-OF-SERVICE lists (VVLs)
2. Value must be 5 characters or less
3. Value must be populated if POLICY-OWNER-CODE = '01'
4. Conditional

FTX136|FTX.004.136|MBESCBES-FORM|MBES or CBES Form|Conditional|The MBES or CBES
to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, 64.9
WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS). This should be determined by th
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.|MBESCBE
FORM|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X(50)|32|735|784|1. Value must
characters or less
2. Value must be in MBES or CBES Form list (VVL)
3. Value must be populated if POLICY-OWNER-CODE = '01'
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 wa
ID number assigned during the state submission and CMS approval process. Waiver IDs sh
actually only be the "core" part of the waiver IDs, without including suffixes for renewals o
amendments.|N/A|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X(20)|34|786|805|1.
Value must be associated with a populated WAIVER-TYPE
2. Value must be 20 characters or less
3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associated Cl
Waiver Type value must be 01 or in [21-30]
4. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation follow
by a period (.), the associated Claim Waiver Type value must be in [02-20, 32, 33]
5. Value must match Eligible Waiver ID (ELG.012.172) for the enrollee for the same time p
6. Conditional

FTX149|FTX.005.149|RECORD-ID|Record ID|Mandatory|The Record ID represents the type
segment being reported. The Record ID communicates how the contents of a given row of
should be interpreted depending on which segment type the Record ID represents. Each t
of segment collects different data elements so each segment type has a distinct layout. Th
first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th
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 exactly 8 characters
2. Value must be in RECORD-ID list (VVL)
3. Value must equal "FTX00005"
4. Mandatory

FTX152|FTX.005.152|ICN-ORIG|ICN Orig|Conditional|A unique item control number assigne 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. If UNIQUE-TRANSACTION-ID is populated, ICN-ORIG must not be populated 4. Conditional
FTX153|FTX.005.153|ICN-ADJ|ICN Adj|Conditional|A unique claim/transaction number assig by the state’s payment system that identifies the adjustment claim/transaction for an orig item control number.|N/A|FTX00005|COST-SHARING-OFFSET|X(50)|5|72|121|1. Value must 50 characters or less 2. Value must not contain a pipe or asterisk symbols 3. If UNIQUE-TRANSACTION-ID is populated, ICN-ADJ must not be populated 4. Conditional
FTX154|FTX.005.154|UNIQUE-TRANSACTION-ID|Unique Transaction ID|Conditional|For transactions that are not assigned an ICN-ORIG or ICN-ADJ in the MMIS, this unique transac ID distinguishes this transaction from all other transactions in T-MSIS.|N/A|FTX00005|COST SHARING-OFFSET|X(50)|6|122|171|1. Value must be 50 characters or less 2. If ICN-ORIG or ICN-ADJ are populated, UNIQUE-TRANSACTION-ID must not be populated 3. Conditional
FTX155|FTX.005.155|ADJUSTMENT-IND|Adjustment Ind|Conditional|Indicates the type of adjustment record.|ADJUSTMENT-IND|FTX00005|COST-SHARING-OFFSET|X(1)|7|172|172|1. Value must be 1 character 2. Value must be in ADJUSTMENT-IND list (VVL) 3. If UNIQUE-TRANSACTION-ID is populated, ADJUSTMENT-IND must not be populated 4. Conditional

FTX160|FTX.005.160|PAYER-ID|Payer ID|Mandatory|This is the identifier that corresponds w
the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking th
action of either making a payment or taking a recoupment, as opposed to the payee who i
object of the transaction. The payer is the entity that is either making a payment or recoup
a payment from another entity or individual. The payee is the individual or entity that is ei
receiving a payment or having a previous payment recouped.

For beneficiary Cost Sharing Offset, the payee is always the state and the payee is always
beneficiary.|N/A|FTX00005|COST-SHARING-OFFSET|X(30)|12|217|246|1. Value must be 30
characters or less
2. Value must equal SUBMITTING-STATE (FTX00001)
5. Mandatory

FTX161|FTX.005.161|PAYER-ID-TYPE|Payer ID Type|Mandatory|This is a qualifier that indica
what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid
CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted a
submitting state code.|PAYER-ID-TYPE|FTX00005|COST-SHARING-OFFSET|X(2)|13|247|248|
Value must be 2 characters
2. Value must be in PAYER-ID-TYPE list (VVL)
3. Mandatory

FTX163|FTX.005.163|PAYEE-ID|Payee ID|Mandatory|This is the identifier that corresponds w
the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or ent
that is either receiving a payment or having a previous payment recouped. The payee is th
object of the transaction, as opposed to the payer who is the subject taking the action of e
making a payment or taking a recoupment.

For beneficiary Cost Sharing Offset, the beneficiary is always the payee. |N/A|FTX00005|CO
SHARING-OFFSET|X(30)|15|349|378|1. Value must be 30 characters or less
2. Value must equal MSIS-IDENTIFICATION-NUM (ELG00002)
3. Mandatory

FTX164|FTX.005.164|PAYEE-ID-TYPE |Payee ID Type|Mandatory|This is a qualifier that indic
what type of ID the payee ID is. For example, if the payee ID represents a provider ID, ther
payee ID type will indicate that the payee ID should be interpreted as a provider ID.|PAYEE
TYPE |FTX00005|COST-SHARING-OFFSET|X(2)|16|379|380|1. Value must be 2 characters
2. Value must be in PAYEE-ID-TYPE list (VVL)
3. Mandatory

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 th
individual or entity that is either receiving a payment or having a previous payment recou
The payee is the object of the transaction, as opposed to the payer who is the subject taki
the action of either making a payment or taking a recoupment.|N/A|FTX00005|COST-SHAR
OFFSET|X(30)|20|583|612|1. Value must be 12 characters or less
2. Mandatory
3. Value must meet requirements of SSN if PAYEE-ID-TYPE = '01'

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 PAYE
TAX-ID-TYPE was reported with a payee tax ID type of "Other".|N/A|FTX00005|COST-SHARI
OFFSET|X(100)|22|615|714|1. Value must be 100 characters or less
2. PAYEE-TAX-ID-TYPE must = '95'
3. Conditional

FTX172|FTX.005.172|INSURANCE-PLAN-ID|Insurance Plan ID|Conditional|The ID number iss
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|C
SHARING-OFFSET|X(20)|24|815|834|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 s
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 da
distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for informatio
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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-blog/entry/4757
N/A|FTX00005|COST-SHARING-OFFSET|X(20)|25|835|854|1. Value must be 20 characters o

2. Mandatory

FTX177|FTX.005.177|MBESCBES-CATEGORY-OF-SERVICE|MBES or CBES Category of Servic
Mandatory|A code indicating the category of service for the paid claim. The category of se
is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM
21, 64.9 WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS) that states use to report
expenditures and request federal financial participation.|MBESCBES-CATEGORY-OF-SERVIC
(XIX), MBESCBES-CATEGORY-OF-SERVICE (XXI)|FTX00005|COST-SHARING-OFFSET|X(5)|29|
877|1. Value must be in XIX-MBESCBES-CATEGORY-OF-SERVICE or XXI-MBESCBES-CATEGO
OF-SERVICE lists (VVLs)
2. Value must be 5 characters or less
3. Mandatory

FTX178|FTX.005.178|MBESCBES-FORM|MBES or CBES Form|Mandatory|The MBES or CBES
to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, 64.9
WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS). This should be determined by th
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.|MBESCBE
FORM|FTX00005|COST-SHARING-OFFSET|X(50)|30|878|927|1. Value must be 50 characters
less
2. Value must be in MBES or CBES Form 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 wa
ID number assigned during the state submission and CMS approval process. Waiver IDs sh
actually only be the "core" part of the waiver IDs, without including suffixes for renewals o
amendments.|N/A|FTX00005|COST-SHARING-OFFSET|X(20)|32|929|948|1. Value must be
associated with a populated WAIVER-TYPE
2. Value must be 20 characters or less
3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associated Cl
Waiver Type value must be 01 or in [21-30]
4. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation follow
by a period (.), the associated Claim Waiver Type value must be in [02-20, 32, 33]
5. Conditional

FTX186|FTX.005.186|SPA-NUMBER|SPA Number|Conditional|State plan amendment (SPA) I
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 th
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 optional entry for specific SPA types|N/A|FTX00005|COST-SHARING-OFFSET|X(15
958|972|1. Value must be 15 characters or less
2. Conditional

FTX192|FTX.006.192|RECORD-ID|Record ID|Mandatory|The Record ID represents the type
segment being reported. The Record ID communicates how the contents of a given row of
should be interpreted depending on which segment type the Record ID represents. Each t
of segment collects different data elements so each segment type has a distinct layout. Th
first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th
segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).|RECORD-ID
FTX00006|VALUE-BASED-PAYMENT|X(8)|1|1|8|1. Value must be exactly 8 characters
2. Value must be in RECORD-ID list (VVL)
3. Value must equal "FTX00006"
4. Mandatory

FTX195|FTX.006.195|ICN-ORIG|ICN Orig|Conditional|A unique item control number assigne
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. If UNIQUE-TRANSACTION-ID is populated, ICN-ORIG must not be populated
4. Conditional

FTX196|FTX.006.196|ICN-ADJ|ICN Adj|Conditional|A unique claim/transaction number assig
by the state’s payment system that identifies the adjustment claim/transaction for an orig
item control number.|N/A|FTX00006|VALUE-BASED-PAYMENT|X(50)|5|72|121|1. Value must
50 characters or less
2. Value must not contain a pipe or asterisk symbols
3. If UNIQUE-TRANSACTION-ID is populated, ICN-ADJ must not be populated
4. Conditional

FTX197|FTX.006.197|UNIQUE-TRANSACTION-ID|Unique Transaction ID|Conditional|For
transactions that are not assigned an ICN-ORIG or ICN-ADJ in the MMIS, this unique transac
ID distinguishes this transaction from all other transactions in T-MSIS.|N/A|FTX00006|VALU
BASED-PAYMENT|X(50)|6|122|171|1. Value must be 50 characters or less
2. If ICN-ORIG or ICN-ADJ are populated, UNIQUE-TRANSACTION-ID must not be populated
3. Conditional

FTX198|FTX.006.198|ADJUSTMENT-IND|Adjustment Ind|Conditional|Indicates the type of
adjustment record.|ADJUSTMENT-IND|FTX00006|VALUE-BASED-PAYMENT|X(1)|7|172|172|1
Value must be 1 character
2. Value must be in ADJUSTMENT-IND list (VVL)
3. If UNIQUE-TRANSACTION-ID is populated, ADJUSTMENT-IND must not be populated
4. Conditional

FTX203|FTX.006.203|PAYER-ID|Payer ID|Mandatory|This is the identifier that corresponds w
the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking th
action of either making a payment or taking a recoupment, as opposed to the payee who i
object of the transaction. The payer is the entity that is either making a payment or recoup
a payment from another entity or individual. The payee is the individual or entity that is ei
receiving a payment or having a previous payment recouped.|N/A|FTX00006|VALUE-BASED
PAYMENT|X(30)|12|217|246|1. Value must be 30 characters or less
2. If PAYER-ID-TYPE = '01' then PAYER-ID = SUBMITTING-STATE (FTX00001)
3. If PAYER-ID-TYPE = '02' then PAYER-ID = STATE-PLAN-ID-NUM (MCR00002)
4. If PAYER-ID-TYPE = '04' then PAYER-ID = SUBMITTING-STATE-PROV-ID (PRV00002)
5. Mandatory

FTX204|FTX.006.204|PAYER-ID-TYPE|Payer ID Type|Mandatory|This is a qualifier that indica
what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid
CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted a
submitting state code.|PAYER-ID-TYPE|FTX00006|VALUE-BASED-PAYMENT|X(2)|13|247|248
Value must be 2 characters
2. Value must be in PAYER-ID-TYPE list (VVL)
3. Mandatory

FTX206|FTX.006.206|PAYEE-ID|Payee ID|Mandatory|This is the identifier that corresponds w
the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or ent
that is either receiving a payment or having a previous payment recouped. The payee is th
object of the transaction, as opposed to the payer who is the subject taking the action of e
making a payment or taking a recoupment.|N/A|FTX00006|VALUE-BASED-PAYMENT|X(30)|
349|378|1. Value must be 30 characters or less
2. If PAYEE-ID-TYPE = '01' then PAYEE-ID = SUBMITTING-STATE (FTX00001)
3. If PAYEE-ID-TYPE = '02' then PAYEE-ID = STATE-PLAN-ID-NUM (MCR00002)
4. If PAYEE-ID-TYPE = '04' or '05' then PAYEE-ID = SUBMITTING-STATE-PROV-ID (PRV0002)
6. If PAYEE-ID-TYPE = '06' then PAYEE-ID = PROV-IDENTIFIER where PROV-IDENTIFIER-TYPE
(PRV00005)
7. If PAYEE-ID-TYPE = '07' then PAYEE-ID = INSURANCE-CARRIER-ID-NUM (TPL00006)
8. If PAYER-ID-TYPE = '08' then PAYEE-ID = MSIS-IDENTIFICATION-NUM (ELG00002)
9. Mandatory

FTX207|FTX.006.207|PAYEE-ID-TYPE |Payee ID Type|Mandatory|This is a qualifier that indic
what type of ID the payee ID is. For example, if the payee ID represents a provider ID, ther
payee ID type will indicate that the payee ID should be interpreted as a provider ID.|PAYEE
TYPE |FTX00006|VALUE-BASED-PAYMENT|X(2)|16|379|380|1. Value must be 2 characters
2. Value must be in PAYEE-ID-TYPE list (VVL)
3. Mandatory

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 th
individual or entity that is either receiving a payment or having a previous payment recou
The payee is the object of the transaction, as opposed to the payer who is the subject taki
the action of either making a payment or taking a recoupment.|N/A|FTX00006|VALUE-BASE
PAYMENT|X(30)|20|583|612|1. Value must be 12 characters or less
2. Mandatory
3. Value must meet requirements of SSN if PAYEE-ID-TYPE = '01'

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 iden MSIS Identification Numbers are a unique “key” value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for informatio reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
N/A|FTX00006|VALUE-BASED-PAYMENT|X(20)|24|815|834|1. Value must be 20 characters o less
2. Conditional

FTX219|FTX.006.219|MBESCBES-CATEGORY-OF-SERVICE|MBES or CBES Category of Servic Mandatory|A code indicating the category of service for the paid claim. The category of se is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM 21, 64.9 WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS) that states use to report expenditures and request federal financial participation.|MBESCBES-CATEGORY-OF-SERVIC (XIX), MBESCBES-CATEGORY-OF-SERVICE (XXI)|FTX00006|VALUE-BASED-PAYMENT|X(5)|28 857|1. Value must be in XIX-MBESCBES-CATEGORY-OF-SERVICE or XXI-MBESCBES-CATEGO OF-SERVICE lists (VVLs)
2. Value must be 5 characters or less
3. Mandatory

FTX220|FTX.006.220|MBESCBES-FORM|MBES or CBES Form|Mandatory|The MBES or CBES
to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, 64.9
WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS). This should be determined by th
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.|MBESCBE
FORM|FTX00006|VALUE-BASED-PAYMENT|X(50)|29|858|907|1. Value must be 50 character
less
2. Value must be in MBES or CBES Form 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 wa
ID number assigned during the state submission and CMS approval process. Waiver IDs sh
actually only be the "core" part of the waiver IDs, without including suffixes for renewals o
amendments.|N/A|FTX00006|VALUE-BASED-PAYMENT|X(20)|31|909|928|1. Value must be
associated with a populated WAIVER-TYPE
2. Value must be 20 characters or less
3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associated Cl
Waiver Type value must be 01 or in [21-30]
4. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation follow
by a period (.), the associated Claim Waiver Type value must be in [02-20, 32, 33]
5. Conditional

FTX228|FTX.006.228|SPA-NUMBER|SPA Number|Conditional|State plan amendment (SPA) I
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 th
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 optional entry for specific SPA types|N/A|FTX00006|VALUE-BASED-PAYMENT|X(1
37|938|952|1. Value must be 15 characters or less
2. Conditional

FTX236|FTX.007.236|RECORD-ID|Record ID|Mandatory|The Record ID represents the type
segment being reported. The Record ID communicates how the contents of a given row of
should be interpreted depending on which segment type the Record ID represents. Each t
of segment collects different data elements so each segment type has a distinct layout. Th
first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th
segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).|RECORD-ID
FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|X(8)|1|1|8|1. Value must
exactly 8 characters
2. Value must be in RECORD-ID list (VVL)
3. Value must equal "FTX00007"
4. Mandatory

FTX239|FTX.007.239|ICN-ORIG|ICN Orig|Conditional|A unique item control number assigne
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 m
be 50 characters or less
2. Value must not contain a pipe or asterisk symbols
3. If UNIQUE-TRANSACTION-ID is populated, ICN-ORIG must not be populated
4. Conditional

FTX240|FTX.007.240|ICN-ADJ|ICN Adj|Conditional|A unique claim/transaction number assig
by the state’s payment system that identifies the adjustment claim/transaction for an orig
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 UNIQUE-TRANSACTION-ID is populated, ICN-ADJ must not be populated
4. Conditional

FTX241|FTX.007.241|UNIQUE-TRANSACTION-ID|Unique Transaction ID|Conditional|For
transactions that are not assigned an ICN-ORIG or ICN-ADJ in the MMIS, this unique transac
ID distinguishes this transaction from all other transactions in T-MSIS.|N/A|FTX00007|STATE
DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|X(50)|6|122|171|1. Value must be 50
characters or less
2. If ICN-ORIG or ICN-ADJ are populated, UNIQUE-TRANSACTION-ID must not be populated
3. Conditional

FTX242|FTX.007.242|ADJUSTMENT-IND|Adjustment Ind|Conditional|Indicates the type of
adjustment record.|ADJUSTMENT-IND|FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-
PAYMENT-TERM|X(1)|7|172|172|1. Value must be 1 character
2. Value must be in ADJUSTMENT-IND list (VVL)
3. If UNIQUE-TRANSACTION-ID is populated, ADJUSTMENT-IND must not be populated
4. Conditional

FTX247|FTX.007.247|PAYER-ID|Payer ID|Mandatory|This is the identifier that corresponds w
the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking th
action of either making a payment or taking a recoupment, as opposed to the payee who i
object of the transaction. The payer is the entity that is either making a payment or recoup
a payment from another entity or individual. The payee is the individual or entity that is ei
receiving a payment or having a previous payment recouped.|N/A|FTX00007|STATE-DIREC
PAYMENT-SEPARATE-PAYMENT-TERM|X(30)|12|217|246|1. Value must be 30 characters or
2. If PAYER-ID-TYPE = '01' then PAYER-ID = SUBMITTING-STATE (FTX00001)
3. If PAYER-ID-TYPE = '02' then PAYER-ID = STATE-PLAN-ID-NUM (MCR00002)
4. If PAYER-ID-TYPE = '04' then PAYER-ID = SUBMITTING-STATE-PROV-ID (PRV00002)
5. Mandatory

FTX248|FTX.007.248|PAYER-ID-TYPE|Payer ID Type|Mandatory|This is a qualifier that indica
what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid
CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted a
submitting state code.|PAYER-ID-TYPE|FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-
PAYMENT-TERM|X(2)|13|247|248|1. Value must be 2 characters
2. Value must be in PAYER-ID-TYPE list (VVL)
3. Mandatory

FTX250|FTX.007.250|PAYEE-ID|Payee ID|Mandatory|This is the identifier that corresponds w
the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or ent
that is either receiving a payment or having a previous payment recouped. The payee is th
object of the transaction, as opposed to the payer who is the subject taking the action of e
making a payment or taking a recoupment.|N/A|FTX00007|STATE-DIRECTED-PAYMENT-
SEPARATE-PAYMENT-TERM|X(30)|15|349|378|1. Value must be 30 characters or less
2. If PAYEE-ID-TYPE = '01' then PAYEE-ID = SUBMITTING-STATE (FTX00001)
3. If PAYEE-ID-TYPE = '02' then PAYEE-ID = STATE-PLAN-ID-NUM (MCR00002)
4. If PAYEE-ID-TYPE = '04' or '05' then PAYEE-ID = SUBMITTING-STATE-PROV-ID (PRV0002)
6. If PAYEE-ID-TYPE = '06' then PAYEE-ID = PROV-IDENTIFIER where PROV-IDENTIFIER-TYPE
(PRV00005)
7. If PAYEE-ID-TYPE = '07' then PAYEE-ID = INSURANCE-CARRIER-ID-NUM (TPL00006)
8. If PAYER-ID-TYPE = '08' then PAYEE-ID = MSIS-IDENTIFICATION-NUM (ELG00002)
9. Mandatory

FTX251|FTX.007.251|PAYEE-ID-TYPE |Payee ID Type|Mandatory|This is a qualifier that indic
what type of ID the payee ID is. For example, if the payee ID represents a provider ID, ther
payee ID type will indicate that the payee ID should be interpreted as a provider ID.|PAYEE
TYPE |FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|X(2)|16|379|380|1
Value must be 2 characters
2. Value must be in PAYEE-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 PAYE
TAX-ID-TYPE was reported with a payee tax ID type of "Other".|N/A|FTX00007|STATE-DIREC
PAYMENT-SEPARATE-PAYMENT-TERM|X(100)|22|615|714|1. Value must be 100 characters
less
2. PAYEE-TAX-ID-TYPE must = '95'
3. Conditional

FTX259|FTX.007.259|PAYMENT-PERIOD-BEGIN-DATE|Payment Period Begin Date|Mandator
date representing the beginning of the time period that the payment is expected to be use
the provider. |N/A|FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|9(8)|2
815|822|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
or Sept 31st)
3. Value must be before or the same as the associated PAYMENT-PERIOD-END-DATE

4. Value of the CC component must be in ['19', '20']
5. Mandatory

FTX261|FTX.007.261|PAYMENT-PERIOD-TYPE|Payment Period Type|Conditional|A qualifier t
identifies what the payment period begin and end dates represent. For example, the paym
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.|PAYMEN
PERIOD-TYPE|FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|X(2)|26|83
832|1. Value must be 2 characters
2. Value must be in PAYMENT-PERIOD-TYPE list
3. Conditional

FTX264|FTX.007.264|MBESCBES-CATEGORY-OF-SERVICE|MBES or CBES Category of Servic
Mandatory|A code indicating the category of service for the paid claim. The category of se
is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM
21, 64.9 WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS) that states use to report
expenditures and request federal financial participation.|MBESCBES-CATEGORY-OF-SERVIC
(XIX), MBESCBES-CATEGORY-OF-SERVICE (XXI)|FTX00007|STATE-DIRECTED-PAYMENT-
SEPARATE-PAYMENT-TERM|X(5)|29|935|939|1. Value must be in XIX-MBESCBES-CATEGORY
SERVICE or XXI-MBESCBES-CATEGORY-OF-SERVICE lists (VVLs)
2. Value must be 5 characters or less
3. Mandatory

FTX265|FTX.007.265|MBESCBES-FORM|MBES or CBES Form|Mandatory|The MBES or CBES
to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, 64.9
WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS). This should be determined by th
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.|MBESCBE
FORM|FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|X(50)|30|940|989|
Value must be 50 characters or less
2. Value must be in MBES or CBES Form 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 wa ID number assigned during the state submission and CMS approval process. Waiver IDs sh actually only be the "core" part of the waiver IDs, without including suffixes for renewals o amendments.|N/A|FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|X(20) 991|1010|1. Value must be associated with a populated WAIVER-TYPE
2. Value must be 20 characters or less
3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associated Cl Waiver Type value must be 01 or in [21-30]
4. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation follow by a period (.), the associated Claim Waiver Type value must be in [02-20, 32, 33]
5. Conditional

FTX279|FTX.008.279|RECORD-ID|Record ID|Mandatory|The Record ID represents the type segment being reported. The Record ID communicates how the contents of a given row of should be interpreted depending on which segment type the Record ID represents. Each t of segment collects different data elements so each segment type has a distinct layout. Th first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).|RECORD-I FTX00008|COST-SETTLEMENT-PAYMENT|X(8)|1|1|8|1. Value must be exactly 8 characters
2. Value must be in RECORD-ID list (VVL)
3. Value must equal "FTX00008"
4. Mandatory

FTX282|FTX.008.282|ICN-ORIG|ICN Orig|Conditional|A unique item control number assigne 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 l
2. Value must not contain a pipe or asterisk symbols
3. If UNIQUE-TRANSACTION-ID is populated, ICN-ORIG must not be populated
4. Conditional

FTX283|FTX.008.283|ICN-ADJ|ICN Adj|Conditional|A unique claim/transaction number assig
by the state’s payment system that identifies the adjustment claim/transaction for an orig
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 UNIQUE-TRANSACTION-ID is populated, ICN-ADJ must not be populated
4. Conditional

FTX284|FTX.008.284|UNIQUE-TRANSACTION-ID|Unique Transaction ID|Conditional|For
transactions that are not assigned an ICN-ORIG or ICN-ADJ in the MMIS, this unique transac
ID distinguishes this transaction from all other transactions in T-MSIS.|N/A|FTX00008|COST
SETTLEMENT-PAYMENT|X(50)|6|122|171|1. Value must be 50 characters or less
2. If ICN-ORIG or ICN-ADJ are populated, UNIQUE-TRANSACTION-ID must not be populated
3. Conditional

FTX284|FTX.008.284|UNIQUE-TRANSACTION-ID|Unique Transaction ID|Conditional|For
transactions that are not assigned an ICN-ORIG or ICN-ADJ in the MMIS, this unique transac
ID distinguishes this transaction from all other transactions in T-MSIS.|N/A|FTX00008|COST
SETTLEMENT-PAYMENT|X(50)|6|122|171|1. Value must be 50 characters or less
2. If ICN-ORIG or ICN-ADJ are populated, UNIQUE-TRANSACTION-ID must not be populated
3. Conditional

FTX285|FTX.008.285|ADJUSTMENT-IND|Adjustment Ind|Conditional|Indicates the type of
adjustment record.|ADJUSTMENT-IND|FTX00008|COST-SETTLEMENT-PAYMENT|X(1)|7|172|1
1. Value must be 1 character
2. Value must be in ADJUSTMENT-IND list (VVL)
3. If UNIQUE-TRANSACTION-ID is populated, ADJUSTMENT-IND must not be populated
4. Conditional

FTX288|FTX.008.288|CHECK-EFF-DATE|Check Eff Date|Conditional|The date a check is issu
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)|10|194|201|1. Value must be 8 digits in the fo
"CCYYMMDD"
2. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April
or Sept 31st)
3. Must have an associated Check Number
4. Conditional

FTX290|FTX.008.290|PAYER-ID|Payer ID|Mandatory|This is the identifier that corresponds w
the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking th
action of either making a payment or taking a recoupment, as opposed to the payee who i
object of the transaction. The payer is the entity that is either making a payment or recoup
a payment from another entity or individual. The payee is the individual or entity that is ei
receiving a payment or having a previous payment recouped.|N/A|FTX00008|COST-
SETTLEMENT-PAYMENT|X(30)|12|217|246|1. Value must be 30 characters or less
2. If PAYER-ID-TYPE = '01' then PAYER-ID = SUBMITTING-STATE (FTX00001)
3. If PAYER-ID-TYPE = '02' then PAYER-ID = STATE-PLAN-ID-NUM (MCR00002)
4. If PAYER-ID-TYPE = '04' then PAYER-ID = SUBMITTING-STATE-PROV-ID (PRV00002)
5. Mandatory

FTX291|FTX.008.291|PAYER-ID-TYPE|Payer ID Type|Mandatory|This is a qualifier that indica
what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid
CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted a
submitting state code.|PAYER-ID-TYPE|FTX00008|COST-SETTLEMENT-PAYMENT|X(2)|13|247
248|1. Value must be 2 characters
2. Value must be in PAYER-ID-TYPE list (VVL)
3. Mandatory

FTX293|FTX.008.293|PAYEE-ID|Payee ID|Mandatory|This is the identifier that corresponds w
the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or ent
that is either receiving a payment or having a previous payment recouped. The payee is th
object of the transaction, as opposed to the payer who is the subject taking the action of e
making a payment or taking a recoupment.|N/A|FTX00008|COST-SETTLEMENT-PAYMENT|X
15|349|378|1. Value must be 30 characters or less
2. If PAYEE-ID-TYPE = '01' then PAYEE-ID = SUBMITTING-STATE (FTX00001)
3. If PAYEE-ID-TYPE = '02' then PAYEE-ID = STATE-PLAN-ID-NUM (MCR00002)
4. If PAYEE-ID-TYPE = '04' or '05' then PAYEE-ID = SUBMITTING-STATE-PROV-ID (PRV0002)
6. If PAYEE-ID-TYPE = '06' then PAYEE-ID = PROV-IDENTIFIER where PROV-IDENTIFIER-TYPE
(PRV00005)
7. If PAYEE-ID-TYPE = '07' then PAYEE-ID = INSURANCE-CARRIER-ID-NUM (TPL00006)
8. If PAYER-ID-TYPE = '08' then PAYEE-ID = MSIS-IDENTIFICATION-NUM (ELG00002)
9. Mandatory

FTX294|FTX.008.294|PAYEE-ID-TYPE |Payee ID Type|Mandatory|This is a qualifier that indic
what type of ID the payee ID is. For example, if the payee ID represents a provider ID, ther
payee ID type will indicate that the payee ID should be interpreted as a provider ID.|PAYEE
TYPE |FTX00008|COST-SETTLEMENT-PAYMENT|X(2)|16|379|380|1. Value must be 2 charact
2. Value must be in PAYEE-ID-TYPE list (VVL)
3. Mandatory

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 th
individual or entity that is either receiving a payment or having a previous payment recou
The payee is the object of the transaction, as opposed to the payer who is the subject taki
the action of either making a payment or taking a recoupment.|N/A|FTX00008|COST-
SETTLEMENT-PAYMENT|X(30)|20|583|612|1. Value must be 12 characters or less
2. Mandatory
3. Value must meet requirements of SSN if PAYEE-ID-TYPE = '01'

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 PAYE
TAX-ID-TYPE was reported with a payee tax ID type of "Other".|N/A|FTX00008|COST-
SETTLEMENT-PAYMENT|X(100)|22|615|714|1. Value must be 100 characters or less
2. PAYEE-TAX-ID-TYPE must = '95'
3. Conditional

FTX304|FTX.008.304|MBESCBES-CATEGORY-OF-SERVICE|MBES or CBES Category of Servic
Mandatory|A code indicating the category of service for the paid claim. The category of se
is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM
21, 64.9 WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS) that states use to report
expenditures and request federal financial participation.|MBESCBES-CATEGORY-OF-SERVIC
(XIX), MBESCBES-CATEGORY-OF-SERVICE (XXI)|FTX00008|COST-SETTLEMENT-PAYMENT|X(
26|733|737|1. Value must be in XIX-MBESCBES-CATEGORY-OF-SERVICE or XXI-MBESCBES-
CATEGORY-OF-SERVICE lists (VVLs)
2. Value must be 5 characters or less
3. Mandatory

FTX305|FTX.008.305|MBESCBES-FORM|MBES or CBES Form|Mandatory|The MBES or CBES
to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, 64.9
WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS). This should be determined by th
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.|MBESCBE
FORM|FTX00008|COST-SETTLEMENT-PAYMENT|X(50)|27|738|787|1. Value must be 50
characters or less
2. Value must be in MBES or CBES Form 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 wa ID number assigned during the state submission and CMS approval process. Waiver IDs sh actually only be the "core" part of the waiver IDs, without including suffixes for renewals o amendments.|N/A|FTX00008|COST-SETTLEMENT-PAYMENT|X(20)|29|789|808|1. Value mus associated with a populated WAIVER-TYPE
2. Value must be 20 characters or less
3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associated Cl Waiver Type value must be 01 or in [21-30]
4. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation follow by a period (.), the associated Claim Waiver Type value must be in [02-20, 32, 33]
5. Conditional

FTX312|FTX.008.312|SPA-NUMBER|SPA Number|Conditional|State plan amendment (SPA) I 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 th 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 optional entry for specific SPA types|N/A|FTX00008|COST-SETTLEMENT-PAYMEN X(15)|34|817|831|1. Value must be 15 characters or less
2. Conditional

FTX318|FTX.009.318|RECORD-ID|Record ID|Mandatory|The Record ID represents the type o segment being reported. The Record ID communicates how the contents of a given row of should be interpreted depending on which segment type the Record ID represents. Each t of segment collects different data elements so each segment type has a distinct layout. Th first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).|RECORD-ID FTX00009| FQHC-WRAP-PAYMENT|X(8)|1|1|8|1. Value must be exactly 8 characters
2. Value must be in RECORD-ID list (VVL)
3. Value must equal "FTX00009"
4. Mandatory

FTX321|FTX.009.321|ICN-ORIG|ICN Orig|Conditional|A unique item control number assigne
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. If UNIQUE-TRANSACTION-ID is populated, ICN-ORIG must not be populated
4. Conditional

FTX322|FTX.009.322|ICN-ADJ|ICN Adj|Conditional|A unique claim/transaction number assig
by the state’s payment system that identifies the adjustment claim/transaction for an orig
item control number.|N/A|FTX00009| FQHC-WRAP-PAYMENT|X(50)|5|72|121|1. Value must
50 characters or less
2. Value must not contain a pipe or asterisk symbols
3. If UNIQUE-TRANSACTION-ID is populated, ICN-ADJ must not be populated
4. Conditional

FTX323|FTX.009.323|UNIQUE-TRANSACTION-ID|Unique Transaction ID|Conditional|For
transactions that are not assigned an ICN-ORIG or ICN-ADJ in the MMIS, this unique transac
ID distinguishes this transaction from all other transactions in T-MSIS.|N/A|FTX00009| FQH
WRAP-PAYMENT|X(50)|6|122|171|1. Value must be 50 characters or less
2. If ICN-ORIG or ICN-ADJ are populated, UNIQUE-TRANSACTION-ID must not be populated
3. Conditional

FTX324|FTX.009.324|ADJUSTMENT-IND|Adjustment Ind|Conditional|Indicates the type of
adjustment record.|ADJUSTMENT-IND|FTX00009| FQHC-WRAP-PAYMENT|X(1)|7|172|172|1.
must be 1 character
2. Value must be in ADJUSTMENT-IND list (VVL)
3. If UNIQUE-TRANSACTION-ID is populated, ADJUSTMENT-IND must not be populated
4. Conditional

FTX329|FTX.009.329|PAYER-ID|Payer ID|Mandatory|This is the identifier that corresponds w
the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking th
action of either making a payment or taking a recoupment, as opposed to the payee who i
object of the transaction. The payer is the entity that is either making a payment or recoup
a payment from another entity or individual. The payee is the individual or entity that is ei
receiving a payment or having a previous payment recouped.|N/A|FTX00009| FQHC-WRAP-
PAYMENT|X(30)|12|217|246|1. Value must be 30 characters or less
2. If PAYER-ID-TYPE = '01' then PAYER-ID = SUBMITTING-STATE (FTX00001)
3. If PAYER-ID-TYPE = '02' then PAYER-ID = STATE-PLAN-ID-NUM (MCR00002)
4. If PAYER-ID-TYPE = '04' then PAYER-ID = SUBMITTING-STATE-PROV-ID (PRV00002)
5. Mandatory

FTX330|FTX.009.330|PAYER-ID-TYPE|Payer ID Type|Mandatory|This is a qualifier that indica
what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid
CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted a
submitting state code.|PAYER-ID-TYPE|FTX00009| FQHC-WRAP-PAYMENT|X(2)|13|247|248|1
Value must be 2 characters
2. Value must be in PAYER-ID-TYPE list (VVL)
3. Mandatory

FTX332|FTX.009.332|PAYEE-ID|Payee ID|Mandatory|This is the identifier that corresponds w
the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or ent
that is either receiving a payment or having a previous payment recouped. The payee is th
object of the transaction, as opposed to the payer who is the subject taking the action of e
making a payment or taking a recoupment.|N/A|FTX00009| FQHC-WRAP-PAYMENT|X(30)|15
349|378|1. Value must be 30 characters or less
2. If PAYEE-ID-TYPE = '01' then PAYEE-ID = SUBMITTING-STATE (FTX00001)
3. If PAYEE-ID-TYPE = '02' then PAYEE-ID = STATE-PLAN-ID-NUM (MCR00002)
4. If PAYEE-ID-TYPE = '04' or '05' then PAYEE-ID = SUBMITTING-STATE-PROV-ID (PRV0002)
6. If PAYEE-ID-TYPE = '06' then PAYEE-ID = PROV-IDENTIFIER where PROV-IDENTIFIER-TYPE
(PRV00005)
7. If PAYEE-ID-TYPE = '07' then PAYEE-ID = INSURANCE-CARRIER-ID-NUM (TPL00006)
8. If PAYER-ID-TYPE = '08' then PAYEE-ID = MSIS-IDENTIFICATION-NUM (ELG00002)
9. Mandatory

FTX333|FTX.009.333|PAYEE-ID-TYPE |Payee ID Type|Mandatory|This is a qualifier that indic
what type of ID the payee ID is. For example, if the payee ID represents a provider ID, ther
payee ID type will indicate that the payee ID should be interpreted as a provider ID.|PAYEE
TYPE |FTX00009| FQHC-WRAP-PAYMENT|X(2)|16|379|380|1. Value must be 2 characters
2. Value must be in PAYEE-ID-TYPE list (VVL)
3. Mandatory

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 th
individual or entity that is either receiving a payment or having a previous payment recou
The payee is the object of the transaction, as opposed to the payer who is the subject taki
the action of either making a payment or taking a recoupment.|N/A|FTX00009| FQHC-WRA
PAYMENT|X(30)|20|583|612|1. Value must be 12 characters or less
2. Mandatory
3. Value must meet requirements of SSN if PAYEE-ID-TYPE = '01'

FTX343|FTX.009.343|MBESCBES-CATEGORY-OF-SERVICE|MBES or CBES Category of Servic
Mandatory|A code indicating the category of service for the paid claim. The category of se
is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM
21, 64.9 WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS) that states use to report
expenditures and request federal financial participation.|MBESCBES-CATEGORY-OF-SERVIC
(XIX), MBESCBES-CATEGORY-OF-SERVICE (XXI)|FTX00009| FQHC-WRAP-PAYMENT|X(5)|26|7
737|1. Value must be in XIX-MBESCBES-CATEGORY-OF-SERVICE or XXI-MBESCBES-CATEGO
OF-SERVICE lists (VVLs)
2. Value must be 5 characters or less
3. Mandatory

FTX344|FTX.009.344|MBESCBES-FORM|MBES or CBES Form|Mandatory|The MBES or CBES
to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, 64.9
WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS). This should be determined by th
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.|MBESCBE
FORM|FTX00009| FQHC-WRAP-PAYMENT|X(50)|27|738|787|1. Value must be 50 characters
less
2. Value must be in MBES or CBES Form 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 wa ID number assigned during the state submission and CMS approval process. Waiver IDs sh actually only be the "core" part of the waiver IDs, without including suffixes for renewals o amendments.|N/A|FTX00009| FQHC-WRAP-PAYMENT|X(20)|29|789|808|1. Value must be associated with a populated WAIVER-TYPE
2. Value must be 20 characters or less
3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associated Cl Waiver Type value must be 01 or in [21-30]
4. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation follow by a period (.), the associated Claim Waiver Type value must be in [02-20, 32, 33]
5. Conditional

FTX357|FTX.095.357|RECORD-ID|Record ID|Mandatory|The Record ID represents the type segment being reported. The Record ID communicates how the contents of a given row of should be interpreted depending on which segment type the Record ID represents. Each t of segment collects different data elements so each segment type has a distinct layout. Th first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).|RECORD-I FTX00095 |MISCELLANEOUS-PAYMENT|X(8)|1|1|8|1. Value must be exactly 8 characters
2. Value must be in RECORD-ID list (VVL)
3. Value must equal "FTX00095"
4. Mandatory

FTX360|FTX.095.360|ICN-ORIG|ICN Orig|Conditional|A unique item control number assigne 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 les
2. Value must not contain a pipe or asterisk symbols
3. If UNIQUE-TRANSACTION-ID is populated, ICN-ORIG must not be populated
4. Conditional

FTX361|FTX.095.361|ICN-ADJ|ICN Adj|Conditional|A unique claim/transaction number assig
by the state’s payment system that identifies the adjustment claim/transaction for an orig
item control number.|N/A|FTX00095 |MISCELLANEOUS-PAYMENT|X(50)|5|72|121|1. Value n
be 50 characters or less
2. Value must not contain a pipe or asterisk symbols
3. If UNIQUE-TRANSACTION-ID is populated, ICN-ADJ must not be populated
4. Conditional

FTX362|FTX.095.362|UNIQUE-TRANSACTION-ID|Unique Transaction ID|Conditional|For
transactions that are not assigned an ICN-ORIG or ICN-ADJ in the MMIS, this unique transac
ID distinguishes this transaction from all other transactions in T-MSIS.|N/A|FTX00095 |
MISCELLANEOUS-PAYMENT|X(50)|6|122|171|1. Value must be 50 characters or less
2. If ICN-ORIG or ICN-ADJ are populated, UNIQUE-TRANSACTION-ID must not be populated
3. Conditional

FTX363|FTX.095.363|ADJUSTMENT-IND|Adjustment Ind|Conditional|Indicates the type of
adjustment record.|ADJUSTMENT-IND|FTX00095 |MISCELLANEOUS-PAYMENT|X(1)|7|172|17
Value must be 1 character
2. Value must be in ADJUSTMENT-IND list (VVL)
3. If UNIQUE-TRANSACTION-ID is populated, ADJUSTMENT-IND must not be populated
4. Conditional

FTX368|FTX.095.368|PAYER-ID|Payer ID|Mandatory|This is the identifier that corresponds w
the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking th
action of either making a payment or taking a recoupment, as opposed to the payee who i
object of the transaction. The payer is the entity that is either making a payment or recoup
a payment from another entity or individual. The payee is the individual or entity that is ei
receiving a payment or having a previous payment recouped.|N/A|FTX00095 |MISCELLANE
PAYMENT|X(30)|12|217|246|1. Value must be 30 characters or less
2. If PAYER-ID-TYPE = '01' then PAYER-ID = SUBMITTING-STATE (FTX00001)
3. If PAYER-ID-TYPE = '02' then PAYER-ID = STATE-PLAN-ID-NUM (MCR00002)
4. If PAYER-ID-TYPE = '04' then PAYER-ID = SUBMITTING-STATE-PROV-ID (PRV00002)
5. Mandatory

FTX369|FTX.095.369|PAYER-ID-TYPE|Payer ID Type|Mandatory|This is a qualifier that indica
what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid
CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted a
submitting state code.|PAYER-ID-TYPE|FTX00095 |MISCELLANEOUS-PAYMENT|X(2)|13|247|2
1. Value must be 2 characters
2. Value must be in PAYER-ID-TYPE list (VVL)
3. Mandatory

FTX373|FTX.095.373|PAYEE-ID|Payee ID|Mandatory|This is the identifier that corresponds w
the payee's role in relation to the Medicaid/CHIP system. The payee is the individual or ent
that is either receiving a payment or having a previous payment recouped. The payee is th
object of the transaction, as opposed to the payer who is the subject taking the action of e
making a payment or taking a recoupment.|N/A|FTX00095 |MISCELLANEOUS-PAYMENT|X(3
17|451|480|1. Value must be 30 characters or less
2. If PAYEE-ID-TYPE = '01' then PAYEE-ID = SUBMITTING-STATE (FTX00001)
3. If PAYEE-ID-TYPE = '02' then PAYEE-ID = STATE-PLAN-ID-NUM (MCR00002)
4. If PAYEE-ID-TYPE = '04' or '05' then PAYEE-ID = SUBMITTING-STATE-PROV-ID (PRV0002)
6. If PAYEE-ID-TYPE = '06' then PAYEE-ID = PROV-IDENTIFIER where PROV-IDENTIFIER-TYPE
(PRV00005)
7. If PAYEE-ID-TYPE = '07' then PAYEE-ID = INSURANCE-CARRIER-ID-NUM (TPL00006)
8. If PAYER-ID-TYPE = '08' then PAYEE-ID = MSIS-IDENTIFICATION-NUM (ELG00002)
9. Mandatory

FTX374|FTX.095.374|PAYEE-ID-TYPE |Payee ID Type|Mandatory|This is a qualifier that indic
what type of ID the payee ID is. For example, if the payee ID represents a provider ID, ther
payee ID type will indicate that the payee ID should be interpreted as a provider ID.|PAYEE
TYPE |FTX00095 |MISCELLANEOUS-PAYMENT|X(2)|18|481|482|1. Value must be 2 characte
2. Value must be in PAYEE-ID-TYPE list (VVL)
3. Mandatory

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 th
individual or entity that is either receiving a payment or having a previous payment recou
The payee is the object of the transaction, as opposed to the payer who is the subject taki
the action of either making a payment or taking a recoupment.|N/A|FTX00095 |
MISCELLANEOUS-PAYMENT|X(30)|22|685|714|1. Value must be 12 characters or less
2. Mandatory
3. Value must meet requirements of SSN if PAYEE-ID-TYPE = '01'

FTX382|FTX.095.382|INSURANCE-CARRIER-ID-NUM|Insurance Carrier ID Num|Conditional|
The state-assigned identification number of the Third Party Liability (TPL) Entity.|N/A|FTX0
|MISCELLANEOUS-PAYMENT|X(12)|26|917|928|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 iden MSIS Identification Numbers are a unique “key” value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for informatio reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
N/A|FTX00095 |MISCELLANEOUS-PAYMENT|X(20)|27|929|948|1. Value must be 20 characte less
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 individua SSN
4. Conditional

FTX386|FTX.095.386|PAYMENT-PERIOD-TYPE|Payment Period Type|Conditional|A qualifier t identifies what the payment period begin and end dates represent. For example, the paym 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.|PAYMEN PERIOD-TYPE|FTX00095 |MISCELLANEOUS-PAYMENT|X(2)|30|965|966|1. Value must be 2 characters
2. Value must be in PAYMENT-PERIOD-TYPE list
3. Conditional

FTX391|FTX.095.391|MBESCBES-CATEGORY-OF-SERVICE|MBES or CBES Category of Servic
Mandatory|A code indicating the category of service for the paid claim. The category of se
is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM
21, 64.9 WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS) that states use to report
expenditures and request federal financial participation.|MBESCBES-CATEGORY-OF-SERVIC
(XIX), MBESCBES-CATEGORY-OF-SERVICE (XXI)|FTX00095 |MISCELLANEOUS-PAYMENT|X(5)
1171|1175|1. Value must be in XIX-MBESCBES-CATEGORY-OF-SERVICE or XXI-MBESCBES-
CATEGORY-OF-SERVICE lists (VVLs)
2. Value must be 5 characters or less
3. Mandatory

FTX392|FTX.095.392|MBESCBES-FORM|MBES or CBES Form|Mandatory|The MBES or CBES
to which the expenditure will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, 64.9
WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS). This should be determined by th
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.|MBESCBE
FORM|FTX00095 |MISCELLANEOUS-PAYMENT|X(50)|36|1176|1225|1. Value must be 50
characters or less
2. Value must be in MBES or CBES Form 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 wa ID number assigned during the state submission and CMS approval process. Waiver IDs sh actually only be the "core" part of the waiver IDs, without including suffixes for renewals o amendments.|N/A|FTX00095 |MISCELLANEOUS-PAYMENT|X(20)|38|1227|1246|1. Value mu associated with a populated WAIVER-TYPE
2. Value must be 20 characters or less
3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associated Cl Waiver Type value must be 01 or in [21-30]
4. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation follow by a period (.), the associated Claim Waiver Type value must be in [02-20, 32, 33]
5. Conditional

FTX400|FTX.095.400|SPA-NUMBER|SPA Number|Conditional|State plan amendment (SPA) I 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 th 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 optional entry for specific SPA types|N/A|FTX00095 |MISCELLANEOUS-PAYMENT| X(15)|44|1256|1270|1. Value must be 15 characters or less
2. Conditional

MCR002|MCR.001.002|DATA-DICTIONARY-VERSION|Data Dictionary Version|Mandatory|A d element to capture the version of the T-MSIS data dictionary that was used to build the file the version number specified on the Cover Sheet of the data dictionary".|DATA-DICTIONAR VERSION|MCR00001|FILE-HEADER-RECORD-MANAGED-CARE|X(10)|2|9|18|1. Value must be characters or less
2. Value must not include the pipe ("|") symbol
3. Mandatory

MCR006|MCR.001.006|FILE-NAME|File Name|Mandatory|A code to identify the subject area 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 C Plan Information,
Inpatient, Long-Term Care, Other, and Pharmacy Claim).|FILE-NAME|MCR00001|FILE-HEAD RECORD-MANAGED-CARE|X(8)|6|32|39|1. Value must equal 'MNGDCARE'
2. Mandatory

MCR008|MCR.001.008|DATE-FILE-CREATED|Date File Created|Mandatory|The date on whic
file was created.|N/A|MCR00001|FILE-HEADER-RECORD-MANAGED-CARE|9(8)|8|42|49|1. Va
of the CC component must be "20"
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
or Sept 31st)
4. Value must be less than current date
5. Value must be equal to or after the value of associated End of Time Period
6. Mandatory

MCR020|MCR.002.020|MANAGED-CARE-CONTRACT-EFF-DATE|Managed Care Contract Effe
Date|Mandatory|The start date of the managed care contract period with the state.
|N/A|MCR00002|MANAGED-CARE-MAIN|9(8)|5|34|41|1. Value must be 8 characters in the fo
'CCYYMMDD'
2. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April
or Sept 31st)
3. Value must be before or the same as the associated Segment End Date value
4. Mandatory
5. Value of the CC component must be in ['18','19,'20']
6. Mandatory
7. Value must occur before Managed Care Contract End Date (MCR.002.021)

MCR024|MCR.002.024|MANAGED-CARE-PLAN-TYPE|Managed Care Plan Type|Mandatory|Th
type of managed care plan that corresponds to the State Plan Identification Number. The
reported in this data element should match the Managed Care Plan Type value reported on
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-Emergen
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/tmsis-blog/entry/4754
See T-MSIS Guidance Document, "CMS Guidance: Best Practice for Reporting Managed Car
Plan Type in the T-MSIS Managed Care File"
https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/4756
MANAGED-CARE-PLAN-TYPE|MCR00002|MANAGED-CARE-MAIN|X(2)|9|106|107|1. Value mu
in Managed Care Plan Type List (VVL)
2. Value must be 2 characters
3. Mandatory

MCR028|MCR.002.028|PERCENT-BUSINESS|Percent Business|Mandatory|The percentage of
managed care entity's total revenue that is derived from contracts with Medicare (Part C a
D) in the state and State Medicaid agency contract(s) prior calendar year. Include Medicaid
Medicare in calculation of percentage of business in public programs for IRS health insurer
exemption as required in ACA.|N/A|MCR00002|MANAGED-CARE-MAIN|9(3)|13|113|115|1. V
must be between 0 and 100 inclusively
2. Mandatory

MCR029|MCR.002.029|MANAGED-CARE-SERVICE-AREA|Managed Care Service Area|Manda
Identifies the geographic unit under which the managed care entity is under contract to pr
services. The value reported in Managed Care Service Area should represent the geograph
unit of the values reported in the Managed Care Service Area Name.
See T-MSIS Guidance Document, "CMS Guidance: Best Practice for Reporting Managed Car
Service Area in the Managed Care File"
https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/4754
MANAGED-CARE-SERVICE-AREA|MCR00002|MANAGED-CARE-MAIN|X(1)|14|116|116|1. Valu
must be in Managed Care Service Area List (VVL)
2. Value must be 1 character
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

MCR047|MCR.003.047|MANAGED-CARE-ZIP-CODE|Managed Care ZIP Code|Mandatory|U.S.
Code 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(9)|14|276|
1. Value may only be 5 digits (0-9) (Example: 91320) or 9 digits (0-9) (Example: 91320001
2. Mandatory

MCR051|MCR.003.051|MANAGED-CARE-FAX-NUMBER|Managed Care Fax Number|Optional
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|Optional

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 c values reported in the Managed Care Service Area Name
See T-MSIS Guidance Document, "CMS Guidance: Best Practice for Reporting Managed Car Service Area in the Managed Care File".
https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/4754
MANAGED-CARE-SERVICE-AREA-NAME|MCR00004|MANAGED-CARE-SERVICE-AREA|X(30)|5|63|1. Value must be in Managed Care Service Area Name List (VVL)
2. If associated Managed Care Service Area (MCR.002.029) is in [2, 3, 4, 5, 6], then value mandatory and must be provided
3. Value must not contain a pipe or asterisk symbol
4. Value must be 30 characters or less
5. Conditional
6. If associated Managed Care Service Area (MCR.002.029) equals '5' (zipcode), then value must be a 5-digit zipcode
7. If associated Managed Care Service Area (MCR.002.029) equals '2' (county code), then value must be a 3-digit number

MCR067|MCR.005.067|OPERATING-AUTHORITY|Operating Authority|Mandatory|The type of operating authority through which the managed care entity receives its contract authority. Managed Care Plan Type assigned to the manage care plan in the Managed Care Main seg should be consistent with the Operating Authority value reported.

See T-MSIS Guidance Document, "CMS Guidance: Best Practice for Reporting Managed Car Plan Type in the T-MSIS Managed Care File"
https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/4756
OPERATING-AUTHORITY|MCR00005|MANAGED-CARE-OPERATING-AUTHORITY|X(2)|5|34|35|Value must be in Operating Authority List (VVL)
2. Value must be 2 characters or less
3. Mandatory

MCR114|MCR.010.114|RECORD-ID|Record ID|Mandatory|The Record ID represents the type segment being reported. The Record ID communicates how the contents of a given row of should be interpreted depending on which segment type the Record ID represents. Each t of segment collects different data elements so each segment type has a distinct layout. Th first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).|N/A|MCR0 MANAGED-CARE-ID|X(8)|1|1|8|1. Mandatory
2. Value must be 8 characters
3. Value must be in Record ID List (VVL)

MCR119|MCR.010.119|MANAGED-CARE-PLAN-ID|Managed Care Plan ID|Mandatory|A data element to capture the various IDs used to identify a managed care plan. The specific type identifier is defined in the corresponding value in the Managed Care Plan Identifier Type da element.|N/A|MCR00010|MANAGED-CARE-ID|X(30)|6|36|65|1. Value must be 2 characters
3. Mandatory

PRV002|PRV.001.002|DATA-DICTIONARY-VERSION|Data Dictionary Version|Mandatory|A da element to capture the version of the T-MSIS data dictionary that was used to build the file the version number specified on the Cover Sheet of the data dictionary".|DATA-DICTIONAR VERSION|PRV00001|FILE-HEADER-RECORD-PROVIDER|X(10)|2|9|18|1. Value must be 10 characters or less
2. Value must not include the pipe ("|") symbol
3. Mandatory

PRV006|PRV.001.006|FILE-NAME|File Name|Mandatory|A code to identify the subject area t 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 C Plan Information,
Inpatient, Long-Term Care, Other, and Pharmacy Claim).|FILE-NAME|PRV00001|FILE-HEADE RECORD-PROVIDER|X(8)|6|32|39|1. Value must equal 'PROVIDER'
2. 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 t
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
2. Value must be 2 characters
3. Mandatory
4. (individual) if value equals '03', then Provider First Name (PRV.002.028) must be popula
5. (organization) if value does not equal '03', then Provider Middle Initial (PRV.002.029) mu
not be populated
6. (individual) if value equals '03', then Provider Last Name (PRV.002.030) must be popula
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 popu
9. (organization) if value equals '01' or '02', then Provider Date of Death (PRV.002.035) mu
not be populated

PRV052|PRV.003.052|ADDR-ZIP-CODE|Provider ZIP Code|Mandatory|U.S. ZIP Code compon
of an address associated with a given entity (e.g. person, organization, agency, etc.)|N/A|
PRV00003|PROV-LOCATION-AND-CONTACT-INFO|X(9)|14|284|292|1. Value may only be 5 c
(0-9) (Example: 91320) or 9 digits (0-9) (Example: 913200011)
2. Mandatory

PRV056|PRV.003.056|ADDR-BORDER-STATE-IND|Address Border State Indicator|Mandatory
code identify an out of state provider enrolled with the state (The provider location is out c
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. V
must be in Address Border State Indicator List (VVL)
2. Mandatory

PRV068|PRV.004.068|LICENSE-ISSUING-ENTITY-ID|License Issuing Entity ID|Mandatory|A fr
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.
-If associated License Type is equal to 1 and issuing authority is a State, then value must b
ANSI State abbreviation code.
- If associated License Type is equal to 1 and issuing authority is a county, then value mus
a 5-digit, concatenated code consisting of the ANSI
state code plus the ANSI county code.A list of codes can be found here:
https://www.nrcs.usda.gov/wps/portal/nrcs/detail/national/home/?cid=nrcs143_013697
- If associated License Type is equal to 1 and issuing authority is a municipality, then enter
text string with the name of the municipality.
-If associated License Type is equal to 3, then enter the text string identifying the professio
society issuing the accreditation.
-If associated License Type is equal to 4, then value must be the text string identifying the
accreditation body's name.|N/A|PRV00004|PROV-LICENSING-INFO|X(60)|9|74|133|1. Value
not contain a pipe or asterisk symbol
2. Value must be 60 characters or less
3. (required) if associated License or Accreditation Number (PRV.004.069) value is populat
then value is mandatory and must be provided
4. Mandatory
5. Value must equal 'DEA' when associated License Type equals '2'

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 Pro
Classification Type and Provider Classification Code in the T-MSIS Provider File'
https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/98581 . 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.
Value must be in Provider Classification Type List (VVL)
2. Value must be 1 character
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 eleme Beds should not be counted twice under different bed types. See T-MSIS Guidance Docume "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/tmsis-blog/entry/47561|N/A|PRV00010|PROV-BED-TYPE-INFO|9(5)|9|78|1. Value must be 5 digits or less
2. Mandatory

TPL002|TPL.001.002|DATA-DICTIONARY-VERSION|Data Dictionary Version|Mandatory|A dat element to capture the version of the T-MSIS data dictionary that was used to build the file the version number specified on the Cover Sheet of the data dictionary".|DATA-DICTIONAR VERSION|TPL00001|FILE-HEADER-RECORD-TPL|X(10)|2|9|18|1. Value must be 10 character less
2. Value must not include the pipe ("|") symbol
3. Mandatory

TPL006|TPL.001.006|FILE-NAME|File Name|Mandatory|A code to identify the subject area t 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 C Plan Information, Inpatient, Long-Term Care, Other, and Pharmacy Claim).|FILE-NAME|TPL00001|FILE-HEADE RECORD-TPL|X(8)|6|32|39|1. Value must equal 'TPL-FILE'
2. Mandatory

TPL008|TPL.001.008|DATE-FILE-CREATED|Date File Created|Mandatory|The date on which file was created.|N/A|TPL00001|FILE-HEADER-RECORD-TPL|9(8)|8|42|49|1. Value of the CC component must be "20"
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 or Sept 31st)
4. Value must be less than current date
5. Value must be equal to or after the value of associated End of Time Period
6. Mandatory

TPL019|TPL.002.019|MSIS-IDENTIFICATION-NUM|MSIS Identification Number|Mandatory|A s
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 da
distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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-blog/entry/4757
|N/A|TPL00002|TPL-MEDICAID-ELIGIBLE-PERSON-MAIN|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

TPL020|TPL.002.020|TPL-HEALTH-INSURANCE-COVERAGE-IND|TPL Health Insurance Covera
Indicator|Mandatory|A flag to indicate that the Medicaid/CHIP eligible person has some form
third party insurance coverage.|TPL-HEALTH-INSURANCE-COVERAGE-IND|TPL00002|TPL-
MEDICAID-ELIGIBLE-PERSON-MAIN|X(1)|5|42|42|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)
4. Value must be 1 character
5. Mandatory
6. When value equals '1', there must be one corresponding TPL Medicaid Eligible Person He
Insurance Coverage Information (TPL.003) segment with the same MSIS ID.

TPL032|TPL.003.032|MSIS-IDENTIFICATION-NUM|MSIS Identification Number|Mandatory|A s
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 da
distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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-blog/entry/4757
|N/A|TPL00003|TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO|X(2
22|41|1. Mandatory
2. Value must be 20 characters or less

TPL066|TPL.005.066|MSIS-IDENTIFICATION-NUM|MSIS Identification Number|Mandatory|A s
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 da
distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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-blog/entry/4757
|N/A|TPL00005|TPL-MEDICAID-ELIGIBLE-OTHER-THIRD-PARTY-COVERAGE-INFORMATION|X(
22|41|1. Mandatory
2. Value must be 20 characters or less

TPL082|TPL.006.082|INSURANCE-CARRIER-ZIP-CODE|Insurance Carrier ZIP Code|Optional|T
ZIP Code for the location being captured on the TPL Entity Contact Information record.|N/A
TPL00006|TPL-ENTITY-CONTACT-INFORMATION|X(9)|11|246|254|1. Value may only be 5 dig
(0-9) (Example: 91320) or 9 digits (0-9) (Example: 913200011)
2. Optional

2|CIP002|CIP.001.002|DATA-DICTIONARY-VERSION|Data Dictionary Version|Mandatory|A da
element to capture the version of the T-MSIS data dictionary that was used to build the file
the version number specified on the Cover Sheet of the data dictionary.|DATA-DICTIONARY
VERSION|CIP00001|FILE-HEADER-RECORD-IP|X(10)|2|9|18|1. Value must be 10 characters
less
2. Value must be in Data Dictionary Version List (VVL)
3. Value must not include the pipe ("|") symbol
4. Mandatory

5|CIP005|CIP.001.005|DATA-MAPPING-DOCUMENT-VERSION|Data Mapping Document Versi
Mandatory|Identifies the version of the T-MSIS data mapping document used to build a sta
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 charact
or less
2. Mandatory

77|CIP126|CIP.002.126|FUNDING-CODE|Funding Code|Conditional|A code to indicate the so
of non-federal share funds.|FUNDING-CODE|CIP00002|CLAIM-HEADER-RECORD-IP|X(2)|62|4
488|1. Value must be 1 character
2. Value must be in Funding Code List (VVL)
3. If Type of Claim is in [3,C,W], then value must be populated
4. Conditional

86|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 combin
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)|71|527|533|1. Value r
be a positive integer
2. Value must be between 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 c
5. Value must be 7 digits or less
6. Value is required if the associated Type of Service (CIP.002.257) 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) in [100-219]

143|CIP196|CIP.002.196|MEDICARE-HIC-NUM|Medicare HIC Number|Conditional|The Medica
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 t
Medicare Beneficiary Identifier (MBI) over the course of 2018 and 2019. HICN continue to b
used by Medicare for limited administrative purposes after 2019 but starting in 2020 the M
became the primary identifier for Medicare beneficiaries. HICN consists of two components
SSN & alpha-suffix or (for Railroad IDs) prefix and ID (not always SSN based)|N/A|CIP00002
CLAIM-HEADER-RECORD-IP|X(12)|128|1014|1025|1. 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
be populated
5. Value must be populated when Crossover Indicator (CIP.002.023) equals "1" and Medica
Beneficiary Identifier (CIP.002.222) is not populated

199|CIP237|CIP.003.237|LINE-NUM-ORIG|Original Line Number|Mandatory|A unique numbe
identify the transaction line number that is being reported on the original claim.|N/A|CIP00
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

208|CIP249|CIP.003.249|REVENUE-CENTER-QUANTITY-ACTUAL|Revenue Center Quantity A
Mandatory|On facility claim entries, 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
blood, etc. However, when HCPCS codes are required for services, the units are equal to th
number of times the procedure/service being reported was performed. For CLAIMOT
claims/encounter records use Service Quantity Actual and CLAIMRX claims/encounter reco
use the Prescription Quantity Actual field|N/A|CIP00003|CLAIM-LINE-RECORD-IP|S9(6)V999|
187|195|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
123456.789
3. Mandatory

209|CIP250|CIP.003.250|REVENUE-CENTER-QUANTITY-ALLOWED|Revenue Center Quantity
Allowed|Conditional|On facility claim entries, 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
units are equal to the number of times the procedure/service being reported was performe
This field is only applicable when the service being billed can be quantified in discrete unit
e.g., a number of visits or the number of units of a prescription/refill that were filled. For
CLAIMOT claims/encounter records use Service Quantity Actual and CLAIMRX claims/encou
records use the Prescription Quantity Actual field.|N/A|CIP00003|CLAIM-LINE-RECORD-IP|
S9(6)V999|17|196|204|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
123456.789
3. Conditional

215|CIP257|CIP.003.257|TYPE-OF-SERVICE|Type of Service|Mandatory|A code to categorize
services provided to a Medicaid or CHIP enrollee.|TYPE-OF-SERVICE|CIP00003|CLAIM-LINE-
RECORD-IP|X(3)|23|259|261|1. Value must be 3 characters
2. Mandatory
3. Value must be in Type of Service List (VVL)
4. If Sex (ELG.002.023) equals "M", then value must not equal "086"
5. Value must be in [001,058,060,084,086,090,091,092,093,123,132,135,136,137]

225|CIP278|CIP.003.278|NDC-QUANTITY|NDC Quantity|Conditional|This field is to capture t
actual quantity of the National Drug Code being prescribed on the claim.|N/A|CIP00003|CL
LINE-RECORD-IP|S9(9)V(9)|33|343|360|1. Value may include up to 9 digits to the left of the
decimal point, and 9 digits to the right e.g. 123456789.123456789
2. Conditional

256|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 th file. Use the version number specified on the Cover Sheet of the data dictionary.|DATA-DICTIONARY-VERSION|CLT00001|FILE-HEADER-RECORD-LT|X(10)|2|9|18|1. Value must be 1 characters or less
2. Value must be in Data Dictionary Version List (VVL)
3. Value must not include the pipe ("|") symbol
4. Mandatory

259|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 bu state submission file. Use the version number specified on the title page of the data mapp document|N/A|CLT00001|FILE-HEADER-RECORD-LT|X(9)|5|23|31|1. Value must be 9 charac or less
2. Mandatory

310|CLT076|CLT.002.076|FUNDING-CODE|Funding Code|Conditional|A code to indicate the source of non-federal share funds.|FUNDING-CODE|CLT00002|CLAIM-HEADER-RECORD-LT|X 41|364|365|1. Value must be 1 character
2. Value must be in Funding Code List (VVL)
3. If Type of Claim is in [3,C,W], then value must be populated
4. Conditional

368|CLT140|CLT.002.140|MEDICARE-HIC-NUM|Medicare HIC Number|Conditional|The Medic 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 t Medicare Beneficiary Identifier (MBI) over the course of 2018 and 2019. HICN continue to b used by Medicare for limited administrative purposes after 2019 but starting in 2020 the M became the primary identifier for Medicare beneficiaries. HICN consists of two components SSN & alpha-suffix or (for Railroad IDs) prefix and ID (not always SSN based)|N/A|CLT0000 CLAIM-HEADER-RECORD-LT|X(12)|99|803|814|1. 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 be populated
5. Value must be populated when Crossover Indicator (CLT.002.023) equals "1" and Medica Beneficiary Identifier (CLT.002.168) is not populated

426|CLT190|CLT.003.190|LINE-NUM-ORIG|Original Line Number|Mandatory|A unique numb
identify the transaction line number that is being reported on the original claim.|N/A|CLT00
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 must be one or greater

435|CLT202|CLT.003.202|REVENUE-CENTER-QUANTITY-ACTUAL|Revenue Center Quantity
Actual|Mandatory|On facility claim entries, this field is to capture the actual service quanti
revenue code category, e.g., number of days in a particular type of accommodation, pints
blood, etc. However, when HCPCS codes are required for services, the units are equal to th
number of times the procedure/service being reported was performed. For CLAIMOT
claims/encounter records use Service Quantity Actual and CLAIMRX claims/encounter reco
use the Prescription Quantity Actual field|N/A|CLT00003|CLAIM-LINE-RECORD-LT|S9(6)V999
187|195|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
123456.789
3. Mandatory

436|CLT203|CLT.003.203|REVENUE-CENTER-QUANTITY-ALLOWED|Revenue Center Quantity
Allowed|Conditional|On facility claim entries, 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
units are equal to the number of times the procedure/service being reported was performe
This field is only applicable when the service being billed can be quantified in discrete unit
e.g., a number of visits or the number of units of a prescription/refill that were filled. For
CLAIMOT claims/encounter records use Service Quantity Actual and CLAIMRX claims/enco
records use the Prescription Quantity Actual field.|N/A|CLT00003|CLAIM-LINE-RECORD-LT|
S9(6)V999|17|196|204|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
123456.789
3. Conditional

444|CLT211|CLT.003.211|TYPE-OF-SERVICE|Type of Service|Mandatory|A code to categoriz
services provided to a Medicaid or CHIP enrollee.|TYPE-OF-SERVICE|CLT00003|CLAIM-LINE-
RECORD-LT|X(3)|25|285|287|1. Value must be 3 characters
2. Mandatory
3. Value must be in Type of Service List (VVL)
4. Value must be in [009,044,045,046,047,048,050,059,133,136,137,146,147]

454|CLT230|CLT.003.230|NDC-QUANTITY|NDC Quantity|Conditional|This field is to capture actual quantity of the National Drug Code being prescribed on the claim.|N/A|CLT00003|CL LINE-RECORD-LT|S9(9)V(9)|35|360|377|1. Value may include up to 9 digits to the left of the decimal point, and 9 digits to the right e.g. 123456789.123456789
2. Conditional

483|COT002|COT.001.002|DATA-DICTIONARY-VERSION|Data Dictionary Version|Mandatory data element to capture the version of the T-MSIS data dictionary that was used to build th file. Use the version number specified on the Cover Sheet of the data dictionary.|DATA-DICTIONARY-VERSION|COT00001|FILE-HEADER-RECORD-OT|X(10)|2|9|18|1. Value must be characters or less
2. Value must be in Data Dictionary Version List (VVL)
3. Value must not include the pipe ("|") symbol
4. Mandatory

486|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 bu state submission file. Use the version number specified on the title page of the data mapp document|N/A|COT00001|FILE-HEADER-RECORD-OT|X(9)|5|23|31|1. Value must be 9 chara or less
2. Mandatory

533|COT062|COT.002.062|FUNDING-CODE|Funding Code|Conditional|A code to indicate the source of non-federal share funds.|FUNDING-CODE|COT00002|CLAIM-HEADER-RECORD-OT 37|344|345|1. Value must be 1 character
2. Value must be in Funding Code List (VVL)
3. If Type of Claim is in [3,C,W], then value must be populated
4. Conditional

583|COT114|COT.002.114|BILLING-PROV-TAXONOMY|Billing Provider Taxonomy|Conditiona taxonomy code for the provider billing for the service.|PROV-TAXONOMY|COT00002|CLAIM-HEADER-RECORD-OT|X(12)|87|704|715|1. Value must be in Provider Taxonomy List (VVL)
2. Value must be 12 characters or less
3. Conditional
4. If associated Type of Service value is in [119,120,121,122], then value should not be populated

588|COT122|COT.002.122|MEDICARE-HIC-NUM|Medicare HIC Number|Conditional|The Med
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 t
Medicare Beneficiary Identifier (MBI) over the course of 2018 and 2019. HICN continue to b
used by Medicare for limited administrative purposes after 2019 but starting in 2020 the M
became the primary identifier for Medicare beneficiaries. HICN consists of two components
SSN & alpha-suffix or (for Railroad IDs) prefix and ID (not always SSN based)|N/A|COT0000
CLAIM-HEADER-RECORD-OT|X(12)|92|760|771|1. 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
be populated
5. Value must be populated when Crossover Indicator (COT.002.023) equals "1" and Medic
Beneficiary Identifier (COT.002.147) is not populated

639|COT160|COT.003.160|LINE-NUM-ORIG|Original Line Number|Mandatory|A unique numb
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 must be one or greater

659|COT183|COT.003.183|SERVICE-QUANTITY-ACTUAL|Service Quantity Actual|Mandatory|
quantity of a service or product that is rendered for a specific date of service or billing time
span as reported by revenue code or procedure code on the claim line. For use with CLAIM
and CLAIMRX claims. For CLAIMIP and CLAIMOT claims/encounter records, use the Service
Quantity Actual field.|N/A|COT00003|CLAIM-LINE-RECORD-OT|S9(8)V999|27|298|308|1. Val
may include up to 8 digits to the left of the decimal point, and 3 digits to the right e.g.
12345678.999
2. Mandatory
3. When populated, corresponding Unit of Measure must be populated

660|COT184|COT.003.184|SERVICE-QUANTITY-ALLOWED|Service Quantity Allowed|Conditi
The maximum allowable quantity of a service that may be rendered per date of service or
month. For use with CLAIMOT and CLAIMRX claims. For CLAIMIP and CLAIMOT claims/encou
records, use the Revenue center -quantity Allowed field. NOTE: One prescription for 100 25
milligram tablets results in Prescription Quantity allowed=100.This field is only applicable
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 Me
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 value in Prescriptio
Quantity allowed must correspond with the value in Unit of measure.|N/A|COT00003|CLAIM
LINE-RECORD-OT|S9(8)V999|28|309|319|1. Value may include up to 8 digits to the left of t
decimal point, and 3 digits to the right e.g. 12345678.999
2. Conditional

661|COT186|COT.003.186|TYPE-OF-SERVICE|Type of Service|Mandatory|A code to categori
the services provided to a Medicaid or CHIP enrollee.|TYPE-OF-SERVICE|COT00003|CLAIM-L
RECORD-OT|X(3)|29|320|322|1. Value must be 3 characters.
2. Mandatory
3. Value must be in Type of Service List (VVL)
4. Value must be in
[002,003,004,005,006,007,008,010,011,012,013,014,015,016,017,018,019,020,
021,022,023,024,025,026,027,028,029,030,031,032,035,036,037,038,039,040,041,042,04
9,050,051,052,053,054,055,056,057,058,060,061,062,063,064,065,066,
067,068,069,070,071,072,073,074,075,076,077,078,079,080,081,082,083,084,085,
086,087,088,089,115,127,136,137,144,145,147]
5. When value is not in [025,085], Sex (ELG.002.023) equals "M"

663|COT188|COT.003.188|HCBS-TAXONOMY|HCBS Taxonomy|Conditional|A code to classif
home and community based services listed on the claim into the HCBS taxonomy.|HCBS-
TAXONOMY|COT00003|CLAIM-LINE-RECORD-OT|X(5)|31|324|328|1. Value must be 5 charac
or less
2. Value must be in HCBS Taxonomy Code List (VVL)
3. Conditional

694|COT225|COT.003.225|NDC-QUANTITY|NDC Quantity|Conditional|This field is to capture
actual quantity of the National Drug Code being prescribed on the claim.|N/A|COT00003|CL
LINE-RECORD-OT|S9(9)V(9)|62|777|794|1. Value may include up to 9 digits to the left of th
decimal point, and 9 digits to the right e.g. 123456789.123456789
2. Conditional

734|CRX002|CRX.001.002|DATA-DICTIONARY-VERSION|Data Dictionary Version|Mandatory
data element to capture the version of the T-MSIS data dictionary that was used to build th
file. Use the version number specified on the Cover Sheet of the data dictionary.|DATA-
DICTIONARY-VERSION|CRX00001|FILE-HEADER-RECORD-RX|X(10)|2|9|18|1. Value must be
characters or less
2. Value must be in Data Dictionary Version List (VVL)
3. Value must not include the pipe ("|") symbol
4. Mandatory

737|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 bu state submission file. Use the version number specified on the title page of the data mapp document|N/A|CRX00001|FILE-HEADER-RECORD-RX|X(9)|5|23|31|1. Value must be 9 chara or less
2. Mandatory

781|CRX053|CRX.002.053|FUNDING-CODE|Funding Code|Conditional|A code to indicate the source of non-federal share funds.|FUNDING-CODE|CRX00002|CLAIM-HEADER-RECORD-RX 34|324|325|1. Value must be 1 character
2. Value must be in Funding Code List (VVL)
3. If Type of Claim is in [3,C,W], then value must be populated
4. Conditional

803|CRX079|CRX.002.079|MEDICARE-HIC-NUM|Medicare HIC Number|Conditional|The Medi 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 t Medicare Beneficiary Identifier (MBI) over the course of 2018 and 2019. HICN continue to b used by Medicare for limited administrative purposes after 2019 but starting in 2020 the M became the primary identifier for Medicare beneficiaries. HICN consists of two components SSN & alpha-suffix or (for Railroad IDs) prefix and ID (not always SSN based)|N/A|CRX0000 CLAIM-HEADER-RECORD-RX|X(12)|56|556|567|1. 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 be populated
5. Value must be populated when Crossover Indicator (CRX.002.023) equals "1" and Medic Beneficiary Identifier (CRX.002.105) is not populated

846|CRX114|CRX.003.114|LINE-NUM-ORIG|Original Line Number|Mandatory|A unique numb identify the transaction line number that is being reported on the original claim.|N/A|CRX0 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

862|CRX131|CRX.003.131|PRESCRIPTION-QUANTITY-ALLOWED|Prescription Quantity Allow
Conditional|The maximum allowable quantity of a drug or service that may be dispensed p
prescription per date of service or per month. Quantity limits are applied to medications w
the majority of appropriate clinical utilizations will be addressed within the quantity allowe
For use with CLAIMOT and CLAIMRX claims. For CLAIMIP and CLAIMLT claims/encounter rec
use the Revenue Center Quantity Actual field. One prescription for 100 250 milligram table
results in Prescription Quantity Allowed =100.|N/A|CRX00003|CLAIM-LINE-RECORD-RX|
S9(9)V(9)|23|290|307|1. Value may include up to 9 digits to the left of the decimal point, a
digits to the right e.g. 123456789.123456789
2. When populated, corresponding Unit of Measure must be populated
3. Conditional

863|CRX132|CRX.003.132|PRESCRIPTION-QUANTITY-ACTUAL|Prescription Quantity Actual|
Mandatory|The quantity of a drug that is dispensed for a prescription as reported by Natio
Drug Code on the claim line. For use with CLAIMOT and CLAIMRX claims. For CLAIMIP and
CLAIMLT claims/encounter records, use the Revenue Center Quantity Actual field.|N/A|
CRX00003|CLAIM-LINE-RECORD-RX|S9(9)V(9)|24|308|325|1. Value may include up to 9 dig
to the left of the decimal point, and 9 digits to the right e.g. 123456789.123456789
2. Mandatory

865|CRX134|CRX.003.134|TYPE-OF-SERVICE|Type of Service|Mandatory|A code to categori
the services provided to a Medicaid or CHIP enrollee.|TYPE-OF-SERVICE|CRX00003|CLAIM-L
RECORD-RX|X(3)|26|328|330|1. Value must be 3 characters
2. Mandatory
3. Value must be in Type of Service List (VVL)
4. Value must be in [011,018,033,034,036,085,089,127,131,136,137,145]

867|CRX136|CRX.003.136|HCBS-TAXONOMY|HCBS Taxonomy|Conditional|A code to classif
home and community based services listed on the claim into the HCBS taxonomy.|HCBS-
TAXONOMY|CRX00003|CLAIM-LINE-RECORD-RX|X(5)|28|332|336|1. Value must be 5 charac
or less
2. Value must be in HCBS Taxonomy Code List (VVL)
3. Conditional

874|CRX143|CRX.003.143|DRUG-UTILIZATION-CODE|Drug Utilization Code|Mandatory|A co
indicating the conflict, intervention and outcome of a prescription presented for fulfillment
T-MSIS Drug Utilization Code data element is composite field comprised of three distinct N
data elements: 'Reason for Service Code' (439-E4); 'Professional Service Code' (440-E5); a
'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 r
in different coverage, pricing, patient financial responsibility, drug utilization review outcor
or if the information affects payment for, or documentation of, professional pharmacy serv
The NCPDP 'Reasons of Service Code' (bytes 1 & 2 of the T-MSIS DRUG-UTILIZATION-
CODE) explains whether the pharmacist filled the prescription, filled part of the prescriptio
etc. The NCPDP 'Professional Service Code' (bytes 3 & 4 of the T-MSIS Drug Utilizatior
Code) describes what the pharmacist did for the patient. The NCPDP 'Result of Service Coc
(bytes 5 & 6 of the T-MSIS Drug Utilization Code) describes the action the pharmacist
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 t
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.|DRUG-UTILIZATION-CODE-E4, DRUG-
UTILIZATION-CODE-E5, DRUG-UTILIZATION-CODE-E6|CRX00003|CLAIM-LINE-RECORD-RX|X(
35|368|373|1. Value must be 6 characters or less
2. Characters 1 and 2 (2-character string) must be in Drug Utilization Reason for Service C
List (VVL)
3. Characters 3 and 4 (2-character string) must be in Drug Utilization Professional Service
List (VVL)
4. Characters 5 and 6 (2-character string) must be in Drug Utilization Result of Service Coc
List (VVL)
5. Mandatory

921|ELG002|ELG.001.002|DATA-DICTIONARY-VERSION|Data Dictionary Version|Mandatory|
data element to capture the version of the T-MSIS data dictionary that was used to build th
file. Use the version number specified on the Cover Sheet of the data dictionary.|DATA-
DICTIONARY-VERSION|ELG00001|FILE-HEADER-RECORD-ELIGIBILITY|X(10)|2|9|18|1. Value
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

924|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 bu
state submission file. Use the version number specified on the title page of the data mapp
document|N/A|ELG00001|FILE-HEADER-RECORD-ELIGIBILITY|X(9)|5|23|31|1. Value must be
characters or less
2. Mandatory

968|ELG050|ELG.003.050|MEDICARE-HIC-NUM|Medicare HIC Number|Conditional|The Medi
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 t
Medicare Beneficiary Identifier (MBI) over the course of 2018 and 2019. HICN continue to b
used by Medicare for limited administrative purposes after 2019 but starting in 2020 the M
became the primary identifier for Medicare beneficiaries. HICN consists of two components
SSN & alpha-suffix or (for Railroad IDs) prefix and ID (not always SSN based)|N/A|ELG0000
VARIABLE-DEMOGRAPHICS-ELIGIBILITY|X(12)|20|126|137|1. Value must be 12 characters o
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
populated.
5. (Medicare Enrolled) if associated Dual Eligible Code (ELG.005.085) value is in
[01,02,03,04,05,06,08,09,10], then value for either HICN or MBI is mandatory and must be
provided

981|ELG066|ELG.004.066|ELIGIBLE-ADDR-LN1|Eligible Address Line 1|Mandatory|The first l
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|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. Mandatory
5. When populated, the associated Address Type is required

991|ELG076|ELG.004.076|ELIGIBLE-ADDR-END-DATE|Eligible Address End Date|Mandatory
last calendar day on which all of the other data elements in the same segment were effect
N/A|ELG00004|ELIGIBLE-CONTACT-INFORMATION|9(8)|16|384|391|1. The date must be a v
calendar date in the form "CCYYMMDD"
2. Value must be before or the same as the associated Segment Effective Date value
3. Mandatory
4. Value of the CC component must be in [18,19,20,99]

998|ELG085|ELG.005.085|DUAL-ELIGIBLE-CODE|Dual Eligible Code|Mandatory|Indicates coverage for individuals entitled to Medicare (Part A and/or B benefits) and eligible for som category of Medicaid benefits.|DUAL-ELIGIBLE-CODE|ELG00005|ELIGIBILITY-DETERMINANT X(2)|6|54|55|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"
3. If value equals "06", then Eligibility Group (ELG.005.087) must be "26"
4. If Dual Eligible Code (ELG.005.085) is in [01,02,03,04,05,06,08,09,10], then Primary Elig Group Indicator (ELG.005.086) must be "1" (Yes)
5. Mandatory
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 equals "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 Medicar Beneficiary Identifier (ELG.003.051) must be populated
12. If value equals "01", then Eligibility Group (ELG.005.087) must be "23"
13. If value equals "03", then Eligibility Group (ELG.005.087) must be "25"

1009|ELG097|ELG.005.097|RESTRICTED-BENEFITS-CODE|Restricted Benefits Code|Mandat
flag that indicates the scope of Medicaid or CHIP benefits to which an individual is entitled
RESTRICTED-BENEFITS-CODE|ELG00005|ELIGIBILITY-DETERMINANTS|X(1)|17|79|79|1. Valu
must be 1 character
2. Value must be in Restricted Benefits Code List (VVL)
3. (Restricted Benefits) if value equals "3" and Dual Eligible Code (ELG.005.085) value equ
"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 equ
"06", then Eligibility Group (ELG.005.087) must be "26"
5. (Restricted Benefits) if value equals "1" and Dual Eligible Code (ELG.005.085) value equ
"02", then Eligibility Group (ELG.005.087) must be "23"
6. (Restricted Benefits) if value equals "1" and Dual Eligible Code (ELG.005.085) value equ
"04", then Eligibility Group (ELG.005.087) must be "25"
7. (Restricted Benefits) if value equals "3", then Dual Eligible Code (ELG.005.085) cannot b
"00"
8. Mandatory
9. If value is populated, then Eligibility Group (ELG.005.087) must be populated.
10. If value is "6" then Eligibility Group(ELG.DE.087) must be in [35,70]
11. If value is in [1,7] then Eligibility Group (EGL.DE.087) must be in [72,73,74,75] and Sta
Plan Option Type (ELG.DE.163) must equal "06"
11. (Restricted Pregnancy-Related) if value equals "4", then associated Sex (ELG.002.023)
value must be "F"
12. (Non-Citizen) if value equals "2", then associated Citizenship Indicator (ELG.003.040) v
must not be equal to "1"
13. If value is "D", there must be a corresponding MFP enrollment segment (ELG00010) wi
Effective and End dates that are within the timespan of this segment
14. (Restricted Benefits) if value equals "3" and Dual Eligible Code (ELG.005.085) value eq
"01", then Eligibility Group (ELG.005.087) must be "23"
16. (Restricted Benefits) if value equals "3" and Dual Eligible Code (ELG.005.085) value eq
"03", then Eligibility Group (ELG.005.087) must be "25"

1012|ELG100|ELG.005.100|ELIGIBILITY-DETERMINANT-END-DATE|Eligibility Determinant En
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)|20|89|96|1. The d
must be a valid calendar date in the form "CCYYMMDD"
2. Value must be before or the same as the associated Segment Effective Date value
3. Mandatory
4. Value of the CC component must be in [18,19,20,99]

1013|ELG274|ELG.005.274|ELIGIBILITY-REDETERMINTATION-DATE|Eligibility Redeterminati
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
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 t
perform a renewal or redetermination of the individual's eligibility. |N/A|ELG00005|ELIGIBIL
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

1020|ELG281|ELG.005.281|ELIGIBILITY-TERMINATION-REASON-OTHER-TYPE-TEXT|Eligibility Termination Reason Other Type Text|Conditional|Value must be populated with a state-spe 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 less
2. Value must not be populated when Eligibility Termination Reason equals "22" (Other)
3. Value must be populated when Eligibility Termination Reason does not equal "22" (Othe
4. Conditional

1029|ELG110|ELG.006.110|HEALTH-HOME-SPA-PARTICIPATION-END-DATE|Health Home SP Participation End Date|Mandatory|The last calendar day on which all of the other data elem in the same segment were effective.|N/A|ELG00006|HEALTH-HOME-SPA-PARTICIPATION-INFORMATION|9(8)|8|250|257|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 Effective Date value
3. Mandatory
4. Value of the CC component must be in [18,19,20,99]

1040|ELG122|ELG.007.122|HEALTH-HOME-SPA-PROVIDER-END-DATE|Health Home Spa Pro End Date|Mandatory|The last calendar day on which all of the other data elements in the s segment were effective.|N/A|ELG00007|HEALTH-HOME-SPA-PROVIDERS|9(8)|9|280|287|1. T date must be a valid calendar date in the form "CCYYMMDD"
2. Value must be before or the same as the associated Segment Effective Date value
3. Mandatory
4. Value of the CC component must be in [18,19,20,99]

1042|ELG124|ELG.007.124|STATE-NOTATION|State Notation|Situational|A free text field for submitting state to enter whatever information it chooses.|N/A|ELG00007|HEALTH-HOME-S 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. Situational

1050|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. The date must be a valid calendar date in the form "CCYYMMDD"
2. Value must be before or the same as the associated Segment Effective Date value
3. Mandatory
4. Value of the CC component must be in [18,19,20,99]

1059|ELG143|ELG.009.143|LOCKIN-END-DATE|Lockin End Date|Mandatory|The last calenda
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. The date must be a valid calendar date i
form "CCYYMMDD"
2. Value must be before or the same as the associated Segment Effective Date value
3. Mandatory
4. Value of the CC component must be in [18,19,20,99]

1061|ELG144|ELG.009.144|STATE-NOTATION|State Notation|Situational|A free text field for
submitting state to enter whatever information it chooses.|N/A|ELG00009|LOCK-IN-
INFORMATION|X(500)|10|93|592|1. Value must be 500 characters or less
2. Value must not contain a pipe or asterisk symbols
3. Situational

1072|ELG156|ELG.010.156|MFP-ENROLLMENT-END-DATE|MFP Enrollment End Date|Manda
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. The date must be a valid cale
date in the form "CCYYMMDD"
2. Value must be before or the same as the associated Segment Effective Date value
3. Mandatory
4. Value of the CC component must be in [18,19,20,99]

1078|ELG163|ELG.011.163|STATE-PLAN-OPTION-TYPE|State Plan Option Type|Mandatory|T
field specifies the State Plan Options in which the individual is enrolled. Use on occurrence
each State Plan Option enrollment.|STATE-PLAN-OPTION-TYPE|ELG00011|STATE-PLAN-OPTI
PARTICIPATION|X(2)|5|42|43|1. Value must be 2 characters
2. Value must be in State Plan Option Type List (VVL)
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"
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"

1098|ELG185|ELG.013.185|LTSS-ELIGIBILITY-END-DATE|LTSS Eligibility End Date|Mandator
last calendar day on which all of the other data elements in the same segment were effect
N/A|ELG00013|LTSS-PARTICIPATION|9(8)|8|81|88|1. The date must be a valid calendar date
the form "CCYYMMDD"
2. Value must be before or the same as the associated Segment Effective Date value
3. Mandatory
4. Value of the CC component must be in [18,19,20,99]

1105|ELG193|ELG.014.193|MANAGED-CARE-PLAN-TYPE|Managed Care Plan Type|Mandato
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 Ca
File"
https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-nonemergency-
medical-transportation-nemt-prepaid-ambulatory-health-plans-pahps-in-the-tmsis-manage
care-filemanaged-care/

See T-MSIS Guidance Document, "CMS Guidance: Best Practice for Reporting Managed Car
Plan Type in the T-MSIS Managed Care File"
https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-managedcareplan
in-the-t-msis-managed-care-file-managed-care/|MANAGED-CARE-PLAN-TYPE|ELG00014|
MANAGED-CARE-PARTICIPATION|X(2)|6|54|55|1. Value must be 2 characters
2. Value must be in Managed Care Plan Type List (VVL)
3. Mandatory
4. Value must not be populated when Managed Care Plan ID (ELG.014.192) is not populate
5. Value must equal the Managed Care Plan Type (MCR.002.024) associated with the State
Identification Number (MCR.002.018)

1107|ELG197|ELG.014.197|MANAGED-CARE-PLAN-ENROLLMENT-END-DATE|Managed Care
Enrollment End Date|Mandatory|The last calendar day on which all of the other data eleme
in the same segment were effective.|N/A|ELG00014|MANAGED-CARE-PARTICIPATION|9(8)|8
71|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 Effective Date value
3. Mandatory
4. Value of the CC component must be in [18,19,20,99]

1115|ELG206|ELG.015.206|ETHNICITY-DECLARATION-END-DATE|Ethnicity Declaration End
Mandatory|The last calendar day on which all of the other data elements in the same segm
were effective.|N/A|ELG00015|ETHNICITY-INFORMATION|9(8)|7|51|58|1. The date must be
valid calendar date in the form "CCYYMMDD"
2. Value must be before or the same as the associated Segment Effective Date value
3. Mandatory
4. Value of the CC component must be in [18,19,20,99]

1134|ELG226|ELG.017.226|DISABILITY-TYPE-END-DATE|Disability Type End Date|Mandator
last calendar day on which all of the other data elements in the same segment were effect
N/A|ELG00017|DISABILITY-INFORMATION|9(8)|7|52|59|1. The date must be a valid calenda
date in the form "CCYYMMDD"
2. Value must be before or the same as the associated Segment Effective Date value
3. Mandatory
4. Value of the CC component must be in [18,19,20,99]

1142|ELG235|ELG.018.235|1115A-END-DATE|1115A End Date|Mandatory|The last calenda
on which all of the other data elements in the same segment were effective.|N/A|ELG0001
1115A-DEMONSTRATION-INFORMATION|9(8)|7|51|58|1. The date must be a valid calendar
in the form "CCYYMMDD"
2. Value must be before or the same as the associated Segment Effective Date value
3. Mandatory
4. Value of the CC component must be in [18,19,20,99]

1150|ELG244|ELG.020.244|HCBS-CHRONIC-CONDITION-NON-HEALTH-HOME-END-DATE|HC
Chronic Condition Non Health Home End Date|Mandatory|The last calendar day on which a
the other data elements in the same segment were effective.|N/A|ELG00020|HCBS-CHRON
CONDITIONS-NON-HEALTH-HOME|9(8)|7|53|60|1. The date must be a valid calendar date i
form "CCYYMMDD"
2. Value must be before or the same as the associated Segment Effective Date value
3. Mandatory
4. Value of the CC component must be in [18,19,20,99]

1158|ELG254|ELG.021.254|ENROLLMENT-END-DATE|Enrollment End Date|Mandatory|The l
calendar day on which all of the other data elements in the same segment were effective.|
ELG00021|ENROLLMENT-TIME-SPAN-SEGMENT|9(8)|7|51|58|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 Effective Date value
3. Mandatory
4. Value of the CC component must be in [18,19,20,99]

1166|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 segr
were effective.|N/A|ELG00022|ELG-IDENTIFIERS|9(8)|7|61|68|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 Effective Date value
3. Mandatory
4. Value of the CC component must be in [18,19,20,99]

1185|FTX002|FTX.001.002|DATA-DICTIONARY-VERSION|Data Dictionary Version|Mandatory
data element to capture the version of the T-MSIS data dictionary that was used to build th
file. Use the version number specified on the Cover Sheet of the data dictionary.|DATA-
DICTIONARY-VERSION|FTX00001|FILE-HEADER-RECORD-FTX|X(10)|2|9|18|1. Value must be
characters or less
2. Value must be in Data Dictionary Version List (VVL)
3. Value must not include the pipe ("|") symbol
4. Mandatory

1188|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 bu state submission file. Use the version number specified on the title page of the data mapp document|N/A|FTX00001|FILE-HEADER-RECORD-FTX|X(9)|5|23|31|1. Value must be 9 characters or less
2. Mandatory

1204|FTX023|FTX.002.023|ADJUSTMENT-IND|Adjustment Indicator|Conditional|Indicates th type of adjustment record.|ADJUSTMENT-IND|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(1 122|122|1. Value must be 1 character
2. Value must be in Adjustment Indicator List (VVL)
3. Conditional

1213|FTX032|FTX.002.032|PAYER-MCR-PLAN-TYPE-OTHER-TEXT|Payer MCR Plan Type Othe Text|Conditional|This is a description of what type of managed care plan or care coordinati 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 charac or less
2. Value must be populated when Payee MCR Plan Type equals "95"
3. Conditional

1224|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 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|FTX000 INDIVIDUAL-CAPITATION-PMPM|9(8)|26|887|894|1. The date must be a valid calendar date the form "CCYYMMDD"
2. Value must be after or the same as the associated Capitation Period End Date

3. Value of the CC component must be equal to "20"
4. Mandatory

1232|FTX051|FTX.002.051|FUNDING-CODE|Funding Code|Conditional|A code to indicate th source of non-federal share funds.|FUNDING-CODE|FTX00002|INDIVIDUAL-CAPITATION-PMP X(2)|34|983|984|1. Value must be 1 character
2. Value must be in Funding Code List (VVL)
3. If Type of Claim is in [3,C,W], then value must be populated
4. Conditional

1233|FTX052|FTX.002.052|FUNDING-SOURCE-NONFEDERAL-SHARE|Funding Source Nonfed
Share|Mandatory|A code to indicate the type of non-federal share used by the state to fina
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. Mandatory

1249|FTX070|FTX.003.070|ADJUSTMENT-IND|Adjustment Indicator|Conditional|Indicates th
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. Conditional

1275|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-INSURA
PREMIUM-PAYMENT|X(2)|32|731|732|1. Value must be 2 characters
2. Value must be in Funding Code List (VVL)
3. Mandatory

1288|FTX111|FTX.004.111|ADJUSTMENT-IND|Adjustment Indicator|Conditional|Indicates th
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. Conditional

1317|FTX140|FTX.004.140|FUNDING-CODE|Funding Code|Conditional|A code to indicate th
source of non-federal share funds.|FUNDING-CODE|FTX00004|GROUP-INSURANCE-PREMIUM
PAYMENT|X(2)|35|758|759|1. Value must be 2 characters
2. Value must be in Funding Code List (VVL)
3. If Policy Owner Code equals"01", then value must be populated
4. Conditional

1330|FTX155|FTX.005.155|ADJUSTMENT-IND|Adjustment Indicator|Conditional|Indicates th
type of adjustment record.|ADJUSTMENT-IND|FTX00005|COST-SHARING-OFFSET|X(1)|6|122
1. Value must be 1 character
2. Value must be in Adjustment Indicator List (VVL)
3. Conditional

1349|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 the calendar month of beneficiary enrollment in the managed care plan to which the off-se 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 payme that is now being returned to them.|N/A|FTX00005|COST-SHARING-OFFSET|9(8)|25|805|81
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 End Date

3. Value of the CC component must be equal to "20"
4. Mandatory

1357|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) 901|902|1. Value must be 2 characters
2. Value must be in Funding Code List (VVL)
3. Mandatory

1371|FTX198|FTX.006.198|ADJUSTMENT-IND|Adjustment Indicator|Conditional|Indicates th type of adjustment record.|ADJUSTMENT-IND|FTX00006|VALUE-BASED-PAYMENT|X(1)|6|12 122|1. Value must be 1 character
2. Value must be in Adjustment Indicator List (VVL)
3. Conditional

1397|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(2 881|882|1. Value must be 2 characters
2. Value must be in Funding Code List (VVL)
3. Mandatory

1413|FTX242|FTX.007.242|ADJUSTMENT-IND|Adjustment Indicator|Conditional|Indicates th type of adjustment record.|ADJUSTMENT-IND|FTX00007|STATE-DIRECTED-PAYMENT-SEPAR PAYMENT-TERM|X(1)|6|122|122|1. Value must be 1 character
2. Value must be in Adjustment Indicator List (VVL)
3. Conditional

1430|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 expecte 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. Mandatory
3. Value of the CC component must be equal to 20

1440|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-PAYMENT-TERM|X(2)|33|963|964|1. Value must be 2 characters
2. Value must be in Funding Code List (VVL)
3. Mandatory

1454|FTX285|FTX.008.285|ADJUSTMENT-IND|Adjustment Indicator|Conditional|Indicates th type of adjustment record.|ADJUSTMENT-IND|FTX00008|COST-SETTLEMENT-PAYMENT|X(1) 122|122|1. Value must be 1 character
2. Value must be in Adjustment Indicator List (VVL)
3. Conditional

1470|FTX301|FTX.008.301|COST-SETTLEMENT-PERIOD-START-DATE|Cost Settlement Perio Start Date|Mandatory|The date representing the beginning of the cost-settlement period. F 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 "CCYYMM
2. Value must be after or the same as the associated Cost Settlement Period End Date

3. Value of the CC component must be equal to "20"
4. Mandatory

1478|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 2 characters
2. Value must be in Funding Code List (VVL)
3. Mandatory

1491|FTX324|FTX.009.324|ADJUSTMENT-IND|Adjustment Indicator|Conditional|Indicates th type of adjustment record.|ADJUSTMENT-IND|FTX00009|FQHC-WRAP-PAYMENT|X(1)|6|122|
1. Value must be 1 character
2. Value must be in Adjustment Indicator List (VVL)
3. Conditional

1507|FTX340|FTX.009.340|WRAP-PERIOD-START-DATE|Wrap Period Start Date|Mandatory|T 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 F wrap payment begin date would be March 1 of that year.|N/A|FTX00009|FQHC-WRAP-PAYM 9(8)|22|665|672|1. The date must be a valid calendar date in the form "CCYYMMDD"

2. Value must be after or the same as the associated Coverage Period End Date

3. Value of the CC component must be equal to "20"
4. Mandatory

1515|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)|3
761|762|1. Value must be 2 characters
2. Value must be in Funding Code List (VVL)
3. Mandatory

1528|FTX363|FTX.095.363|ADJUSTMENT-IND|Adjustment Indicator|Conditional|Indicates th
type of adjustment record.|ADJUSTMENT-IND|FTX00095 |MISCELLANEOUS-PAYMENT|X(1)|6
122|1. Value must be 1 character
2. Value must be in Adjustment Indicator List (VVL)
3. Conditional

1561|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|
39|1199|1200|1. Value must be 2 characters
2. Value must be in Funding Code List (VVL)
3. Mandatory

1572|MCR002|MCR.001.002|DATA-DICTIONARY-VERSION|Data Dictionary Version|Mandato
data element to capture the version of the T-MSIS data dictionary that was used to build th
file. Use the version number specified on the Cover Sheet of the data dictionary.|DATA-
DICTIONARY-VERSION|MCR00001|FILE-HEADER-RECORD-MANAGED-CARE|X(10)|2|9|18|1. V
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

1575|MCR005|MCR.001.005|DATA-MAPPING-DOCUMENT-VERSION|Data Mapping Documen
Version|Mandatory|Identifies the version of the T-MSIS data mapping document used to bu
state submission file. Use the version number specified on the title page of the data mapp
document|N/A|MCR00001|FILE-HEADER-RECORD-MANAGED-CARE|X(9)|5|23|31|1. Value m
be 9 characters or less
2. Mandatory

1597|MCR027|MCR.002.027|CORE-BASED-STATISTICAL-AREA-CODE|Core Based Statistical Code|Mandatory|A code signifying whether the Managed Care Organization's (MCO) servic area falls into one or more metropolitan or micropolitan statistical areas. Whenever a serv area straddles two types of areas (e.g., metropolitan & micropolitan, metropolitan & non-C area) classify the service area based on the denser classification. Metropolitan and micropolitan statistical areas (metro and micro areas) are geographic entities defined by t U.S. Office of Management and Budget (OMB). The term "Core Based Statistical Area" (CBS a collective term for both metro and micro areas. A metro area contains a core urban area 50,000 or more population, and a micro area contains an urban core of at least 10,000 (bu 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 tha have a high degree of social and economic integration (as measured by commuting to wor with the urban core. The U.S. Office of Management and Budget (OMB) defines metropolita 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. Betw 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.
http://www.whitehouse.gov/sites/default/files/omb/assets/bulletins/b10-02.pdf|CORE-BASE STATISTICAL-AREA-CODE|MCR00002|MANAGED-CARE-MAIN|X(1)|12|112|112|1. Value must character
2. Value must be in Core Based Statistical Area Code List (VVL)
3. Mandatory

1601|MCR031|MCR.002.031|MANAGED-CARE-MAIN-REC-END-DATE|Managed Care Main Re End Date|Mandatory|The last calendar day on which all of the other data elements in the s segment were effective.|N/A|MCR00002|MANAGED-CARE-MAIN|9(8)|16|125|132|1. The dat must be a valid calendar date in the form "CCYYMMDD"
2. Value must be before or the same as the associated Segment Effective Date value
3. Mandatory
4. Value of the CC component must be in [18,19,20,99]

1609|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 the other data elements in the same segment were effective.|N/A|MCR00003|MANAGED-C LOCATION-AND-CONTACT-INFO|9(8)|7|57|64|1. The date must be a valid calendar date in t form "CCYYMMDD"
2. Value must be before or the same as the associated Segment Effective Date value
3. Mandatory
4. Value of the CC component must be in [18,19,20,99]

1628|MCR060|MCR.004.060|MANAGED-CARE-SERVICE-AREA-END-DATE|Managed Care Ser
Area End Date|Mandatory|The last calendar day on which all of the other data elements in
same segment were effective.|N/A|MCR00004|MANAGED-CARE-SERVICE-AREA|9(8)|7|72|79
The date must be a valid calendar date in the form "CCYYMMDD"
2. Value must be before or the same as the associated Segment Effective Date value
3. Mandatory
4. Value of the CC component must be in [18,19,20,99]

1637|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 elemen
the same segment were effective.|N/A|MCR00005|MANAGED-CARE-OPERATING-AUTHORITY
9(8)|8|64|71|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 Effective Date value
3. Mandatory
4. Value of the CC component must be in [18,19,20,99]

1645|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 eleme
in the same segment were effective.|N/A|MCR00006|MANAGED-CARE-PLAN-POPULATION-
ENROLLED|9(8)|7|44|51|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 Effective Date value
3. Mandatory
4. Value of the CC component must be in [18,19,20,99]

1653|MCR088|MCR.007.088|DATE-ACCREDITATION-END|Date Accreditation End|Mandatory
date when organization's accreditation ends.|N/A|MCR00007|MANAGED-CARE-ACCREDITAT
ORGANIZATION|9(8)|7|44|51|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 [18,19,20]

1659|MCR118|MCR.010.118|MANAGED-CARE-PLAN-ID-TYPE|Managed Care Plan 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 whenev
identifier is retired or issued.|MANAGED-CARE-PLAN-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 ID Type List (VVL)
3. Mandatory

1660|MCR119|MCR.010.119|MANAGED-CARE-PLAN-ID|Managed Care Plan ID|Mandatory|A element to capture the various IDs used to identify a managed care plan. The specific type identifier is defined in the corresponding value in the Managed Care Plan Identifier Type da 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

1662|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-CA ID|9(8)|8|74|81|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 Effective Date value
3. Mandatory
4. Value of the CC component must be in [18,19,20,99]

1665|PRV002|PRV.001.002|DATA-DICTIONARY-VERSION|Data Dictionary Version|Mandatory data element to capture the version of the T-MSIS data dictionary that was used to build th file. Use the version number specified on the Cover Sheet of the data dictionary.|DATA-DICTIONARY-VERSION|PRV00001|FILE-HEADER-RECORD-PROVIDER|X(10)|2|9|18|1. Value n 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

1668|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 bu state submission file. Use the version number specified on the title page of the data mapp document|N/A|PRV00001|FILE-HEADER-RECORD-PROVIDER|X(9)|5|23|31|1. Value must be characters or less
2. Mandatory

1707|PRV044|PRV.003.044|PROV-LOCATION-AND-CONTACT-INFO-EFF-DATE|Provider Locat & Contact Info Effective Date|Mandatory|The first calendar day on which all of the oth data elements in the same segment were effective.|N/A|PRV00003|PROV-LOCATION-AND-CONTACT-INFO|9(8)|6|57|64|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 [18,19,20]

1708|PRV045|PRV.003.045|PROV-LOCATION-AND-CONTACT-INFO-END-DATE|Provider Locat
& Contact Info End Date|Mandatory|The last calendar day on which all of the other da
elements in the same segment were effective.|N/A|PRV00003|PROV-LOCATION-AND-CONT
INFO|9(8)|7|65|72|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 [18,19,20,99]

1710|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|7
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. Mandatory
5. When populated, the associated Address Type is required

1787|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.|
PRV00010|PROV-BED-TYPE-INFO|9(8)|7|65|72|1. The date must be a valid calendar date in
form "CCYYMMDD"
2. Value must be before or the same as the associated Segment Effective Date value
3. Mandatory
4. Value of the CC component must be in [18,19,20,99]

1792|TPL002|TPL.001.002|DATA-DICTIONARY-VERSION|Data Dictionary Version|Mandatory
data element to capture the version of the T-MSIS data dictionary that was used to build th
file. Use the version number specified on the Cover Sheet of the data dictionary.|DATA-
DICTIONARY-VERSION|TPL00001|FILE-HEADER-RECORD-TPL|X(10)|2|9|18|1. Value must be
characters or less
2. Value must be in Data Dictionary Version List (VVL)
3. Value must not include the pipe ("|") symbol
4. Mandatory

1795|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 bu
state submission file. Use the version number specified on the title page of the data mapp
document|N/A|TPL00001|FILE-HEADER-RECORD-TPL|X(9)|5|23|31|1. Value must be 9 chara
or less
2. Mandatory

1817|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 segn
were effective.|N/A|TPL00002|TPL-MEDICAID-ELIGIBLE-PERSON-MAIN|9(8)|11|113|120|1. Th
date must be a valid calendar date in the form "CCYYMMDD"
2. Value must be before or the same as the associated Segment Effective Date value
3. Mandatory
4. Value of the CC component must be in [18,19,20,99]

1834|TPL049|TPL.003.049|INSURANCE-COVERAGE-END-DATE|Insurance Coverage End Dat
Mandatory|The last calendar day on which all of the other data elements in the same segn
were effective.|N/A|TPL00003|TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-
COVERAGE-INFO|9(8)|16|204|211|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 [18,19,20]
5. When associated Date of Death (ELG.002.025) is populated, data element value must b
than or equal to Date of Death

1845|TPL060|TPL.004.060|INSURANCE-CATEGORIES-END-DATE|Insurance Categories End D
Mandatory|The last calendar day on which all of the other data elements in the same segn
were effective.|N/A|TPL00004|TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-
COVERAGE-CATEGORIES|9(8)|9|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 Effective Date value
3. Mandatory
4. Value of the CC component must be in [18,19,20,99]

After
A code used to distinguish among Medicaid, Medicaid Expansion CHIP, and Separate CHIP populations
N/A
N/A
If associated Race (ELG.016.213) value is not in ["010", "015"], then value must be null.
N/A
N/A
N/A
|Definition||The amount paid by Medicaid/CHIP agency or the managed care plan on this cl or adjustment at the claim detail level.|
|DE NO| DATA ELEMENT NAME| DEFINITION| NECESSITY |CODING REQUIREMENT||CIP103 | CLAIM-STATUS-CATEGORY| Not Applicable |Not Applicable |(Denied Claim) if associated Ty Claim equals Z or associated Claim Status is in [26, 87, 542, 585, 654], then value must b "F2"||CLT055 |CLAIM-STATUS-CATEGORY| Not Applicable |Not Applicable |(Denied Claim) if associated Type of Claim equals Z or associated Claim Status is in [26, 87, 542, 585, 654 then value must be "F2"||COT040 |CLAIM-STATUS-CATEGORY| Not Applicable |Not Applicab (Denied Claim) if associated Type of Claim equals Z or associated Claim Status is in [26, 8 542, 585, 654], then value must be "F2"||CRX031 |CLAIM-STATUS-CATEGORY| Not Applica Not Applicable |(Denied Claim) if associated Type of Claim equals Z or associated Claim St is in [26, 87, 542, 585, 654], then value must be "F2"|

|DE NO| DATA ELEMENT NAME| DEFINITION| NECESSITY |CODING REQUIREMENT||ELG213|R
Not Applicable |Not Applicable |A code indicating the individual's race in accordance with requirements of Section 4302 of the Affordable Care Act classifications Race Code clarifica
If state has beneficiaries coded in their database as "Asian" with no additional detail, then 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 "N 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 appropr 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 aty 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 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 an individual who explicitly did not provide information or refused to answer a question.|

|DE No|Data Element Name|Definition||CIP098|ADJUDICATION-DATE|The date on which the payment status of the claim was finally adjudicated by the state. For Encounter Records (T of Claim = 3, C, W), use date the encounter was processed by the state.||CLT050| ADJUDICATION-DATE|The date on which the payment status of the claim was finally adjudi by the state. For Encounter Records (Type of Claim = 3, C, W), use date the encounter was processed by the state.||COT035|ADJUDICATION-DATE|The date on which the payment sta the claim was finally adjudicated by the state. For Encounter Records (Type of Claim = 3, C use date the encounter was processed by the state.||CRX027|ADJUDICATION-DATE|The dat 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.|| CIP286|ADJUDICATION-DATE|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.||CLT233|ADJUDICATION-DATE|TThe date on which t payment status of the claim was finally adjudicated by the state. For Encounter Records (T of Claim = 3, C, W), use date the encounter was processed by the state.||COT221| ADJUDICATION-DATE|The date on which the payment status of the claim was finally adjudi by the state. For Encounter Records (Type of Claim = 3, C, W), use date the encounter was processed by the state.||CRX157|ADJUDICATION-DATE|The date on which the payment sta the claim was finally adjudicated by the state. For Encounter Records (Type of Claim = 3, C use date the encounter was processed by the state.|

|DE NO| DATA ELEMENT NAME| DEFINITION| NECESSITY |CODING REQUIREMENT||COT112| BILLING-PROV-NUM| Not Applicable |Not Applicable |When Type of Service (COT.003.186) r ('119', ‘120’, ‘122’), then value must be reported in Provider Identifier (PRV.005.080) with associated Provider Identifier Type (PRV.005.081) equal to '1'|

|DE NO| DATA ELEMENT NAME| DEFINITION| NECESSITY |CODING REQUIREMENT||COT112| BILLING-PROV-NUM| Not Applicable |Not Applicable |When Type of Claim not in ('Z','3','C','W',"2","B","V"," 4","D","X") then value may match (PRV.002.019) Submitting Sta Provider IDorWhen Type of Claim not in ('Z','3','C','W',"2","B","V"," 4","D","X") then value m match (PRV.005.081) Provider Identifier where the Provider Identifier Type = '1'|

|DE NO| DATA ELEMENT NAME| DEFINITION| NECESSITY |CODING REQUIREMENT||COT112| BILLING-PROV-NUM| Not Applicable |Not Applicable |Not Applicable|

|DE NO|DEFINITION||ELG046|A code indicating the language that is the individuals' preferr spoken or written language.|

|DE NO| DATA ELEMENT NAME |DEFINITION||CIP025|1115A-DEMONSTRATION-IND|Indicates the claim or encounter was covered under the authority of an 1115A demonstration. 1115A Center for Medicare and Medicaid Innovation demonstration.|

|DE NO| DATA ELEMENT NAME |DEFINITION||CLT024|1115A-DEMONSTRATION-IND|Indicates the claim or encounter was covered under the authority of an 1115A demonstration. 1115A Center for Medicare and Medicaid Innovation demonstration.|

|DE NO| DATA ELEMENT NAME |DEFINITION||COT024|1115A-DEMONSTRATION-IND|Indicate that the claim or encounter was covered under the authority of an 1115A demonstration. 1115A is a Center for Medicare and Medicaid Innovation demonstration.|

|DE NO| DATA ELEMENT NAME |DEFINITION||CRX024|1115A-DEMONSTRATION-IND|Indicate that the claim or encounter was covered under the authority of an 1115A demonstration. 1115A is a Center for Medicare and Medicaid Innovation demonstration.|

|DE NO| DATA ELEMENT NAME| DEFINITION| NECESSITY |CODING REQUIREMENT||ELG086| PRIMARY-ELIGIBILITY-GROUP-IND| Not Applicable |Not Applicable |A person enrolled in Medicaid/CHIP should always have a primary eligibility group classification for any given da enrollment. (There may or may not be a secondary eligibility group classification for that s day.) It is expected that an enrollee's 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 multip ELIGIBILITY-DETERMINANTS record segments, each covering a different effective time span 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).

|DE NO| DATA ELEMENT NAME| DEFINITION| NECESSITY |CODING REQUIREMENT||ELG086| PRIMARY-ELIGIBILITY-GROUP-IND| Not Applicable |Not Applicable |Should a situation arise w 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 grou and the other(s) for the secondary eligibility group(s). To differentiate the primary eligibilit group from the secondary group(s), only one segment should be assigned as the primary g using PRIMARY-ELIGIBILITY-GROUP-IND = 1; the others should be assigned PRIMARY-ELIGIBILITY-GROUP-IND = 0.|

|DE NO| DATA ELEMENT NAME |DEFINITION||ELG233|1115A-DEMONSTRATION-IND|Indicate that the claim or encounter was covered under the authority of an 1115A demonstration. 1115A is a Center for Medicare and Medicaid Innovation demonstration.|

|FILE SEGMENT NAME WITH RECORD ID COMPUTING||ELIGIBLE-IDENTIFIERS-ELG00022|

|DE NO| DATA ELEMENT NAME |DEFINITION||ELG095|ELIGIBILITY-CHANGE-REASON|The rea for a change in an individual's eligibility status. The end date of the segment in which the v is reported must represent the date that the change occurred. The reason for change represents the reason that the segment in which it was reported was closed.|

|DE NO| DATA ELEMENT NAME| DEFINITION| NECESSITY |CODING REQUIREMENT||COT191| SERVICING-PROV-TAXONOMY| The taxonomy code for the provider who treated the recipie Conditional | Value must be equal to a valid value.|COT191|SERVICING-PROV-TAXONOMY|N Applicable |Not Applicable | Leave blank or space-fill field for capitation or premium payme (TYPE-OF-SERVICE = 119, 120, 121, 122)|COT191|SERVICING-PROV-TAXONOMY|Not Applic Not Applicable| Generally, the provider taxonomy requires 10 bytes. However, two addition bytes have been provided for future expansion.|

|DE NO| DATA ELEMENT NAME| DEFINITION| NECESSITY ||ELG224|DISABILITY-TYPE-CODE|A to identify disability status in accordance with requirements of Section 4302 of the Afforda Care Act.| Mandatory|

DE NO| DATA ELEMENT NAME| DEFINITION|CIP228 | MEDICARE-PAID-AMT |The amount paid Medicare on this claim. For claims where Medicare payment is only available at the line lev report the sum of all the line level Medicare payment amounts at the header.|

DE NO| DATA ELEMENT NAME| DEFINITION|CLT179 | MEDICARE-PAID-AMT |The amount pai Medicare on this claim. For claims where Medicare payment is only available at the line lev report the sum of all the line level Medicare payment amounts at the header.|

DE NO| DATA ELEMENT NAME| DEFINITION|COT182 | MEDICARE-PAID-AMT |The amount pa 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 o 1st non-denied line. Zero fill Medicare Paid Amount on all other claim lines.|

DE NO| DATA ELEMENT NAME| DEFINITION|CRX129 | MEDICARE-PAID-AMT |The amount pa
Medicare on this claim. For claims where Medicare payment is only available at the heade
level, report the entire payment amount on the T-MSIS claim line with the highest charge
1st non-denied line. Zero fill Medicare Paid Amount on all other claim lines.|

DE NO| DATA ELEMENT NAME| NECESSITY|CODING REQUIREMENT|ELG073|ELIGIBLE-PHON
NUM|Conditional|Value is mandatory and must be provided when the ELIGIBLE-ADDR-TYPE
(ELG.004.065) = ‘01’|

DE NO| DATA ELEMENT NAME|NECESSITY|CIP184|ADMITTING-PROV-NPI-NUM|Conditional|
CLT006|FILE-NAME|Mandatory|CRX006|FILE-NAME|Mandatory|ELG006|FILE-NAME|Mandato
MCR006|FILE-NAME|Mandatory|PRV006|FILE-NAME|Mandatory|TPL006|FILE-NAME|Mandato
CIP127|FUNDING-SOURCE-NONFEDERAL-SHARE|Conditional|CLT077|FUNDING-SOURCE-
NONFEDERAL-SHARE|Conditional|COT063|FUNDING-SOURCE-NONFEDERAL-SHARE|Conditi
CRX054|FUNDING-SOURCE-NONFEDERAL-SHARE|Conditional|ELG111|HEALTH-HOME-ENTIT
EFF-DATE|Mandatory|TPL044|POLICY-OWNER-FIRST-NAME|Mandatory|TPL045|POLICY-OWN
LAST-NAME|Mandatory|CIP093|PROCEDURE-CODE-DATE-6|Conditional|CIP088|PROCEDURE
CODE-FLAG-5|Conditional|PRV043|PROV-LOCATION-ID|Mandatory|PRV064|PROV-LOCATION
Mandatory|PRV076|PROV-LOCATION-ID|Mandatory|PRV129|PROV-LOCATION-ID|Mandatory|
COT191|SERVICING-PROV-TAXONOMY|Conditional|

DE NO| DATA ELEMENT NAME|DEFINITION|CIP202|REMITTANCE-NUM|The Remittance Advic
Number is a sequential number that identifies the current Remittance Advice (RA) produce
a provider. The number is incremented by one each time a new RA is generated. The first
(5) positions are Julian date following a YYDDD format. The RA is the detailed explanation
reason for the payment amount.|CLT144|REMITTANCE-NUM|The Remittance Advice Numbe
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 fiv
positions are Julian date following a YYDDD format. The RA is the detailed explanation of th
reason for the payment amount.|COT126|REMITTANCE-NUM|The Remittance Advice Numb
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 fiv
positions are Julian date following a YYDDD format. The RA is the detailed explanation of th
reason for the payment amount.|CRX081|REMITTANCE-NUM|The Remittance Advice Numb
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 fiv
positions are Julian date following a YYDDD format. The RA is the detailed explanation of th
reason for the payment amount.|

|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME| SEGMENT NAMECRX098|THIRD-PARTY-COINSURANCE-AMOUNT-PAID|Optional|The amount money paid by a third party on behalf of the beneficiary towards coinsurance.|1. Value mu between -99999999999.99 and 99999999999.99, 2. Value must be expressed as a numbe with 2-digit precision (e.g. 100.50), 3.Optional|CLAIMRX|CLAIM-HEADER-RECORD-RX-CRX0

DE NO| DATA ELEMENT NAME|DEFINITION|CRX143|DRUG-UTILIZATION-CODE|A code indica the conflict, intervention and outcome of a prescription presented for fulfillment. The T-MS Drug Utilization Code data element is composite field comprised of three distinct NCPDP da elements: "Reason for Service Code" (439-E4); "Professional Service Code" (440-E5); and "Result of Service Code" (441-E6). All 3 of these NCPDP fields are situationally required an 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 r in different coverage, pricing, patient financial responsibility, drug utilization review outcor or if the information affects payment for, or documentation of, professional pharmacy service.The NCPDP "Reason for Service Code" (bytes 1 & 2 of the T-MSIS Drug Utilization C explains whether the pharmacist filled the prescription, filled part of the prescription, etc. NCPDP "Professional Service Code" (bytes 3 & 4 of the T-MSIS Drug Utilization Code) descr what the pharmacist did for the patient. The NCPDP "Result of Service Code" (bytes 5 & 6 T-MSIS Drug Utilization Code) describes the action the pharmacist took in response to a co or the result of a pharmacist's professional service.Because the T-MSIS Drug Utilization Co data element is a composite field, it is necessary for the state to populate all six bytes if a the three NCPDP fields has a value. In such situations, use 'spaces' as placeholders for not applicable codes.|

|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME| SEGMENT NAMECRX144|DTL-METRIC-DEC-QTY|Conditional|Metric decimal quantity of the product with the appropriate unit of measure (each, gram, or milliliter).|1. Value must be numeric, 2. Value may include up to 7 digits to the left of the decimal point, and 3 digits to right, e.g. 1234567.890, 3. Value must be populated when Compound Drug Indicator (CRX.002.086) equals 1, 4.Conditional|CLAIMRX|CLAIM-LINE-RECORD-RX-CRX00003

DE NO| DATA ELEMENT NAME|CODING REQUIREMENT|ELG087|ELIGIBILITY-GROUP|Benefici reported with ELIGIBILITY-GROUP="72", "73", "74", "75" are expected to be covered by an alternative benefit plan and should be reported with STATE-PLAN-OPTION-TYPE="06” and RESTRICTED-BENEFITS-CODE=”1” or "7".

DE NO| DATA ELEMENT NAME|CODING REQUIREMENT|ELG097|RESTRICTED-BENEFITS-COD Beneficiaries reported with ELIGIBILITY-GROUP="72", "73", "74", "75" are expected to be covered by an alternative benefit plan and should be reported with STATE-PLAN-OPTION-TYPE="06” and either RESTRICTED-BENEFITS-CODE=”1” or "7".|

DE NO| DATA ELEMENT NAME|CODING REQUIREMENT|ELG163|STATE-PLAN-OPTION-TYPE| Beneficiaries reported with ELIGIBILITY-GROUP="72", "73", "74", "75" are expected to be covered by an alternative benefit plan and should be reported with STATE-PLAN-OPTION-TYPE="06” and either RESTRICTED-BENEFITS-CODE=”1” or "7".|

DE No|Data Element Name|Definition| CODING REQUIREMENT|CIP025|1115A-DEMONSTRAT
IND|In the claims files this data element indicates whether the claim or encounter was cov
under the authority of an 1115(A) demonstration. In the Eligibility file, this data element
indicates whether the individual participates in an 1115(A) demonstration.|1. Value must b
1115A Demonstration Indicator List (VVL)2.(FD1) when value equals '0', is invalid or not
populated, then the associated 1115A Demonstration Indicator (ELG.018.233) must equal
invalid or not populated3. Value must be 1 character4. Conditional5. Value must be in [0, 1
not populated

DE No|Data Element Name|Definition| CODING REQUIREMENT|COT024|1115A-
DEMONSTRATION-IND|In the claims files this data element indicates whether the claim or
encounter was covered under the authority of an 1115(A) demonstration. In the Eligibility f
this data element indicates whether the individual participates in an 1115(A) demonstratio
Value must be in 1115A Demonstration Indicator List (VVL)2.(FD1) when value equals '0', i
invalid or not populated, then the associated 1115A Demonstration Indicator (ELG.018.233
must equal '0', is invalid or not populated3. Value must be 1 character4. Conditional5. Valu
must be in [0, 1] or not populated

DE No|Data Element Name|Definition| CODING REQUIREMENT|CRX024|1115A-
DEMONSTRATION-IND|In the claims files this data element indicates whether the claim or
encounter was covered under the authority of an 1115(A) demonstration. In the Eligibility f
this data element indicates whether the individual participates in an 1115(A) demonstratio
Value must be in 1115A Demonstration Indicator List (VVL)2.(FD1) when value equals '0', i
invalid or not populated, then the associated 1115A Demonstration Indicator (ELG.018.233
must equal '0', is invalid or not populated3. Value must be 1 character4. Conditional5. Valu
must be in [0, 1] or not populated

DE No|Data Element Name|Definition| CODING REQUIREMENT|CLT024|1115A-
DEMONSTRATION-IND|In the claims files this data element indicates whether the claim or
encounter was covered under the authority of an 1115(A) demonstration. In the Eligibility f
this data element indicates whether the individual participates in an 1115(A) demonstratio
Value must be in 1115A Demonstration Indicator List (VVL)2.(FD1) when value equals '0', i
invalid or not populated, then the associated 1115A Demonstration Indicator (ELG.018.233
must equal '0', is invalid or not populated3. Value must be 1 character4. Conditional5. Valu
must be in [0, 1] or not populated

DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|CLT045|ADMISSION-HOU
The time of admission to a psychiatric or long-term care facility.|1.(LV) value must be in Ho
List (VVL)2.(S) value must be 2 characters3.(N) conditional4.(FD1) when populated, Admiss
Date (CLT.002.044) must be populated|

|DE NO|DATA ELEMENT NAME| DEFINITION||CIP030|ADMITTING-DIAGNOSIS-CODE|The ICD-9
CM Diagnosis Code provided at the time of admission by the physician. Since the Admittin
Diagnosis is formulated before all tests and examinations are complete, it may be stated i
form of a problem or symptom and it may differ from any of the final diagnoses recorded i
medical record.|

|DE NO|DATA ELEMENT NAME| DEFINITION||CLT027|ADMITTING-DIAGNOSIS-CODE|The ICD-
CM Diagnosis Code provided at the time of admission by the physician. Since the Admittin
Diagnosis is formulated before all tests and examinations are complete, it may be stated i
form of a problem or symptom and it may differ from any of the final diagnoses recorded i
medical record.|

|DE No|Data Element Name|Definition|CLT.027|ADMITTING-DIAGNOSIS-CODE|The ICD-9/10
Diagnosis Code provided at the time of admission by the physician.1.(GS) value must satis
the requirements of Diagnosis Code (CE)|

|DE No|Data Element Name|Definition||CLT174|ADMITTING-PROV-NPI-NUM|The National
Provider ID (NPI) of the doctor responsible for admitting a patient to a hospital or other
inpatient health facility.|

|DE No|Data Element Name|Definition||CIP184|ADMITTING-PROV-NPI-NUM|The National Pro
ID (NPI) of the doctor responsible for admitting a patient to a hospital or other inpatient he
facility.|

|DE No|Data Element Name|Definition||PRV120|AFFILIATED-PROGRAM-IDA data element to
identify the Medicaid/CHIP programs, waivers and demonstrations in which the provider
participates.If Affiliated ProgramType = 2 (Health Plan State-assigned health plan ID), ther
value in Affiliated Program ID is the state-assigned plan ID of the health plan in whicha pro
is enrolled to provide services. If Affiliated Program Type = 3 (Waiver), then the value in
Affiliated Program ID is the core Federal WaiverID in which a provider isallowed to deliver
services to eligible beneficiaries. If Affiliated Program Type = 4 (Health Home Entity), then
valuein Affiliated Program ID is the name of a health home in which a provider is participat
If Affiliated Program Type = 5 (Other), then the value in AffiliatedProgram ID is an identifie
something other than a health plan,waiver, or health home entity.

|DE No|Data Element Name|Definition||PRV119|AFFILIATED-PROGRAM-TYPE|A code to iden
the category of program that the provider is affiliated.|

|DE No|Data Element Name|Definition||CIP180|BILLING-PROV-NPI-NUM|The National Provid
(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 provide
except for Long Term Care.|

|DE No|Data Element Name|Definition||CLT131|BILLING-PROV-NPI-NUM|The National Provic
(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 provide
except for Long Term Care.|

|DE No|Data Element Name|Definition||COT113|BILLING-PROV-NPI-NUM|The National Provi
ID (NPI) of the billing entity responsible for billing a patient for healthcare services. The bil
provider can also be servicing, referring, or prescribing provider. Can be admitting provide
except for Long Term Care.|

|DE No|Data Element Name|Definition||CRX071|BILLING-PROV-NPI-NUM|The National Provi
ID (NPI) of the billing entity responsible for billing a patient for healthcare services. The bil
provider can also be servicing, referring, or prescribing provider. Can be admitting provide
except for Long Term Care.|

N/A

N/A

N/A

N/A

N/A

N/A

N/A

N/A
N/A
N/A
N/A
N/A
N/A
N/A
N/A
N/A
N/A
N/A
N/A
N/A
N/A
N/A
N/A
N/A
N/A
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE SEGMENT (with RECORD-ID)CIP195|DRG-REL-WEIG S9(3)V99999)|CLAIM-HEADER-RECORD-IP-CIP00002
DE_NO|DATA_ELEMENT_NAME|SIZE|CIP195|DRG-REL-WEIGHT|S9(3)V99999
N/A
N/A
|DE NO| DATA ELEMENT NAME|DEFINITIONCIP206|TOT-BENEFICIARY-COINSURANCE-PAID-AMOUNT|The amount 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/ies on behalf of the beneficiary.
DE No|Data Element Name |CIP206|TOT-BENEFICIARY-COINSURANCE-PAID-AMOUNT
|DE NO| DATA ELEMENT NAME|DEFINITIONCIP208|TOT-BENEFICIARY-COPAYMENT-PAID-AMOUNT|The amount 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 third party/ies on behalf of the beneficiary.

DE No|Data Element NameCIP208|TOT-BENEFICIARY-COPAYMENT-PAID-AMOUNT
|DE NO| DATA ELEMENT NAME|DEFINITIONCIP210|TOT-BENEFICIARY-DEDUCTIBLE-PAID-AMOUNT|The amount the beneficiary or his or her representative (e.g., their guardian) pai towards their deductible for the covered services on the claim. Do not include deductible payments made by a third party/ies on behalf of the beneficiary.
DE No|Data Element NameCIP210|TOT-BENEFICIARY-DEDUCTIBLE-PAID-AMOUNT
|DE NO| DATA ELEMENT NAME|DEFINITIONCIP213|COPAY-WAIVED-IND|An indicator signifyi that the copay was discounted or waived by the provider (e.g., physician or hospital). Do n use to indicate administrative-level, Medicaid State Agency or Medicaid MCO copayment waived decisions.
DE No|Data Element Name|Definition| CODING REQUIREMENT|CIP214|HEALTH-HOME-ENTI NAME||1.1.(IV) value must not contain a pipe or asterisk symbols2.(S) value must 50 chara or less3.(N) conditional
N/A
N/A
N/A
N/A
N/A
N/A
N/A
N/A
|DE NO| DATA ELEMENT NAME|CODING REQUIREMENTCIP249|REVENUE-CENTER-QUANTITY ACTUAL|For use with CLAIMIP and CLAIMLT claims. For CLAIMOT claims/encounter records SERVICE-QUANTITY-ACTUAL and CLAIMRX claims/encounter records use the PRESCRIPTION QUANTITY-ACTUAL field|
DE No|Data Element NameCIP249|REVENUE-CENTER-QUANTITY-ACTUAL
|DE NO| DATA ELEMENT NAME|CODING REQUIREMENTCIP250|REVENUE-CENTER-QUANTITY ALLOWED|For use with CLAIMIP and CLAIMLT claims. For CLAIMOT claims/encounter record use SERVICE-QUANTITY-ACTUAL and CLAIMRX claims/encounter records use the PRESCRIP QUANTITY-ACTUAL field
DE No|Data Element NameCIP250|REVENUE-CENTER-QUANTITY-ALLOWED
N/A

N/A
N/A
N/A
SIZEX(5)
SIZES9(8)V999
|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME| SEGMENT NAMECIP290|BEGINNING-DATE-OF-SERVICE|Mandatory|For services received du a single encounter with a provider, the date the service covered by this claim was received services involving multiple encounters on different days, or periods of care extending over or more days, this would be the date on which the service covered by this claim began. Fo 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 d the time period covered by this financial transaction.|Value must be 8 characters in the for "CCYYMMDD"The date must be a valid calendar date (i.e. Feb 29th only on the leap year, n April 31st or Sept 31st)When Type of Claim is not in ['2', '4', 'B', 'D', 'V'] value must be less or equal to associated End of Time Period valueValue must be less than or equal to associa Ending Date of Service valueWhen Type of Claim is not in ['2', '4', 'B', 'D', 'V'] value must b less than or equal to associated Adjudication Date valueValue must be less than or equal t associated Date of Death (ELG.002.025) value when populatedValue must be less than or to at least one of the eligible's Enrollment End Date (ELG.021.254) values|CLAIMIP|CLAIM-HEADER-RECORD-IP-CIP00002
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCIP290|BEGINNING-DATE-OF-SERVICE|9(8)|CLAIMIP|CLAIM-HEADER-RECORD-IP-CIP00002

|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME| SEGMENT NAMECIP291|ENDING-DATE-OF-SERVICE|Mandatory|For services received during single encounter with a provider, the date the service covered by this claim was received. services involving multiple encounters on different days, or periods of care extending over or more days, the date on which the service covered by this claim ended. For capitation premium payments, the date onwhich the period of coverage related to this payment ends/ended. For financial transactions reported to the OT file, populate with the last day of time period covered by this financial transaction.|Value must be 8 characters in the form "CCYYMMDD"The date must be a valid calendar date (i.e. Feb 29th only on the leap year, n April 31st or Sept 31st)When Type of Claim is not in ['2', '4', 'B', 'D', 'V'] value must be less or equal to associated End of Time Period valueValue must be greater than or equal to associated Beginning Date of Service valueWhen Type of Claim is not in ['2', '4', 'B', 'D', 'V' value must be less than or equal to associated Adjudication Date valueValue must be less or equal to associated Date of Death (ELG.002.025) value when populatedValue must be e to or greater than associated Date of Birth (ELG.002.024) value|CLAIMIP|CLAIM-HEADER-RECORD-IP-CIP00002

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCIP291| ENDING-DATE-OF-SERVICE|9(8)|CLAIMIP|CLAIM-HEADER-RECORD-IP-CIP00002

|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME| SEGMENT NAMECIP292|TOT-BENEFICIARY-COPAYMENT-LIABLE-AMOUNT |Conditional|The to 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.|Valu must be between -99999999999.99 and 99999999999.99Value must be expressed as a number with 2-digit precision (e.g. 100.50)|CLAIMIP|CLAIM-HEADER-RECORD-IP-CIP00002

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCIP292|TOT-BENEFICIARY-COPAYMENT-LIABLE-AMOUNT |S9(11)V99|CLAIMIP|CLAIM-HEADER-RECORD-IP-CIP00002

|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME| SEGMENT NAMECIP293|TOT-BENEFICIARY-COINSURANCE-LIABLE-AMOUNT|Conditional|The coinsurance amount on a claim the beneficiary is obligated to pay for covered services. Th amount is the total Medicaid or contract negotiated beneficiary coinsurance liability for cov services on the claim. Do not subtract out any payments made toward the coinsurance.|Va must be between -99999999999.99 and 99999999999.99Value must be expressed as a number with 2-digit precision (e.g. 100.50)|CLAIMIP|CLAIM-HEADER-RECORD-IP-CIP00002

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCIP293|TOT-BENEFICIARY-COINSURANCE-LIABLE-AMOUNT |S9(11)V99|CLAIMIP|CLAIM-HEADER-RECORD-IP-CIP00002

|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME| SEGMENT NAMECIP294|TOT-BENEFICIARY-DEDUCTIBLE-LIABLE-AMOUNT|Conditional|The to 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 for cove services on the claim. Do not subtract out any payments made toward the deductible.|Valu must be between -99999999999.99 and 99999999999.99Value must be expressed as a number with 2-digit precision (e.g. 100.50)|CLAIMIP|CLAIM-HEADER-RECORD-IP-CIP00002

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCIP294|TOT-BENEFICIARY-DEDUCTIBLE-LIABLE-AMOUNT|S9(11)V99|CLAIMIP|CLAIM-HEADER-RECORD-IP-CIP00002

|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME| SEGMENT NAMECIP295|COMBINED-BENE-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 c 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 benefici cost sharing payments made by a third party/ies on behalf of the beneficiary.|Value must b between -99999999999.99 and 99999999999.99Value must be expressed as a number wi digit precision (e.g. 100.50)|CLAIMIP|CLAIM-HEADER-RECORD-IP-CIP00002

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCIP295|COMBINED-BENE-COS SHARING-PAID-AMOUNT |S9(11)V99|CLAIMIP|CLAIM-HEADER-RECORD-IP-CIP00002

|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME| SEGMENT NAMECIP296|IHS-SERVICE-IND|Mandatory|To indicate Services received by Medi eligible individuals who are American Indian or Alaska Native (AI/AN) through facilities of th Indian Health Service (IHS), whether operated by IHS or by Tribes.|Value must be 1 characterValue must be in [0, 1] or not populated|CLAIMIP|CLAIM-LINE-RECORD-IP-CIP0000

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCIP296|IHS-SERVICE-IND|X(1) CLAIMIP|CLAIM-LINE-RECORD-IP-CIP00003

|DE No|Data Element Name|Coding Requirement||CIP103,CLT055,COT040,CRX031|CLAIM-STATUS-CATEGORY|(Denied Claim) if associated Type of Claim equals Z or associated Clai Status is in [26, 87, 542, 585, 654], then value must be "F2"

N/A

N/A

N/A

N/A

N/A

N/A
N/A
N/A
N/A
N/A
N/A
N/A
|DE NO| DATA ELEMENT NAME|DEFINITIONCLT153|TOT-BENEFICIARY-COINSURANCE-PAID-AMOUNT|The amount 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/ies on behalf of the beneficiary.
DE No|Data Element NameCLT153|TOT-BENEFICIARY-COINSURANCE-PAID-AMOUNT
|DE NO| DATA ELEMENT NAME|DEFINITIONCLT155|TOT-BENEFICIARY-COPAYMENT-PAID-AMOUNT|The amount 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 third party/ies on behalf of the beneficiary.
DE No|Data Element NameCLT155|TOT-BENEFICIARY-COPAYMENT-PAID-AMOUNT
|DE NO| DATA ELEMENT NAME|DEFINITIONCLT157|TOT-BENEFICIARY-DEDUCTIBLE-PAID-AMOUNT|The amount the beneficiary or his or her representative (e.g., their guardian) paid towards their deductible for the covered services on the claim. Do not include deductible payments made by a third party/ies on behalf of the beneficiary.
DE No|Data Element NameCLT157|TOT-BENEFICIARY-DEDUCTIBLE-PAID-AMOUNT
|DE NO| DATA ELEMENT NAME|DEFINITIONCLT160|COPAY-WAIVED-IND|An indicator signify that the copay was discounted or waived by the provider (e.g., physician or hospital). Do n use to indicate administrative-level, Medicaid State Agency or Medicaid MCO copayment waived decisions.
DE No|Data Element Name|Definition| CODING REQUIREMENT|CLT.161|HEALTH-HOME-ENT NAME||1.(GS) value must satisfy the requirements of Health Home Entity Name (CE)2.(S) v must 50 characters or less3.(N) conditional
N/A
N/A
N/A
N/A

N/A
N/A
N/A
N/A
|DE NO| DATA ELEMENT NAME|CODING REQUIREMENTCLT202|REVENUE-CENTER-QUANTIT ACTUAL|For use with CLAIMIP and CLAIMLT claims. For CLAIMOT claims/encounter records SERVICE-QUANTITY-ACTUAL and CLAIMRX claims/encounter records use the PRESCRIPTION QUANTITY-ACTUAL field
DE No|Data Element NameCLT202|REVENUE-CENTER-QUANTITY-ACTUAL
|DE NO| DATA ELEMENT NAME|CODING REQUIREMENTCLT203|REVENUE-CENTER-QUANTIT ALLOWED|For use with CLAIMIP and CLAIMLT claims. For CLAIMOT claims/encounter record use SERVICE-QUANTITY-ACTUAL and CLAIMRX claims/encounter records use the PRESCRIP QUANTITY-ACTUAL field
DE No|Data Element NameCLT203|REVENUE-CENTER-QUANTITY-ALLOWED
N/A
N/A
SIZEX(5)
SIZES9(8)V999
|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME| SEGMENT NAMECLT239|TOT-BENEFICIARY-COPAYMENT-LIABLE-AMOUNT|Conditional|The to 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.|Valu must be between -99999999999.99 and 99999999999.99Value must be expressed as a number with 2-digit precision (e.g. 100.50)|CLAIMLT|CLAIM-HEADER-RECORD-LT-CLT0000
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCLT239|TOT-BENEFICIARY-COPAYMENT-LIABLE-AMOUNT|S9(11)V99|CLAIMLT|CLAIM-HEADER-RECORD-LT-CLT00002

|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME| SEGMENT NAMECLT240|TOT-BENEFICIARY-COINSURANCE-LIABLE-AMOUNT|Conditional|The coinsurance amount on a claim the beneficiary is obligated to pay for covered services. Th amount is the total Medicaid or contract negotiated beneficiary coinsurance liability for co services on the claim. Do not subtract out any payments made toward the coinsurance.|Va must be between -99999999999.99 and 99999999999.99Value must be expressed as a number with 2-digit precision (e.g. 100.50)|CLAIMLT|CLAIM-HEADER-RECORD-LT-CLT0000

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENT-CLT240|TOT-BENEFICIARY-COINSURANCE-LIABLE-AMOUNT|S9(11)V99|CLAIMLT|CLAIM-HEADER-RECORD-LT-CLT00002

|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME| SEGMENT NAMECLT241|TOT-BENEFICIARY-DEDUCTIBLE-LIABLE-AMOUNT|Conditional|The t 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 for cove services on the claim. Do not subtract out any payments made toward the deductible.|Valu must be between -99999999999.99 and 99999999999.99Value must be expressed as a number with 2-digit precision (e.g. 100.50)|CLAIMLT|CLAIM-HEADER-RECORD-LT-CLT0000

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCLT241|TOT-BENEFICIARY-DEDUCTIBLE-LIABLE-AMOUNT|S9(11)V99|CLAIMLT|CLAIM-HEADER-RECORD-LT-CLT00002

|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME| SEGMENT NAMECLT242|COMBINED-BENE-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 c 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 benefici cost sharing payments made by a third party/ies on behalf of the beneficiary.|Value must b between -99999999999.99 and 99999999999.99Value must be expressed as a number wi digit precision (e.g. 100.50)|CLAIMLT|CLAIM-HEADER-RECORD-LT-CLT00002

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCLT242|COMBINED-BENE-CO SHARING-PAID-AMOUNT|S9(11)V99|CLAIMLT|CLAIM-HEADER-RECORD-LT-CLT00002

|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME| SEGMENT NAMECLT243|IHS-SERVICE-IND|Mandatory|To indicate Services received by Med eligible individuals who are American Indian or Alaska Native (AI/AN) through facilities of th Indian Health Service (IHS), whether operated by IHS or by Tribes.|Value must be 1 characterValue must be in [0, 1] or not populated|CLAIMLT|CLAIM-LINE-RECORD-LT-CLT000

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCLT243|IHS-SERVICE-IND|X(1 CLAIMLT|CLAIM-LINE-RECORD-LT-CLT00003

DE NO|DATA ELEMENT NAME|DEFINITION|CODING REQUIREMENT|CRX086|COMPOUND-DRU IND Indicator to specify if the drug is compound or not.|1.(S) value must be 1 character2.(L value must be in [0, 1] or not populated3.(LV) value must be in Compound Drug Indicator I (VVL)4.(N) conditional
N/A
N/A
N/A
N/A
N/A
N/A
N/A
N/A
N/A
N/A
N/A
N/A
|DE NO| DATA ELEMENT NAME|DEFINITIONCOT130|TOT-BENEFICIARY-COINSURANCE-PAID-AMOUNT|The amount 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/ies on behalf of the beneficiary.
DE No|Data Element NameCOT130|TOT-BENEFICIARY-COINSURANCE-PAID-AMOUNT
|DE NO| DATA ELEMENT NAME|DEFINITIONCOT132|TOT-BENEFICIARY-COPAYMENT-PAID-AMOUNT|The amount 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 third party/ies on behalf of the beneficiary.
DE No|Data Element NameCOT132|TOT-BENEFICIARY-COPAYMENT-PAID-AMOUNT
|DE NO| DATA ELEMENT NAME|DEFINITIONCOT134|TOT-BENEFICIARY-DEDUCTIBLE-PAID-AMOUNT|The amount the beneficiary or his or her representative (e.g., their guardian) paid towards their deductible for the covered services on the claim. Do not include deductible payments made by a third party/ies on behalf of the beneficiary.
DE No|Data Element NameCOT134|TOT-BENEFICIARY-DEDUCTIBLE-PAID-AMOUNT

|DE NO| DATA ELEMENT NAME|DEFINITIONCOT137|COPAY-WAIVED-IND|An indicator signify that the copay was discounted or waived by the provider (e.g., physician or hospital). Do n use to indicate administrative-level, Medicaid State Agency or Medicaid MCO copayment waived decisions.

DE No|Data Element Name|Definition| CODING REQUIREMENT|COT138|HEALTH-HOME-ENT NAME||1.1.(IV) value must not contain a pipe or asterisk symbols2.(S) value must 50 chara or less3.(N) conditional

N/A

N/A

N/A

N/A

N/A

N/A

N/A

N/A

N/A

|DE NO| DATA ELEMENT NAME|NECESSITY|DEFINITIONCOT176|BENEFICIARY-COPAYMENT-P AMOUNT |Optional|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 in 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 RX claim file types, only. If the beneficiary copayment paid amount is not available at the line level, report the total copayment paid amount in the header level copayment data element.

DE No|Data Element NameCOT176|BENEFICIARY-COPAYMENT-PAID-AMOUNT

SIZES9(8)V999

DE No|Data Element NameCOT183|SERVICE-QUANTITY-ACTUAL

|DE NO| DATA ELEMENT NAME|DEFINITION|CODING REQUIREMENTCOT183|SERVICE-QUANT
ACTUAL|The quantity of a service or product that is rendered for a specific date of service
billing time span as reported by revenue code or procedure code on the claim line.| For use
with CLAIMOT and CLAIMRX claims. For CLAIMIP and CLAIMOT claims/encounter records, us
the SERVICE-QUANTITY-ACTUAL field.The value in SERVICE-QUANTITY-ACTUAL must corres
with the value in UNIT-OF-MEASURE.This field is only applicable when the service being bil
can be quantified in discrete units, e.g., a number of visits or the number of units of a
prescription/refill that were filled.

SIZES9(8)V999

DE No|Data Element NameCOT184|SERVICE-QUANTITY-ALLOWED

|DE NO| DATA ELEMENT NAME|DEFINITION|CODING REQUIREMENTCOT184|SERVICE-QUANT
ALLOWED|The maximum allowable quantity of a service that may be rendered per date of
service or per month.|For use with CLAIMOT and CLAIMRX claims. For CLAIMIP and CLAIMO
claims/encounter records, use the IP-LT-QUANTITY-OF-SERVICE field. NOTE: One prescriptio
100 250 milligram tablets results in OT-RX-CLAIM-QUANTITY-ALLOWED =100.This field is o
applicable when the service being billed can be quantified in discrete units, e.g., a number
visits or the number of units of a prescription/refill that were filled. For prescriptions/refills,
the Medicaid Drug Rebate definition of a unit, which is the smallest unit by which the drug
normally measured; e.g. tablet, capsule, milliliter, etc. For drugs not identifiable or dispens
by a normal unit, e.g. powder filled vials, use 1 as the number of units.The value in OT-RX-
CLAIM-QUANTITY-ALLOWED must correspond with the value in UNIT-OF-MEASURE.

SIZEX(5)

N/A

N/A

SIZES9(8)V999

|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME|
SEGMENT NAMECOT228|ORDERING-PROV-NUM|Conditional|The Medicaid provider ID of the
Ordering Provider is the individual who requested the services or items being reported on t
service line. Examples include, but are not limited to, provider ordering diagnostic tests an
medical equipment or supplies|Value must be 30 characters or less|CLAIMOT|CLAIM-HEADI
RECORD-OT-COT00002

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCOT228|ORDERING-PROV-NU
X(30)|CLAIMOT|CLAIM-HEADER-RECORD-OT-COT00002

|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME|
SEGMENT NAMECOT229|ORDERING-PROV-NPI-NUM|Conditional|A National Provider Identifi
(NPI) is a unique 10-digit identification number issued to health care providers in the Unite
States by CMS. Healthcare providers acquire their unique 10-digit NPIs to identify themselv
a standard way throughout their industry. The NPI is a 10-position, intelligence-free numer
identifier (10-digit number).|Value must be 10 digits, consisting of 9 numeric digits followe
one check digit calculated using the Luhn formula (algorithm)|CLAIMOT|CLAIM-HEADER-
RECORD-OT-COT00002

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCOT229|ORDERING-PROV-NP
NUM|X(10)|CLAIMOT|CLAIM-HEADER-RECORD-OT-COT00002

|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME|
SEGMENT NAMECOT230|TOT-BENEFICIARY-COPAYMENT-LIABLE-AMOUNT|Conditional|The t
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.|Valu
must be between -99999999999.99 and 99999999999.99Value must be expressed as a
number with 2-digit precision (e.g. 100.50)|CLAIMOT|CLAIM-HEADER-RECORD-OT-COT000

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCOT230|TOT-BENEFICIARY-
COPAYMENT-LIABLE-AMOUNT|S9(11)V99|CLAIMOT|CLAIM-HEADER-RECORD-OT-COT00002

|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME|
SEGMENT NAMECOT231|TOT-BENEFICIARY-COINSURANCE-LIABLE-AMOUNT|Conditional|The
total coinsurance amount on a claim the beneficiary is obligated to pay for covered service
This amount is the total Medicaid or contract negotiated beneficiary coinsurance liability fo
covered services on the claim. Do not subtract out any payments made toward the
coinsurance.|Value must be between -99999999999.99 and 99999999999.99Value must b
expressed as a number with 2-digit precision (e.g. 100.50)|CLAIMOT|CLAIM-HEADER-RECO
OT-COT00002

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCOT231|TOT-BENEFICIARY-
COINSURANCE-LIABLE-AMOUNT|S9(11)V99|CLAIMOT|CLAIM-HEADER-RECORD-OT-COT000

|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME|
SEGMENT NAMECOT232|TOT-BENEFICIARY-DEDUCTIBLE-LIABLE-AMOUNT|Conditional|The t
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 for cove
services on the claim. Do not subtract out any payments made toward the deductible.|Valu
must be between -99999999999.99 and 99999999999.99Value must be expressed as a
number with 2-digit precision (e.g. 100.50)|CLAIMOT|CLAIM-HEADER-RECORD-OT-COT000

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCOT232|TOT-BENEFICIARY-DEDUCTIBLE-LIABLE-AMOUNT|S9(11)V99|CLAIMOT|CLAIM-HEADER-RECORD-OT-COT00002
|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME| SEGMENT NAMECOT233|COMBINED-BENE-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 c 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 benefici cost sharing payments made by a third party/ies on behalf of the beneficiary.|Value must b between -99999999999.99 and 99999999999.99Value must be expressed as a number wi digit precision (e.g. 100.50)|CLAIMOT|CLAIM-HEADER-RECORD-OT-COT00002
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCOT233|COMBINED-BENE-CO SHARING-PAID-AMOUNT|S9(11)V99|CLAIMOT|CLAIM-HEADER-RECORD-OT-COT00002
|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME| SEGMENT NAMECOT234|IHS-SERVICE-IND|Mandatory|To indicate Services received by Medicaid-eligible individuals who are American Indian or Alaska Native (AI/AN) through fac of the Indian Health Service (IHS), whether operated by IHS or by Tribes.|Value must be 1 characterValue must be in [0, 1] or not populated|CLAIMOT|CLAIM-LINE-RECORD-OT-COT0
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCOT234|IHS-SERVICE-IND|X(1 CLAIMOT|CLAIM-LINE-RECORD-OT-COT00003
|DE NO| DATA ELEMENT NAME|DEFINITION||TPL058|COVERAGE-TYPE |Code indicating the l of coverage being provided under this policy for the insured by the TPL carrier.|
N/A
N/A
N/A
N/A
N/A
N/A
N/A
N/A
N/A
N/A

|DE NO| DATA ELEMENT NAME|DEFINITIONCRX087|TOT-BENEFICIARY-COINSURANCE-PAID-AMOUNT|The amount 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/ies on behalf of the beneficiary.

DE No|Data Element NameCRX087|TOT-BENEFICIARY-COINSURANCE-PAID-AMOUNT

|DE NO| DATA ELEMENT NAME|DEFINITIONCRX089|TOT-BENEFICIARY-COPAYMENT-PAID-AMOUNT|The amount 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 third party/ies on behalf of the beneficiary.

DE No|Data Element NameCRX089|TOT-BENEFICIARY-COPAYMENT-PAID-AMOUNT

|DE NO| DATA ELEMENT NAME|DEFINITIONCRX092|TOT-BENEFICIARY-DEDUCTIBLE-PAID-AMOUNT|The amount the beneficiary or his or her representative (e.g., their guardian) paid towards their deductible for the covered services on the claim. Do not include deductible payments made by a third party/ies on behalf of the beneficiary.

DE No|Data Element NameCRX092|TOT-BENEFICIARY-DEDUCTIBLE-PAID-AMOUNT

|DE NO| DATA ELEMENT NAME|DEFINITIONCRX095|COPAY-WAIVED-IND|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.

DE No|Data Element Name|Definition| CODING REQUIREMENT|CRX.096|HEALTH-HOME-ENTITY-NAME||1.(GS) value must satisfy the requirements of Health Home Entity Name (CE)2.(S) value must 50 characters or less3.(N) conditional

N/A

N/A

|DE NO| DATA ELEMENT NAME|NECESSITY|DEFINITIONCRX123|BENEFICIARY-COPAYMENT-PAID-AMOUNT|Optional|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 copayment paid amount in the header level copayment data element.

DE No|Data Element NameCRX123|BENEFICIARY-COPAYMENT-PAID-AMOUNT

SIZES9(8)V999

DE No|Data Element NameCRX131|PRESCRIPTION-QUANTITY-ALLOWED
|DE NO| DATA ELEMENT NAME|NECESSITY|DEFINITION |CODING REQUIREMENTCRX131| PRESCRIPTION-QUANTITY-ALLOWED||The maximum allowable quantity of a drug that may dispensed per prescription per date of service. Quantity limits are applied to medications w the majority of appropriate clinical utilizations will be addressed within the quantity allowe NOTE: One prescription for 100 250 milligram tablets results in PRESCRIPTION-QUANTITY-ALLOWED =100.
|DE NO| DATA ELEMENT NAME|CODING REQUIREMENTCRX131|PRESCRIPTION-QUANTITY-ALLOWED|The value in PRESCRIPTION-QUANTITY-ALLOWED must correspond with the valu UNIT-OF-MEASURE.
SIZES9(8)V999
DE No|Data Element NameCRX132|PRESCRIPTION-QUANTITY-ACTUAL
|DE NO| DATA ELEMENT NAME|NECESSITY|DEFINITION |CODING REQUIREMENTCRX132| PRESCRIPTION-QUANTITY-ACTUAL||The quantity of a drug that is dispensed for a prescripti reported by National Drug Code on the claim line.|The value in PRESCRIPTION-QUANTITY-ACTUAL must correspond with the value in UNIT-OF-MEASURE.
|DE NO| DATA ELEMENT NAME|NECESSITY|DEFINITIONCRX141|DISPENSE-FEE-SUBMITTED | charge to cover the cost of the professional dispensing fee for the prescription.
DE No|Data Element NameCRX141|DISPENSE-FEE-SUBMITTED
SIZEX(5)
|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME| SEGMENT NAMECRX162|PRESCRIPTION-ORIGIN-CODE|Conditional|How the prescription wa sent to the pharmacy.|Value must be one digitValue must be 1:4|CLAIMRX|CLAIM-HEADER-RECORD-RX-CRX00002
DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCRX162|PRESCRIPTION-ORIG CODE|X(1)|CLAIMRX|CLAIM-HEADER-RECORD-RX-CRX00002
|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME| SEGMENT NAMECRX163|TOT-BENEFICIARY-COPAYMENT-LIABLE-AMOUNT|Conditional|The t 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.|Valu must be between -99999999999.99 and 99999999999.99Value must be expressed as a number with 2-digit precision (e.g. 100.50)|CLAIMRX|CLAIM-HEADER-RECORD-RX-CRX000

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCRX163|TOT-BENEFICIARY-COPAYMENT-LIABLE-AMOUNT|S9(11)V99|CLAIMRX|CLAIM-HEADER-RECORD-RX-CRX00002

|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME| SEGMENT NAMECRX164|TOT-BENEFICIARY-COINSURANCE-LIABLE-AMOUNT|Conditional|The total coinsurance amount on a claim the beneficiary is obligated to pay for covered service This amount is the total Medicaid or contract negotiated beneficiary coinsurance liability fo covered services on the claim. Do not subtract out any payments made toward the coinsurance.|Value must be between -99999999999.99 and 99999999999.99Value must b expressed as a number with 2-digit precision (e.g. 100.50)|CLAIMRX|CLAIM-HEADER-RECO RX-CRX00002

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCRX164|TOT-BENEFICIARY-COINSURANCE-LIABLE-AMOUNT|S9(11)V99|CLAIMRX|CLAIM-HEADER-RECORD-RX-CRX0000

|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME| SEGMENT NAMECRX165|TOT-BENEFICIARY-DEDUCTIBLE-LIABLE-AMOUNT|Conditional|The t 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 for cove services on the claim. Do not subtract out any payments made toward the deductible.|Valu must be between -99999999999.99 and 99999999999.99Value must be expressed as a number with 2-digit precision (e.g. 100.50)|CLAIMRX|CLAIM-HEADER-RECORD-RX-CRX000

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCRX165|TOT-BENEFICIARY-DEDUCTIBLE-LIABLE-AMOUNT|S9(11)V99|CLAIMRX|CLAIM-HEADER-RECORD-RX-CRX00002

|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME| SEGMENT NAMECRX166|COMBINED-BENE-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 c 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 benefici cost sharing payments made by a third party/ies on behalf of the beneficiary.|Value must b between -99999999999.99 and 99999999999.99Value must be expressed as a number wi digit precision (e.g. 100.50)|CLAIMRX|CLAIM-HEADER-RECORD-RX-CRX00002

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCRX166|COMBINED-BENE-CO SHARING-PAID-AMOUNT|S9(11)V99|CLAIMRX|CLAIM-HEADER-RECORD-RX-CRX00002

|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME| SEGMENT NAMECRX167|INGREDIENT-COST-SUBMITTED |Conditional|The charge to cover t cost of ingredients for the prescription or drug.|Value must be between -99999999999.99 a 99999999999.99Value must be expressed as a number with 2-digit precision (e.g. 100.50 CLAIMRX|CLAIM-LINE-RECORD-RX-CRX00003

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCRX167|INGREDIENT-COST-SUBMITTED|S9(11)V99|CLAIMRX|CLAIM-LINE-RECORD-RX-CRX00003

|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME| SEGMENT NAMECRX168|INGREDIENT-COST-PAID-AMT |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.|Value must be between -99999999999.99 and 99999999999.99Value must be expressed as a number with 2-digit precision (e.g. 100.50)|CLAIMRX|CLAIM-LINE-RECORD-RX-CRX00003

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCRX168|INGREDIENT-COST-PAID-AMT|S9(11)V99|CLAIMRX|CLAIM-LINE-RECORD-RX-CRX00003

|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME| SEGMENT NAMECRX169|DISPENSE-FEE-PAID-AMT|Conditional|The amount paid by Medicai the managed care plan on this claim or adjustment towards the cost of the pharmacy's professional dispensing fee for the prescription.|Value must be between -99999999999.99 99999999999.99Value must be expressed as a number with 2-digit precision (e.g. 100.50 CLAIMRX|CLAIM-LINE-RECORD-RX-CRX00003

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCRX169|DISPENSE-FEE-PAID-S9(11)V99|CLAIMRX|CLAIM-LINE-RECORD-RX-CRX00003

|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME| SEGMENT NAMECRX170|PROFESSIONAL-SERVICE-FEE-SUBMITTED|Conditional|The charge cover the clinical services, not otherwise covered under the professional dispensing fee. (Example "not filling a prescription because of therapeutic duplication")|Value must be bet -99999999999.99 and 99999999999.99Value must be expressed as a number with 2-digit precision (e.g. 100.50)|CLAIMRX|CLAIM-LINE-RECORD-RX-CRX00003

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCRX170|PROFESSIONAL-SERV FEE-SUBMITTED|S9(11)V99|CLAIMRX|CLAIM-LINE-RECORD-RX-CRX00003

|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME| SEGMENT NAMECRX171|PROFESSIONAL-SERVICE-FEE-PAID-AMT|Conditional|The amount p by Medicaid or the managed care plan on this claim or adjustment towards the costs of cli services not otherwise covered under the professional dispensing fee.|Value must be betw 99999999999.99 and 99999999999.99Value must be expressed as a number with 2-digit precision (e.g. 100.50)|CLAIMRX|CLAIM-LINE-RECORD-RX-CRX00003

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCRX171|PROFESSIONAL-SERV
FEE-PAID-AMT|S9(11)V99|CLAIMRX|CLAIM-LINE-RECORD-RX-CRX00003

|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME|
SEGMENT NAMECRX172|IHS-SERVICE-IND|Mandatory|To indicate Services received by
Medicaid-eligible individuals who are American Indian or Alaska Native (AI/AN) through fac
of the Indian Health Service (IHS), whether operated by IHS or by Tribes.|Value must be 1
characterValue must be in [0, 1] or not populated|CLAIMRX|CLAIM-LINE-RECORD-RX-CRX0

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTCRX172|IHS-SERVICE-IND|X(1
CLAIMRX|CLAIM-LINE-RECORD-RX-CRX00003

DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|PRV034|DATE-OF-BIRTH
individual's date of birth.|1.Value must be 8 characters in the form "CCYYMMDD"2. The dat
must be a valid calendar date (i.e. Feb 29th only on the leap year, never April 31st or Sept
31st)3.(FD1) value must be less than or equal to associated End of Time Period
(PRV.001.010)4.(N) conditional5.(FDN) the difference between current value and Start of T
Period (PRV.001.009) must be between 18 and 85 years|

DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|CLT126|DATE-OF-BIRTH|
individual's date of birth.|Description: An individual's date of birth.1.Value must be 8 chara
in the form "CCYYMMDD"2. The date must be a valid calendar date (i.e. Feb 29th only on t
leap year, never April 31st or Sept 31st)3.(N) mandatory|

DE No|Data Element Name|Definition| CODING REQUIREMENT|COT207|DESTINATION-STAT
The ANSI state numeric code for the U.S. state, Territory, or the District of Columbia code c
destination state in which a patient is transported either from home or a long term care fa
to a health care provider for healthcare services or vice versa.|1.(GS) value must satisfy th
requirements of Address State (CE)|

|DE NO| DATA ELEMENT NAME| DEFINITION||COT208|DESTINATION-ZIP-CODE|The zip code
the destination city to which a patient is transported either from home or long term care fa
to a health care provider for healthcare services or vice versa. For transportation claims or
Required if state has captured this information, otherwise it is conditional.|

|DE No|Data Element Name|Definition||CIP069|DIAGNOSIS-RELATED-GROUP-IND|An indicat
identifying the grouping algorithm used to assign Diagnosis Related Group (DRG) values.V
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 CM
Grouper, fill with 'HG'.If any other system, fill with 'XX'.Position 3-4, fill with the number tha
represents the DRG version used (01-98).For example, 'HG15" wouldrepresent CMS Group
version 15. If version is unknown, fill with '99".|

DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|ELG224 |DISABILITY-TYP CODE |A code to identify disability status in accordance with requirements of Section 4302 the Affordable Care Act.|1.(LV) value must be in Disability Type Code List (VVL)2.(S) value be 2 characters3.(N) mandatory
DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|CRX141|DISPENSE-FEE|T 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 t provider towards the professional dispensing fee.If the provider does not break out the professional dispensingfee on the NCPDP transaction, this field should be left blank in T-MS (LVR) value must be between -99999999999.99 and 99999999999.992.(S) value must be expressed as a number with 2-digit precision (e.g. 100.50)3.(S) value may include up to 6 digits to the left of the decimal point, and 3 digits to the right e.g. 123456.784.(N) mandat
|DE No|Data Element Name|Definition||CRX102|DISPENSING-PRESCRIPTION-DRUG-PROV-N The National Provider ID (NPI) of the provider responsible for dispensing the prescription d
|DE No|Data Element Name|Definition||CIP029|DRG-DESCRIPTION|Description of the associ state-specific DRG code. If using standard MS-DRG classification system, leave blank.|
|DE No|Data Element Name|Definition| CODING REQUIREMENTCIP194 |DRG-OUTLIER-AMT|T 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 "diagn related group" discharge with extra dollars for patient stays that substantially exceed the typical requirements for patient stays in the same DRG category |1.(GS) value must satisfy requirements of US Dollar Amount (DT)2.(FD1) value must not be populated, if Outlier Cod (CIP.002.197) equals '00' or '09'3.(N) conditional
|DE No|Data Element Name|Definition||CIP195|DRG Relative Weight|The relative weight for 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 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 0.5000was half the average. This da element in T-MSIS is expected to capture the relative weight of the DRG in the state's syst regardless of which DRG system the state uses.|

DE No|Data Element Name|CODING REQUIREMENT|CRX143|DRUG-UTILIZATION-CODE|1.(S value must be 6 characters or less2.(S) characters 1 and 2 (2-character string) must be in Utilization Reason of Service Code List (VVL)3.(S) characters 3 and 4 (2-character string) m be in Drug Utilization Professional Service Code List (VVL)4.(S) characters 5 and 6 (2-chara string) must be in Drug Utilization Result For Service Code List (VVL)5.(N) mandatory|
DE No|Data Element Name|Definition| CODING REQUIREMENT|ELG262|ELG-IDENTIFIER-ISSUING-ENTITY-ID|This data element is reserved for future use|1.(S) value must be 18 characters or less|
|DE NO| DATA ELEMENT NAMEELG045|ENGL-PROF-CODE
DE No|Data Element NameELG045|ENGL-PROF-CODE
DE NO| DATA ELEMENT NAME COMPUTING|ELG065|ELIGIBLE-ADDR-TYPE
DE No|Segment Name|DE Name|DefinitionELG095|ELIGIBILITY-DETERMINANTS-ELG00005| ELIGIBILITY-CHANGE-REASON|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 reporte 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 was reported was closed.
DE No|Data Element Name|Definition| CODING REQUIREMENT|ELG108|HEALTH-HOME-ENT NAME|A field to identify the health home SPA in which an individual is enrolled. Because ar identification numbering schema has not been established, the entities' names are being u instead.|1.(GS) value must satisfy the requirements of Health Home Entity Name (CE)2.(S) value must 100 characters or less3.(N) mandatory|
DE No|Data Element Name|Definition| CODING REQUIREMENT|ELG119|HEALTH-HOME-ENT NAME|A field to identify the health home SPA in which an individual is enrolled. Because ar identification numbering schema has not been established, the entities' names are being u instead.|1.(GS) value must satisfy the requirements of Health Home Entity Name (CE)2.(S) value must 100 characters or less3.(N) mandatory
N/A
N/A
N/A
N/A
|DE NO| DATA ELEMENT NAMEELG215|AMERICAN-INDIAN-ALASKA-NATIVE-INDICATOR
DE No|Data Element NameELG215|AMERICAN-INDIAN-ALASKA-NATIVE-INDICATOR

|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME| SEGMENT NAMEELG269|ELIGIBLE-FEDERAL-POVERTY-LEVEL-PERCENTAGE |Conditional|The beneficiary's or their household's income as a percentage of the federal poverty level. Use assign the beneficiary to the eligibility group that covered their Medicaid or CHIP benefits. beneficiary's income was assessed using multiple methodologies (MAGI and Non-MAGI), re the one that applies to their primary eligibility group.|(LVR) value must be between 0 and 4 inclusively|ELIGIBLE|VARIABLE-DEMOGRAPHICS-ELIGIBILITY-ELG00003

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTELG269|ELIGIBLE-FEDERAL-POVERTY-LEVEL-PERCENTAGE|9(3)|ELIGIBLE|VARIABLE-DEMOGRAPHICS-ELIGIBILITY-ELG00

|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME| SEGMENT NAMEELG270|LOCKED-IN-SRVCS|Conditional|The type(s) of service that are lock in|Value must be 3 characters|ELIGIBLE|LOCK-IN-INFORMATION-ELG00009

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTELG270|LOCKED-IN-SRVCS |X ELIGIBLE|LOCK-IN-INFORMATION-ELG00009

|DE NO| DATA ELEMENT NAME|NECESSITY |DEFINITION|CODING REQUIREMENT|FILENAME| SEGMENT NAMEELG271|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)|If associated Ethnicity-Code (ELG.015.204) valu in ["4"], then value must be populated.|ELIGIBLE|ETHNICITY-INFORMATION-ELG00015

DE_NO|DATA_ELEMENT_NAME|SIZE|FILE NAME|FILE SEGMENTELG271|ETHNICITY-OTHER |X ELIGIBLE|ETHNICITY-INFORMATION-ELG00015

|DE No|Data Element Name|Definition||ELG131|HEALTH-HOME-CHRONIC-CONDITION-OTHE EXPLANATION|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 data element.|

DE No|Data Element Name|Definition| CODING REQUIREMENT|ELG111|HEALTH-HOME-ENT EFF-DATE|The date on which the health home entity was approved by CMS to participate i Health Home Program.|1.(GS) value must satisfy the requirements of Health Home Entity Effective Date (CE)

DE No|Data Element Name|Definition| CODING REQUIREMENT|ELG123|HEALTH-HOME-ENT EFF-DATE|The date on which the health home entity was approved by CMS to participate i Health Home Program.|1.(S) value must be 8 characters in the form 'YYYYMMDD'2.(LV) the must be a valid calendar date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3.(N) mandatory

|DE No|Data Element Name|Definition||CIP221|HEALTH-HOME-PROVIDER-NPI|The National Provider ID (NPI) of the health home provider.||CLT167|HEALTH-HOME-PROVIDER-NPI|The National Provider ID (NPI) of the health home provider.||COT146|HEALTH-HOME-PROVIDER-The National Provider ID (NPI) of the health home provider.||CRX104|HEALTH-HOME-PROVI NPI|The National Provider ID (NPI) of the health home provider.|

DE No|Data Element Name|Definition| CODING REQUIREMENT|ELG044|IMMIGRATION-STAT FIVE-YEAR-BAR-END-DATE||1.(GS) value must satisfy the requirements of Date (CE)2.(N) conditional3.(FD1) (U.S. Citizen) value should not be populated when Immigration Status (ELG.003.042) equals '8'

|DE No|Data Element Name|Definition|CIP250|IP-LT-QUANTITY-OF-SERVICE-ALLOWED| On facility claim entries, 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 times the procedure/servicebeing reported was performed. This field is only applicable wh 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.|

DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|ELG088|LEVEL-OF-CARE STATUS||1. Value must be in Level of Care Status List (VVL)2. Value must be 3 characters3 Mandatory

|DE No|Data Element Name|Definition||PRV069|LICENSE-OR-ACCREDITATION-NUMBER|A da element to capture the license or accreditation number issued to the provider by the licens entity or accreditation body identified in the License Issuing Entity ID data element.|

|DE No|Data Element Name|Definition||PRV067|LICENSE-TYPE|A code to identify the kind o license or accreditation number that is captured in the License or Accreditation Number da element.|

DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|ELG140|LOCKIN-PROV-N The State-specific Medicaid Provider Identifier is a state-assigned unique identifier that sta should report with all individual providers,practice groups, facilities, and other entities. Thi should be the identifier that is used in the state's Medicaid Management Information Syste 1.Value must be 30 characters or less2.(N) mandatory
DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|ELG141|LOCKIN-PROV-T 1.(LV) value must be in Provider Type Code List (VVL)2.Value must be 2 characters3.Mand
DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|ELG182|LTSS-LEVEL-CAR (LV) value must be in LTSS Level of Care List (VVL)|
DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|ELG183|LTSS-PROV-NUM unique identification number assigned by the state to the long term care facility furnishing healthcare services to the individual.|1.Value must be 30 characters or less2.(N) mandator
DE No|Data Element Name|Definition| CODING REQUIREMENT|ELG035|MARITAL-STATUS- OTHER-EXPLANATION||1.(FD1) if associated Marital Status (ELG.003.035) equals '14' (Othe then value is mandatory and must be provided2.(S) value must be 50 characters or less3.(value must not contain a pipe or asterisk symbol4.(N) conditional
N/A

N/A

DE NO|DATA ELEMENT NAME|DEFINITION|CODING REQUIREMENT|CRX128|MEDICARE-COIN
AMT|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 Deduct Amount.|1. Value must be between -99999999999.99 and 99999999999.992. if associated Medicare Combined Deductible Indicator is '1', then value must not be populated (or must 99998)3. Value must be expressed as a number with 2-digit precision (e.g. 100.50)4. Valu must not be populated if Medicare Deductible Amount is not populated5. Conditional

DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|CRX127|MEDICARE-DEDUCTIBLE-AMT|The amount paid by Medicaid/CHIP on this claim at the claim line level toward the beneficiary's Medicare deductible. If the Medicare deductibleamount can be identified separately from Medicare coinsurance payments, code that amount in this field. Medicare coinsurance and deductible paymentscannot be separated, fill this field with thecombined payment amount and Medicare Coinsurance Payment is not required.|1.(GS) value must satisfy the requirements of US Dollar Amount (DT)2.(N) conditional3.(FD1) valu should not be populated if associated Crossover Indicator value

DE No|Data Element Name|Definition|CODING REQUIREMENT|ELG152|MFP-QUALIFIED-RESIDENCE|A code indicating the type of qualified residence.|

DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|ELG153|MFP-REASON-PARTICIPATION-ENDED| A code describing why an individual's participation in Money Follow the Person demonstration ended.1. (LV) value must be in MFP Reason Participation Ended (VVL)2.(S) value must be 2 characters3.(N) conditional4.(FD1) value must not be populate when Enrollment End Date equals '9999-12-31'5.(FD1) value must be populated when Enrollment End Date does not equal '9999-12-31'
ELG00005.R.4 (FD2) an eligibility determinant segment (ELG005) with Primary Eligibility G Indicator = “1” must exist for each timespan for which a person is eligible for Medicaid or
DE No|Data Element Name|Definition| CODING REQUIREMENT|CIP134|NON-COV-DAYS|The number of days of inpatient care not covered by the payer for this sequence as qualified b payer organization. The number of non-covereddays does not refer to days not covered fo other service.1. (S) value must be 5 digits or less2.(N) conditional
DE No|Data Element Name|Definition| CODING REQUIREMENT|CLT084|NON-COV-DAYS||1.(value must satisfy the requirements of Non-Covered Days (CE)
|DE No|Data Element Name|Definition||CIP265|OPERATING-PROV-NPI-NUM|The National Provider ID (NPI) of the provider who performed the surgical procedures on the beneficiary
|DE NO| DATA ELEMENT NAME| DEFINITION||COT200|ORIGINATION-ADDR-LN2|The second of the street address of the destination point to which a patient is transported either from or Long term care facility to a health care provider for healthcare services or vice versa. Fo transportation claims, this is only required if state has captured this information, otherwise conditional.|
|DE No|Data Element Name|Definition| CODING REQUIREMENT||COT202|ORIGINATION-STA 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.|1.Value must be in State Code List (VVL)2. Value must b characters3.(N) conditional|
|DE No|Data Element Name|Definition| CODING REQUIREMENT||CIP197|OUTLIER-CODE| Th 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 denotes thesource for developing the DRG. https://www.resdac.org/cms-data/variables/me drgoutlier-stay-code1.(LV) value must be in Outlier Code List (VVL)2.(S) value must be 2 characters3.(FD1) value is mandatory if either DRG Outlier Amount (CIP.002.194) or Outlie Days (CIP.002.198) are populated4.(N) conditional|

DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|TPL044|POLICY-OWNER-FIRST-NAME|Individual's first name; first name component of full name (e.g. First Name, M Initial, Last Name).|1.Value must be 30 characters or less2. Value must not contain a pipe asterisk symbols3.(N) Mandatory|
DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|TPL045|POLICY-OWNER-LAST-NAME|Individual's last name; last name component of full name (e.g. First Name, Mid Initial, Last Name).1.Value must be 30 characters or less2. Value must not contain a pipe c asterisk symbols3.(FD1) if TPL Health Insurance Coverage Indicator (TPL.002.020) equals " then value is mandatory
|DE No|Data Element Name|Definition||CRX075|PRESCRIBING-PROV-NPI-NUM|The National Provider ID (NPI) of the provider who prescribed a medication to a patient.|
DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|ELG045|ENGL-PROF-COD
DE No|Data Element Name|Definition| CODING REQUIREMENT|CIP070|PROCEDURE-CODE-1 (FD1) when populated, there must be a corresponding Procedure Code Flag2.(FD2) 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 code3.(FD2) if associated Procedure Code Flag L (VVL) value indicates an ICD-10-CM encoding '07', then value must be a valid ICD-10-CM procedure code4.(FDN)if associated Procedure Code Flag List (VVL) value indicates an "Oth encoding '10-87', then State must provide T-MSIS system with State-specificprocedure cod list, and value must be a valid State-specific procedure code5.(S) value must be 8 characte less6.(LV) value must be in Procedure Code List (VVL)7.(N) conditional
|DE No|Data Element Name|Definition||PRV081|PROV-IDENTIFIER|A data element to captur various ways used to distinguish providers from one another on claims and other interactio between providers and other entities. The specific type of identifier is defined in the corresponding value in the Provider Identifier Type data element.|
|DE No|Data Element Name|Definition||PRV078|PROV-IDENTIFIER-ISSUING-ENTITY-ID| A fre text field to capture the identity of the entity that issued the provider identifier in the Prov Identifier (PRV.005.081) data element. For (State Tax ID), if associated Provider Identifier T (PRV.005.077) value is equal to 6, then value must be the name of the state's taxation div For (Other), if associated Provider Identifier Type (PRV.005.077) value is equal to 8, then v must be the name of the entity that issued the identifier.|
DE No|Data Element Name| CODING REQUIREMENT|PRV043|PROV-LOCATION-ID|1. (IV) valu must not contain a pipe or asterisk symbols2. (S) value must be 5 characters or less3. (N) mandatory

DE No|Data Element Name|Definition| CODING REQUIREMENT|PRV064|PROV-LOCATION-ID (IV) value must not contain a pipe or asterisk symbols2. (S) value must be 5 characters or less3. (N) mandatory
DE No|Data Element Name|Definition| CODING REQUIREMENT|PRV.076|PROV-LOCATION-ID (IV) value must not contain a pipe or asterisk symbols2. (S) value must be 5 characters or less3. (N) mandatory
DE No|Data Element Name|Definition| CODING REQUIREMENT|PRV129|PROV-LOCATION-ID (IV) value must not contain a pipe or asterisk symbols2. (S) value must be 5 characters or less3. (N) mandatory
DE NO| DATA ELEMENT NAME COMPUTING|PRV046|PROV-ADDR-TYPE
SIZEX(30)
SIZEX(30)
|DE No|Data Element Name|Definition||ELG266|REASON-FOR-CHANGE|A code to identify th reason for changing the MSIS Identification Number of a beneficiary and only required for Eligibile Identifier Type = '2-Old MSIS Identification Number'. For example, If MSIS Identific Number of a beneficiary is being changed due to 'Merge with other MSIS ID' or 'Unmerge'.|
|DE No|Data Element Name|Definition||CIP190|REFERRING-PROV-NPI-NUM|The National Provider ID (NPI) of the provider who recommended the servicing provider to the patient.|| CLT136|REFERRING-PROV-NPI-NUM|The National Provider ID (NPI) of the provider who recommended the servicing provider to the patient.||COT118|REFERRING-PROV-NPI-NUM|T National Provider ID (NPI) of the provider who recommended the servicing provider to the patient.|

|DE No|Data Element Name|Definition||CLT213|SERVICING-PROV-NPI-NUM|The NPI of the h
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 diffe
than the attending provider and state or federal regulatory requirements call for a "combi
claim" (i.e., a claim that includes both facility and professional components). Examples are
Medicaid clinic bills or critical access hospital claims.||COT190|SERVICING-PROV-NPI-NUM|T
NPI of the health care professional who delivers or completes a particular medical service
non-surgical procedure. The Servicing Provider NPI Number is required when rendering pro
is different than the attending provider and state or federal regulatory requirements call fo
"combined claim" (i.e., a claim that includes both facility and professional components).
Examples are Medicaid clinic bills or critical access hospital claims.|

DE NO|DATA ELEMENT NAME|DEFINITION|CODING REQUIREMENTELG090|SSI-IND| A flag
indicating if the individual receives Supplemental Security Income (SSI) administered via t
Social Security Administration (SSA).|1.(GS) value must satisfy the requirements of Boolea
(DT)2.(LV) value must be in SSI Indicator List (VVL)3.(S) value must be 1 character4.(N)
conditional5.(FD1) value must equal '0' when SSI status (ELG.005.092) equals '000' or '003
is not populated6.(FD1) value must equal '1' when SSI status (ELG.005.092) equals '001' o
'002'|

DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|ELG091|SSI-STATE-
SUPPLEMENT-STATUS-CODE|Indicates the individual's State Supplemental Income Status.|
(LV) value must be in SSI State Supplement Status Code List (VVL)2.(S) value must be 3
characters3.(FD1) (individual not receiving Federal SSI)If value is "001" or "002", then SSI
Status (ELG.005.092) must be "001" or "002"4.(FD1) (Individual not receiving Federal SSI)I
value is "001" or "002", then SSI Indicator (ELG.005.090) must be '1'5.(FD1) value must no
populated or must be '000' when SSI Status (ELG.005.092) is not populated or is '000'

DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|ELG092|SSI-STATUS|
Indicates the individual's SSI Status.|1.(LV) value must be in SSI Status List (VVL)2.(S) valu
must be 3 characters3.(N) conditional4.(FD1) when value is '001' or '002', then SSI Indicat
must be '1'5. (FD1) when value is '000' or '003' or not populate, then SSI Indicator must be

DE No|Data Element Name|CODING REQUIREMENT|ELG093|STATE-SPEC-ELIG-GROUP||

DE No|Data Element Name|Definition| CODING REQUIREMENT|PRV027|TEACHING-IND||1.(L
value must be in Teaching Indicator List (VVL)2.(S) value must be 1 character3. (FD) value
must be '0' when Facility Group Individual Code (PRV.002.026) equals '02' or '03'4.(N)
conditional

|DE No|Data Element Name|Definition||CIP115|TOT-COPAY-AMT|The total amount paid by
Medicaid/CHIP enrollee towards a copayment for the service.1.(GS) value must satisfy the
requirements of Total Copayment Amount (CE)

DE No|Data Element Name|Definition| CODING REQUIREMENT|TPL.076|TPL-ENTITY-ADDR-T 1.(LV) value must be in TPL Entity Address Type List (VVL)2.(S) value must be 2 characters mandatory
N/A
N/A
N/A
N/A
N/A
N/A
DE NO|DATA ELEMENT NAME| DEFINITION|CODING REQUIREMENT|TPL067 |TYPE-OF-OTHER THIRD-PARTY-LIABILITY|This code identifies the other types of liabilities an individual may h which are not necessarily defined as a health insurance plan listed Insurance Type Plan.|1. value must be 1 character2.(LV) value must be in Type of Other Third Party Liability List (V (N) mandatory
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCIP100|TYPE-OF-CLAIM|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 rec
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCIP104|SOURCE-LOCATION|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, repor 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 th service directly to the enrollee.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCIP112|TOT-BILLED-AMT|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 [3, C, or W], then value must equal amou the provider billed to the managed care plan. Total Billed Amount is not expected on finan transactions.For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the total amount that the provider billed the sub-capita entity for the service. Report a null value in this field if the provider is a sub-capitated netw 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.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCIP113|TOT-ALLOWED-AMT|The clai
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 Allow
Amount is determined by the managed care organization.For sub-capitated encounters fro
sub-capitated entity that is not a sub-capitated network provider, report the total amount t
the sub-capitated entity allowed for the service. Report a null value in this field if the provi
is a sub-capitated network provider.For sub-capitated encounters from a sub-capitated net
provider, if the sub-capitated network provider directly employs the provider that renders
service to the enrollee, report a null value in this field.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCIP114|TOT-MEDICAID-PAID-AMT|Th
total amount paid by Medicaid/CHIP or the managed care plan on this claim or adjustment
the claim header level, which is the sum of the amounts paid by Medicaid or the managed
plan at the detail level for the claim.For sub-capitated encounters from a sub-capitated ent
that is not a sub-capitated network provider, report the total amount that the sub-capitate
entity paid the provider for the service. Report a null value in this field if the provider is a s
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
service to the enrollee, report a null value in this field.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCIP251|REVENUE-CHARGE|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
themanaged care plan.For sub-capitated encounters from a sub-capitated entity that is no
sub-capitated network provider, report the amount that the provider billed the sub-capitat
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
service to the enrollee, report a null value in this field.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCIP252|ALLOWED-AMT|The maximu
amount displayed at the claim line level as determined by the payer as being 'allowable' u
the provisions of the contract prior to the determination of actual payment. On Fee for Ser
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 provi
report the amount that the sub-capitated entity allowed at the claim line detail level. Repo
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
field.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCIP254|MEDICAID-PAID-AMT|The am
paid by Medicaid/CHIP agency or the managed care plan on this claim or adjustment at the
claim detail level.For sub-capitated encounters from a sub-capitated entity that is not a su
capitated network provider, report the amount that the sub-capitated entity paid the provi
at the claim line detail level. Report a null value in this field if the provider is a sub-capitate
network provider.For sub-capitated encounters from a sub-capitated network provider, if th
sub-capitated network provider directly employs the provider that renders the service to th
enrollee, report a null value in this field.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCLT052|TYPE-OF-CLAIM|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 rec

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCLT056|SOURCE-LOCATION|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, repor
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 th
service directly to the enrollee.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCLT063|TOT-BILLED-AMT|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 [3, C, or W], then value must equal amou
the provider billed to the managed care plan. Total Billed Amount is not expected on finan
transactions.For sub-capitated encounters from a sub-capitated entity that is not a sub-
capitated network provider, report the total amount that the provider billed the sub-capita
entity for the service. Report a null value in this field if the provider is a sub-capitated netw
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.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCLT064|TOT-ALLOWED-AMT|The cla
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 Allow
Amount is determined by the managed care organization.For sub-capitated encounters fro
sub-capitated entity that is not a sub-capitated network provider, report the total amount t
the sub-capitated entity allowed for the service. Report a null value in this field if the provi
is a sub-capitated network provider.For sub-capitated encounters from a sub-capitated net
provider, if the sub-capitated network provider directly employs the provider that renders t
service to the enrollee, report a null value in this field.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCLT065|TOT-MEDICAID-PAID-AMT|Th total amount paid by Medicaid/CHIP or the managed care plan on this claim or adjustment the claim header level, which is the sum of the amounts paid by Medicaid or the managed plan at the detail level for the claim.For sub-capitated encounters from a sub-capitated ent that is not a sub-capitated network provider, report the total amount that the sub-capitate entity paid the provider for the service. Report a null value in this field if the provider is a s 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 service to the enrollee, report a null value in this field.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCLT204|REVENUE-CHARGE|The tota amount billed for the related Revenue Code. Total amount billed includes both covered an 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 themanaged care plan.For sub-capitated encounters from a sub-capitated entity that is no sub-capitated network provider, report the amount that the provider billed the sub-capitat 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 service to the enrollee, report a null value in this field.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCLT205|ALLOWED-AMT|The maximu amount displayed at the claim line level as determined by the payer as being 'allowable' u the provisions of the contract prior to the determination of actual payment. On Fee for Ser 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 provi report the amount that the sub-capitated entity allowed at the claim line detail level. Repo 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 field.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCLT208|MEDICAID-PAID-AMT|The am paid by Medicaid/CHIP agency or the managed care plan on this claim or adjustment at the claim detail level.For sub-capitated encounters from a sub-capitated entity that is not a su capitated network provider, report the amount that the sub-capitated entity paid the provi at the claim line detail level. Report a null value in this field if the provider is a sub-capitate network provider.For sub-capitated encounters from a sub-capitated network provider, if th sub-capitated network provider directly employs the provider that renders the service to th enrollee, report a null value in this field.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCOT033|BEGINNING-DATE-OF-SERVI For services received during a single encounter with a provider, the date the service cover 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 serv covered by this claim began. For capitation premium payments, the date on which the per 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.For sub- capitation payments, this represents the first date of the period the sub-capitation paymer covers.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCOT034|ENDING-DATE-OF-SERVICE| services received during a single encounter with a provider, the date the service covered b this claim was received. For services involving multiple encounters on different days, or pe of care extending over two or more days, the date on which the service covered by this cla ended. For capitation premium payments, the date on which the period of coverage relate this payment ends/ended. For financial transactions reported to the OT file, populate with t last day of the time period covered by this financial transaction.For sub-capitation paymen this represents the last date of the period the sub-capitation payment covers.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCOT037|TYPE-OF-CLAIM|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.For sub-capitation payments, report TYPE-OF-CLAIM = '6' or “F”.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCOT041|SOURCE-LOCATION|The fiel 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, repor 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 th service directly to the enrollee.For sub-capitation payments, report a SOURCE-LOCATION o '20', indicating the managed care plan is the source of payment.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCOT048|TOT-BILLED-AMT|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 [3, C, or W], then value must equal amou the provider billed to the managed care plan. Total Billed Amount is not expected on finan transactions.For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the total amount that the provider billed the sub-capita entity for the service. Report a null value in this field if the provider is a sub-capitated netw 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.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCOT049|TOT-ALLOWED-AMT|The cla 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 Allow Amount is determined by the managed care organization.For sub-capitated encounters fro sub-capitated entity that is not a sub-capitated network provider, report the total amount t the sub-capitated entity allowed for the service. Report a null value in this field if the provi is a sub-capitated network provider.For sub-capitated encounters from a sub-capitated net provider, if the sub-capitated network provider directly employs the provider that renders service to the enrollee, report a null value in this field.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCOT050|TOT-MEDICAID-PAID-AMT|T total amount paid by Medicaid/CHIP or the managed care plan on this claim or adjustment the claim header level, which is the sum of the amounts paid by Medicaid or the managed plan at the detail level for the claim.For sub-capitated encounters from a sub-capitated ent that is not a sub-capitated network provider, report the total amount that the sub-capitate entity paid the provider for the service. Report a null value in this field if the provider is a s 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 service to the enrollee, report a null value in this field.For sub-capitation payments, this represents the amount paid by the managed care plan to the sub-capitated entity.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCOT066|PLAN-ID-NUMBER|A unique number assigned by the state which represents a distinct comprehensive managed care p prepaid health plan, primary care case management program, a program for all-inclusive c 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 MC (MCO, PIHP, or PAHP that has a contract with a state) that is making the payment to the su capitated entity or sub-capitated network provider.For sub-capitation payments, report the PLAN-ID-NUMBER for the managed care plan making the payment to the sub-capitated ent

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCOT112|BILLING-PROV-NUM|A uniqu
identification number assigned by the state to a provider or capitation plan. This data elem
should represent the entity billing for the service. For encounter records, if associated Typ
Claim value equals 3, C, or W, then value must be the state identifier of the provider or en
(billing or reporting) to the managed care plan.For sub-capitation payments, report the sta
assigned provider identifier for the sub-capitated entity, when available or required.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCOT113|BILLING-PROV-NPI-NUM|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 b
admitting provider except for Long Term Care.For sub-capitation payments, report the nat
provider identifier (NPI) for the sub-capitated entity if the provider has one.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCOT166|BEGINNING-DATE-OF-SERVI
For services received during a single encounter with a provider, the date the service cover
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 serv
covered by this claim began. For capitation premium payments, the date on which the per
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.For sub-
capitation payments, this represents the first date of the period the sub-capitation paymen
covers.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCOT167|ENDING-DATE-OF-SERVICE|
services received during a single encounter with a provider, the date the service covered b
this claim was received. For services involving multiple encounters on different days, or pe
of care extending over two or more days, the date on which the service covered by this cla
ended. For capitation premium payments, the date on which the period of coverage relate
this payment ends/ended. For financial transactions reported to the OT file, populate with t
last day of the time period covered by this financial transaction.For sub-capitation paymen
this represents the last date of the period the sub-capitation payment covers.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCOT174|BILLED-AMT|The amount bi
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 mana
care plan.For sub-capitated encounters from a sub-capitated entity that is not a sub-capita
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 netw
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.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCOT175|ALLOWED-AMT|The maximu amount displayed at the claim line level as determined by the payer as being 'allowable' u the provisions of the contract prior to the determination of actual payment. On Fee for Ser 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 provi report the amount that the sub-capitated entity allowed at the claim line detail level. Repo 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 field.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCOT178|MEDICAID-PAID-AMT|The amount paid by Medicaid/CHIP agency or the managed care plan on this claim or adjustme the claim detail level.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 service to the enrollee, report a null value in this field.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCOT186|TYPE-OF-SERVICE|A code to categorize the services provided to a Medicaid or CHIP enrollee.For sub-capitation paymen report a TYPE-OF-SERVICE value 119, 120, or 122.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCRX029|TYPE-OF-CLAIM|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 rec
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCRX032|SOURCE-LOCATION|The fiel 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, repor 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 th service directly to the enrollee.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCRX039|TOT-BILLED-AMT|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 [3, C, or W], then value must equal amou the provider billed to the managed care plan. Total Billed Amount is not expected on finan transactions.For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated network provider, report the total amount that the provider billed the sub-capita entity for the service. Report a null value in this field if the provider is a sub-capitated netw 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.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCRX040|TOT-ALLOWED-AMT|The cla 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 Allow Amount is determined by the managed care organization.For sub-capitated encounters fro sub-capitated entity that is not a sub-capitated network provider, report the total amount t the sub-capitated entity allowed for the service. Report a null value in this field if the provi is a sub-capitated network provider.For sub-capitated encounters from a sub-capitated net provider, if the sub-capitated network provider directly employs the provider that renders service to the enrollee, report a null value in this field.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCRX041|TOT-MEDICAID-PAID-AMT|T total amount paid by Medicaid/CHIP or the managed care plan on this claim or adjustment the claim header level, which is the sum of the amounts paid by Medicaid or the managed plan at the detail level for the claim.For sub-capitated encounters from a sub-capitated ent that is not a sub-capitated network provider, report the total amount that the sub-capitate entity paid the provider for the service. Report a null value in this field if the provider is a s 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 service to the enrollee, report a null value in this field.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCRX121|BILLED-AMT|The amount bi at the claim detail level as submitted by the provider. For encounter records, Type of Clain 3, C, or W, this field should be populated with the amount that the provider billed the man care plan.For sub-capitated encounters from a sub-capitated entity that is not a sub-capita network provider, report the amount that the provider billed the sub-capitated entity at th claim line detail level. Report a null value in this field if the provider is a sub-capitated netw 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.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCRX122|ALLOWED-AMT|The maximu amount displayed at the claim line level as determined by the payer as being 'allowable' u the provisions of the contract prior to the determination of actual payment. On Fee for Ser 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 provi report the amount that the sub-capitated entity allowed at the claim line detail level. Repo 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 i field.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITIONCRX125|MEDICAID-PAID-AMT|The amount paid by Medicaid/CHIP agency or the managed care plan on this claim or adjustme the claim detail level.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 su 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 service to the enrollee, report a null value in this field.

DE NO| DATA ELEMENT NAME COMPUTING|CODING REQUIREMENTCIP194|DRG-OUTLIER-AM Value must be populated when Outlier Code (CIP.002.197) is '01' ,'02' or '10'

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|CODING REQUIREMENTCIP202| REMITTANCE-NUM|The Remittance Advice Number is a sequential number that identifies th current Remittance Advice (RA) produced for a provider. The number is incremented by or each time a new RA is generated. The RA is the detailed explanation of the reason for the payment amount.||

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|CODING REQUIREMENTCLT144| REMITTANCE-NUM|The Remittance Advice Number is a sequential number that identifies th current Remittance Advice (RA) produced for a provider. The number is incremented by or each time a new RA is generated. The RA is the detailed explanation of the reason for the payment amount.||

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|CODING REQUIREMENTCOT126| REMITTANCE-NUM|The Remittance Advice Number is a sequential number that identifies th current Remittance Advice (RA) produced for a provider. The number is incremented by or each time a new RA is generated. The RA is the detailed explanation of the reason for the payment amount.||

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|CODING REQUIREMENTCRX081| REMITTANCE-NUM|The Remittance Advice Number is a sequential number that identifies th current Remittance Advice (RA) produced for a provider. The number is incremented by on each time a new RA is generated. The RA is the detailed explanation of the reason for the payment amount.||
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|CIP132|PAYMENT-LEVEL-IND|The fie 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-L IND = 1), the claim lines' associated allowed (ALLOWED-AMT) and paid (MEDICAID-PAID-AM 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 pa (MEDICAID-PAID-AMT) amounts on the associated claim lines should sum to the total allow (TOT-ALLOWED-AMT) and total paid (TOT-MEDICAID-PAID-AMT) amounts reported on the cl header.For claims where payment/allowed amount is determined at the individual lines bu then cost sharing or coordination of benefits was deducted from the total paid/allowed am at the header only (PAYMENT-LEVEL-IND = 3), then the line-level paid amount (MEDICAID-I 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 popula but the line level allowed amounts are not expected to sum exactly to the header level tot allowed.For example, if a claim for an office visit and a procedure is assigned a separate lin level allowed amount for each line, but then at the header level a copay is deducted from t 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 directl the total paid amount. If the state cannot distinguish between the scenarios for value 1 an value 3, then value 1 can be used for all claims with only header-level total allowed/paid amounts.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|CLT082|PAYMENT-LEVEL-IND|The fi
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-L
IND = 1), the claim lines' associated allowed (ALLOWED-AMT) and paid (MEDICAID-PAID-AM
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 pa
(MEDICAID-PAID-AMT) amounts on the associated claim lines should sum to the total allow
(TOT-ALLOWED-AMT) and total paid (TOT-MEDICAID-PAID-AMT) amounts reported on the c
header.For claims where payment/allowed amount is determined at the individual lines bu
then cost sharing or coordination of benefits was deducted from the total paid/allowed am
at the header only (PAYMENT-LEVEL-IND = 3), then the line-level paid amount (MEDICAID-
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 popul
but the line level allowed amounts are not expected to sum exactly to the header level tot
allowed.For example, if a claim for an office visit and a procedure is assigned a separate li
level allowed amount for each line, but then at the header level a copay is deducted from
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 direct
the total paid amount. If the state cannot distinguish between the scenarios for value 1 an
value 3, then value 1 can be used for all claims with only header-level total allowed/paid
amounts.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|COT068|PAYMENT-LEVEL-IND|The fi
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-L
IND = 1), the claim lines' associated allowed (ALLOWED-AMT) and paid (MEDICAID-PAID-AM
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 pa
(MEDICAID-PAID-AMT) amounts on the associated claim lines should sum to the total allow
(TOT-ALLOWED-AMT) and total paid (TOT-MEDICAID-PAID-AMT) amounts reported on the c
header.For claims where payment/allowed amount is determined at the individual lines bu
then cost sharing or coordination of benefits was deducted from the total paid/allowed am
at the header only (PAYMENT-LEVEL-IND = 3), then the line-level paid amount (MEDICAID-
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 popul
but the line level allowed amounts are not expected to sum exactly to the header level tot
allowed.For example, if a claim for an office visit and a procedure is assigned a separate li
level allowed amount for each line, but then at the header level a copay is deducted from
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 direct
the total paid amount. If the state cannot distinguish between the scenarios for value 1 an
value 3, then value 1 can be used for all claims with only header-level total allowed/paid
amounts.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|CRX058|PAYMENT-LEVEL-IND|The fi
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-L
IND = 1), the claim lines' associated allowed (ALLOWED-AMT) and paid (MEDICAID-PAID-AM
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 pa
(MEDICAID-PAID-AMT) amounts on the associated claim lines should sum to the total allow
(TOT-ALLOWED-AMT) and total paid (TOT-MEDICAID-PAID-AMT) amounts reported on the c
header.For claims where payment/allowed amount is determined at the individual lines bu
then cost sharing or coordination of benefits was deducted from the total paid/allowed am
at the header only (PAYMENT-LEVEL-IND = 3), then the line-level paid amount (MEDICAID-
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 popul
but the line level allowed amounts are not expected to sum exactly to the header level tot
allowed.For example, if a claim for an office visit and a procedure is assigned a separate li
level allowed amount for each line, but then at the header level a copay is deducted from
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 direct
the total paid amount. If the state cannot distinguish between the scenarios for value 1 an
value 3, then value 1 can be used for all claims with only header-level total allowed/paid
amounts.

DE NO| DATA ELEMENT NAME COMPUTING|CODING REQUIREMENT|ELG252|ENROLLMENT-T
A person enrolled in Medicaid/CHIP must have a primary eligibility group classification for a
given day of enrollment. (There may or may not be a secondary eligibility group classificat
for that same day.)

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|CIP293|TOT-BENEFICIARY-COINSURANCE-LIABLE-AMOUNT|The total coinsurance amount on a claim the beneficiary is obligated to pay for covered services. This amount is the total Medicaid or contract negotia beneficiary coinsurance liability for covered services on the claim. Do not subtract out any payments made toward the coinsurance.CLT240|TOT-BENEFICIARY-COINSURANCE-LIABLE-AMOUNT|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 toward the coinsurance.COT231|TOT-BENEFICIARY-COINSURANCE-LIABLE-AMOUNT|The tot coinsurance amount on a claim the beneficiary is obligated to pay for covered services. Th amount is the total Medicaid or contract negotiated beneficiary coinsurance liability for co services on the claim. Do not subtract out any payments made toward the coinsurance.CRX164|TOT-BENEFICIARY-COINSURANCE-LIABLE-AMOUNT|The total coinsura amount on a claim the beneficiary is obligated to pay for covered services. This amount is total Medicaid or contract negotiated beneficiary coinsurance liability for covered services the claim. Do not subtract out any payments made toward the coinsurance.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|CIP294|TOT-BENEFICIARY-DEDUCTI LIABLE-AMOUNT|The total deductible amount on a claim the beneficiary is obligated to pay covered services. This amount is the total Medicaid or contract negotiated beneficiary deductible liability minus previous beneficiary payments that went toward their deductible not subtract out any payments for the given claim that went toward the deductible.CLT24 TOT-BENEFICIARY-DEDUCTIBLE-LIABLE-AMOUNT|The total deductible amount on a claim th beneficiary is obligated to pay for covered services. This amount is the total Medicaid or contract negotiated beneficiary deductible liability minus previous beneficiary payments th went toward their deductible. Do not subtract out any payments for the given claim that w toward the deductible.COT232|TOT-BENEFICIARY-DEDUCTIBLE-LIABLE-AMOUNT|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.CRX165|TOT-BENEFICIARY-DEDUCTIBLE-LIABLE-AMOUNT|The total deductible amount on a claim the beneficiary is obligated to pay for covered services. This amount is the total Medicaid or contract negotia beneficiary deductible liability minus previous beneficiary payments that went toward thei deductible. Do not subtract out any payments for the given claim that went toward the deductible.

DE NO| DATA ELEMENT NAME COMPUTING|CODING REQUIREMENT|ELG040|CITIZENSHIP-IN Value must be in [0, 1, 2] or not populated

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|PRV024|PROV-ORGANIZATION-NAM The name of the provider when the provider is an organization. If the provider organizatio 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.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|CIP099|MEDICAID-PAID-DATE|The d Medicaid paid this claim or adjustment. For Encounter Records (Type of Claim = 3, C, W), t date the managed care organization paid the provider for the claim or adjustment.CLT051 MEDICAID-PAID-DATE|The date Medicaid paid this claim or adjustment. For Encounter Reco (Type of Claim = 3, C, W), the date the managed care organization paid the provider for th claim or adjustment.COT036|MEDICAID-PAID-DATE|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.CRX028|MEDICAID-PAID-DATE|T date Medicaid paid this claim or adjustment. For Encounter Records (Type of Claim = 3, C, the date the managed care organization paid the provider for the claim or adjustment.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|ELG095|ELIGIBILITY-CHANGE-REASO The reason for a complete loss/termination in an individual's eligibility for Medicaid and CH The end date of the segment in which the value is reported must represent the date that t 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 a single termination in eligibility for a single individual there are multiple distinct co-occurr 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' (Othe '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 stat 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 o value over another.
DE NO| DATA ELEMENT NAME COMPUTING|CODING REQUIREMENT|ELG097|RESTRICTED-BENEFITS-CODE|(Restricted Benefits) if value is "G", then Dual Eligible Code (ELG.005.085) must be in (‘01’, ‘03', ‘06’)
DE NO| DATA ELEMENT NAME COMPUTING|CODING REQUIREMENT|ELG270|LOCKED-IN-SRV Must be a 3 digit value from the Type-of-Service valid value list
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|MCR020|MANAGED-CARE-CONTRAC EFF-DATE|The start date of the managed care contract period with the state.

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|CIP296|IHS-SERVICE-IND|To indicat Services received by Medicaid-eligible individuals who are American Indian or Alaska Nativ (AI/AN) through facilities of the Indian Health Service (IHS), whether operated by IHS or by Tribes.CLT243|IHS-SERVICE-IND|To indicate Services received by Medicaid-eligible individu who are American Indian or Alaska Native (AI/AN) through facilities of the Indian Health Se (IHS), whether operated by IHS or by Tribes.COT234|IHS-SERVICE-IND|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.CRX172|IHS-SERVICE-IND|To indicate Services received by Medicaid-eligible individu who are American Indian or Alaska Native (AI/AN) through facilities of the Indian Health Se (IHS), whether operated by IHS or by Tribes.
The date Medicaid paid this claim or adjustment. For Encounter Records (Type of Claim = W), the date the managed care organization paid the provider for the claim or adjustment.
The date Medicaid paid this claim or adjustment. For Encounter Records (Type of Claim = W), the date the managed care organization paid the provider for the claim or adjustment.
The date Medicaid paid this claim or adjustment. For Encounter Records (Type of Claim = W), the date the managed care organization paid the provider for the claim or adjustment.
The date Medicaid paid this claim or adjustment. For Encounter Records (Type of Claim = W), the date the managed care organization paid the provider for the claim or adjustment.
The reason for a complete loss/termination in an individual's eligibility for Medicaid and CH The end date of the segment in which the value is reported must represent the date that t 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. I a single termination in eligibility for a single individual, there are multiple distinct co-occur 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' (Othe '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 stat 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 o value over another.
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-blog/98581 . A provider may be reported with multiple active record segments with the same Provider Classification Type if different Provider Classification Code values apply.

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 operate IHS or by Tribes.
1. Value must be 1 character2. Value must be in [0, 1]
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 operate IHS or by Tribes.
1. Value must be 1 character2. Value must be in [0, 1]
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 operate IHS or by Tribes.
1. Value must be 1 character2. Value must be in [0, 1]
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 operate IHS or by Tribes.
1. Value must be 1 character2. Value must be in [0, 1]
The date Medicaid paid this claim or adjustment. For Encounter Records (Type of Claim = 3 W), the date the managed care organization paid the provider for the claim or adjustment.
The date Medicaid paid this claim or adjustment.
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|ELG034|MARITAL-STATUS|A code to classify eligible individual's marital/domestic-relationship status. 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 system and a data user can choose to use them as-is or roll the values up in broader categ depending on whichever approach best meets their needs. CMS periodically reviews the va reported to MARITAL-STATUS-OTHER-EXPLANATION to determine if states are appropriatel using it only when there is no existing MARITAL-STATUS value that reflects the state’s mar status description for an individual AND to determine whether it is necessary to add additi T-MSIS MARITAL-STATUS values to reflect commonly used state martial status descriptions which there is no existing T-MSIS MARITAL-STATUS value.|
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|ELG074|TYPE-OF-LIVING-ARRANGEMENT|A free-form text field to describe the type of living arrangement used for th eligibility determination process.|

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|ELG095|ELIGIBILITY-CHANGE-REASO The reason for a complete loss/termination in an individual's eligibility for Medicaid and CH The end date of the segment in which the value is reported must represent the date that t 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. I a single termination in eligibility for a single individual there are multiple distinct co-occurr 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' (Othe '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 stat 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 o 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.|
CRX - CLAIM PRESCRIPTION
CRX - CLAIM PRESCRIPTION
Conditional
1. Value must be in Income Code List (VVL)2. Value must be 2 characters3. Conditional
Conditional
Value must be in Funding Code List (VVL)2. Value must be 1 character3. Conditional
Value must be 3 characters2. Mandatory3. Value must not equal '086' if Sex (ELG.002.023 equals 'M'4. Value must be in ['001', '058', '060', '084', '086', '090', '091', '092', '093', '123 '132', '135', '136', '137'] when associated Claim Type is CIP (Inpatient Claim)
Conditional
1. Value must be in Funding Code List (VVL)2. Value must be 1 character3. Conditional
Value must be in Funding Code List (VVL)2. Value must be 1 character3. Conditional
1. Value must be 3 characters2. Mandatory3. Value must be in ['009', '044', '045', '046', '0 '048', '050', '059', '133', '136', '137', '146', '147'] when associated Claim Type is CLT (Long Term Claim)
Conditional
1. Value must be in Funding Code List (VVL)2. Value must be 1 character3. Conditional
The Medicaid provider ID of the Ordering Provider is the individual who requested the serv or items being reported on this service line. Examples include, but are not limited to, provi ordering diagnostic tests and medical equipment or supplies. [Ordering provider informatio only captured at the line level in the X12 837P format but in v3.0.0 of the T-MSIS file layou only captured at the header level. This discrepancy will be addressed in a future version of T-MSIS OT file layout. Until Ordering provider information has been moved from the T-MSIS claim header to the line, there is no need to report it at the header.]

A National Provider Identifier (NPI) is a unique 10-digit identification number issued to heal care providers in the United States by CMS. Healthcare providers acquire their unique 10-d NPIs to identify themselves in a standard way throughout their industry. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number).|Value must be 10 digits, consisting of 9 numeric digits followed by one check digit calculated using the Luhn formul (algorithm).The NPI of Ordering Provider represents the individual who requested the servi items being reported on this service line. Example include, but are not limited to, provider ordering diagnostic tests and medical equipment or supplies.[Ordering provider informatio only captured at the line level in the X12 837P format but in v3.0.0 of the T-MSIS file layou only captured at the header level. This discrepancy will be addressed in a future version of T-MSIS OT file layout. Until Ordering provider information has been moved from the T-MSIS claim header to the line, there is no need to report it at the header.]
1. Value must be 3 characters2. Mandatory3. When value is in [119-122], Servicing Provide Num (COT.002.190) should not be populated4. Value must be in ['002', '003', '004', '005', ' '007', '008', '010', '011', '012', '013', '014', '015', '016', '017', '018', '019', '020', '021', '022 '023', '024', '025', '026', '027', '028', '029', '030', '031', '032', '035', '036', '037', '038', '039 '040', '041', '042', '043', '049', '050', '051', '052', '053', '054', '055', '056', '057', '058', '060 '061', '062', '063', '064', '065', '066', '067', '068', '069', '070', '071', '072', '073', '074', '075 '076', '077', '078', '079', '080', '081', '082', '083', '084', '085', '086', '087', '088', '089', '115 '119', '120', '121', '122', '127', '131', '134', '135', '136', '137', '138', '139', '140', '141', '142 '143', '144', '145', '147'] when associated Claim Type is COT (Other Claim)5. When value is [119-122], Servicing Provider Taxonomy (COT.003.191) should not be populated6. When v is in [119-122], Referring Provider NPI Num (COT.002.118) should not be populated7. Valu must be 3 characters8. Mandatory9. When value is in [119-122], Billing Provider NPI Num (COT.002.113) should not be populated10. When value is in [119-122], Billing Provider Taxonomy (COT.002.114) should not be populated11. When value is in [119-122], Referrin Provider Taxonomy (COT.002.119) should not be populated12. When value is not in ['025','085'], Sex (ELG.002.023) equals 'M'13. When value is in [119-122], Servicing Provid Num (COT.002.189) should not be populated
Conditional
1. Value must be in Funding Code List (VVL)2. Value must be 1 character3. Conditional
Mandatory

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 then Primary Eligibility Group Indicator (ELG.005.086) must be "1" (Yes)5. Mandatory6. A p 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 Iden (ELG.003.051) value must not be populated.8. Value must be 2 characters9. If value is in ["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 populated11. If value equals "10", then CHIP Code (ELG.003.054) must be "03" (S-CHIP) an Medicare Beneficiary Identifier (ELG.003.051) must be populated12. 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 in Funding Code List (VVL)2. Value must be 1 character3. Only required if Type-of-claim is not equal to '3', 'C', 'W', '6'4. Conditional
1. Value must be in Funding Source Non-Federal Share List (VVL)2. Value must be 2 characters3. Only required if Type-of-claim is not equal to '3', 'C', 'W', '6'4. Conditional
Value must be in Funding Code List (VVL)2. Value must be 1 character3. Only required if Ty of-claim is not equal to '3', 'C', 'W', '6'4. Conditional
1. Value must be in Funding Source Non-Federal Share List (VVL)2. Value must be 2 characters3. Only required if Type-of-claim is not equal to '3', 'C', 'W', '6'4. Conditional
1. Value must be in Funding Code List (VVL)2. Value must be 1 character3. Only required if Type-of-claim is not equal to '3', 'C', 'W', '6'4. Conditional
1. Value must be in Funding Source Non-Federal Share List (VVL)2. Value must be 2 characters3. Only required if Type-of-claim is not equal to '3', 'C', 'W', '6'4. Conditional
The NPI of Ordering Provider represents the individual who requested the service or items being reported on this service line. Example include, but are not limited to, provider orderi diagnostic tests and medical equipment or supplies.[Ordering provider information is only captured at the line level in the X12 837P format but in v3.0.0 of the T-MSIS file layout it is captured at the header level. This discrepancy will be addressed in a future version of the MSIS OT file layout. Until Ordering provider information has been moved from the T-MSIS c header to the line, there is no need to report it at the header.]
Value must be in Funding Code List (VVL)2. Value must be 1 character3. Only required if Ty of-claim is not equal to '3', 'C', 'W', '6'4. Conditional
1. Value must be in Funding Source Non-Federal Share List (VVL)2. Value must be 2 characters3. Only required if Type-of-claim is not equal to '3', 'C', 'W', '6'4. Conditional

1. Value must be 3 characters2. Mandatory3. Value must be in ['011', '018', '033', '034', '0 '085', '089', '127', '131', '136', '137', '145'] when associated Claim Type is CRX (RX Claim)
1. Value must be in Funding Code List (VVL)2. Value must be 1 character3. Value must be populated if TYPE-OF-CLAIM <> ‘3', ‘C’, ‘W’, or '6’4. Conditional
1. Value must be in Funding Source Non-Federal Share List (VVL)2. Value must be 2 characters3. Value must be populated if TYPE-OF-CLAIM <> ‘3', ‘C’, ‘W’, or '6’4. Conditiona
1. Value must be 3 characters2. Mandatory3. Value must not equal '086' if Sex (ELG.002.0 equals 'M'4. Value must be in ['001', '058', '060', '084', '086', '090', '091', '092', '093', '123 '132', '135', '136', '137']
1. Value must be 3 characters2. Mandatory3. Value must not equal '086' if Sex (ELG.002.0 equals 'M'4. Value must be in ['001', '058', '060', '084', '086', '090', '091', '092', '093', '123 '132', '135', '136', '137'] when associated Claim Type is CIP (Inpatient Claim)
1. Value must be in Funding Code List (VVL)2. Value must be 1 character3. Value must be populated if TYPE-OF-CLAIM <> ‘3', ‘C’, ‘W’, or '6’4. Conditional
1. Value must be in Funding Code List (VVL)2. Value must be 1 character3. Only required if Type-of-claim is not equal to '3', 'C', 'W', '6'4. Conditional
1. Value must be in Funding Source Non-Federal Share List (VVL)2. Value must be 2 characters3. Value must be populated if TYPE-OF-CLAIM <> ‘3', ‘C’, ‘W’, or '6’4. Conditiona
1. Value must be 3 characters2. Mandatory3. Value must be in ['009', '044', '045', '046', '0 '048', '050', '059', '133', '136', '137', '146', '147']
1. Value must be in Funding Code List (VVL)2. Value must be 1 character3. Value must be populated if TYPE-OF-CLAIM <> ‘3', ‘C’, ‘W’, or '6’4. Conditional
1. Value must be in Funding Source Non-Federal Share List (VVL)2. Value must be 2 characters3. Value must be populated if TYPE-OF-CLAIM <> ‘3', ‘C’, ‘W’, or '6’4. Conditiona
1. Value must be 3 characters2. Mandatory3. When value is in [119-122], Servicing Provide Num (COT.002.190) should not be populated4. Value must be in ['002', '003', '004', '005', ' '007', '008', '010', '011', '012', '013', '014', '015', '016', '017', '018', '019', '020', '021', '022 '023', '024', '025', '026', '027', '028', '029', '030', '031', '032', '035', '036', '037', '038', '039 '040', '041', '042', '043', '049', '050', '051', '052', '053', '054', '055', '056', '057', '058', '060 '061', '062', '063', '064', '065', '066', '067', '068', '069', '070', '071', '072', '073', '074', '075 '076', '077', '078', '079', '080', '081', '082', '083', '084', '085', '086', '087', '088', '089', '115 '119', '120', '121', '122', '127', '131', '134', '135', '136', '137', '138', '139', '140', '141', '142 '143', '144', '145', '147']5. When value is in [119-122], Servicing Provider Taxonomy (COT.003.191) should not be populated6. When value is in [119-122], Referring Provider N Num (COT.002.118) should not be populated7. Value must be 3 characters8. Mandatory9. When value is in [119-122], Billing Provider NPI Num (COT.002.113) should not be populate When value is in [119-122], Billing Provider Taxonomy (COT.002.114) should not be populated11. When value is in [119-122], Referring Provider Taxonomy (COT.002.119) sho not be populated12. When value is not in ['025','085'], Sex (ELG.002.023) equals 'M'13. Wh value is in [119-122], Servicing Provider Num (COT.002.189) should not be populated

1. Value must be in Funding Code List (VVL)2. Value must be 1 character3. Value must be populated if TYPE-OF-CLAIM <> ‘3', ‘C’, ‘W’, or '6’4. Conditional
1. Value must be in Funding Code List (VVL)2. Value must be 1 character3. Only required if Type-of-claim is not equal to '3', 'C', 'W', '6'4. Conditional
1. Value must be in Funding Source Non-Federal Share List (VVL)2. Value must be 2 characters3. Value must be populated if TYPE-OF-CLAIM <> ‘3', ‘C’, ‘W’, or '6’4. Conditiona
1. Value must be 3 characters2. Mandatory3. Value must be in ['011', '018', '033', '034', '0 '085', '089', '127', '131', '136', '137', '145']
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) a total paid (TOT-MEDICAID-PAID-AMT) amount is reported at the header level only.For claim 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- payment/allowed amounts (PAYMENT-LEVEL-IND = 2), the allowed (ALLOWED-AMT) and pa (MEDICAID-PAID-AMT) amounts on the associated claim lines should sum to the total allow (TOT-ALLOWED-AMT) and total paid (TOT-MEDICAID-PAID-AMT) amounts reported on the c header.For claims where payment/allowed amount is determined at the individual lines bu then cost sharing or coordination of benefits was deducted from the total paid/allowed am at the header only (PAYMENT-LEVEL-IND = 3), then the line-level paid amount (MEDICAID-I 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 popul but the line level allowed amounts are not expected to sum exactly to the header level tot allowed.For example, if a claim for an office visit and a procedure is assigned a separate li level allowed amount for each line, but then at the header level a copay is deducted from t 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 directl the total paid amount. If the state cannot distinguish between the scenarios for value 1 an value 3, then value 1 can be used for all claims with only header-level total allowed/paid amounts.

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) a total paid (TOT-MEDICAID-PAID-AMT) amount is reported at the header level only.For claim 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- payment/allowed amounts (PAYMENT-LEVEL-IND = 2), the allowed (ALLOWED-AMT) and pa (MEDICAID-PAID-AMT) amounts on the associated claim lines should sum to the total allow (TOT-ALLOWED-AMT) and total paid (TOT-MEDICAID-PAID-AMT) amounts reported on the c header.For claims where payment/allowed amount is determined at the individual lines bu then cost sharing or coordination of benefits was deducted from the total paid/allowed am at the header only (PAYMENT-LEVEL-IND = 3), then the line-level paid amount (MEDICAID- AMT) would be blank and line-level allowed (ALLOWED-AMT) and header level total allowe (TOT-ALLOWED-AMT) and total paid (TOT-MEDICAID-PAID-AMT) amounts must all be popul but the line level allowed amounts are not expected to sum exactly to the header level tot allowed.For example, if a claim for an office visit and a procedure is assigned a separate li level allowed amount for each line, but then at the header level a copay is deducted from 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 direct the total paid amount. If the state cannot distinguish between the scenarios for value 1 an value 3, then value 1 can be used for all claims with only header-level total allowed/paid amounts.

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A data element to identify the Medicaid/CHIP programs, waivers and demonstrations in wh the provider participates.

A code to classify eligible individual's marital/domestic-relationship status. This element sh 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 system and a data user can choose to use them as-is or roll the values up in broader categ depending on whichever approach best meets their needs. CMS periodically reviews the va reported to MARITAL-STATUS-OTHER-EXPLANATION to determine if states are appropriatel using it only when there is no existing MARITAL-STATUS value that reflects the state's mar status description for an individual AND to determine whether it is necessary to add additi T-MSIS MARITAL-STATUS values to reflect commonly used state martial status descriptions which there is no existing T-MSIS MARITAL-STATUS value.
DE NO||DATA ELEMENT NAME COMPUTING|||DEFINITIONPRV120|AFFILIATED-PROGRAM-ID|| data element to identify the Medicaid/CHIP programs, waivers and demonstrations in whic provider participates.
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Value must be populated when Outlier C (CIP.002.197) is '01' ,'02' or '10'4. Conditional
Value must be between -99999999999.99 and 99999999999.992. Value must be expresse a number with 2-digit precision (e.g. 100.50)3. Value must be populated when Outlier Cod (CIP.002.197) is '01' ,'02' or '10'4. Conditional
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Value must be populated, if Outlier Code (CIP.002.197) equals '00' or '09'4. Conditional
The Remittance Advice Number is a sequential number that identifies the current Remittan Advice (RA) produced for a provider. The number is incremented by one each time a new R generated. The RA is the detailed explanation of the reason for the payment amount.
1. Value must be 30 characters or less2. Value must not contain a pipe or asterisk symbols Mandatory

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1. Value must be 30 characters or less2. Value must not contain a pipe or asterisk symbols Mandatory
1. Value must be 1 character2. Value must be in [0, 1, 2] or not populated3. Value must be Citizenship Indicator List (VVL)4. If value is coded as '0', then associated Immigration Statu (ELG.003.042) value must be in [1, 2, 3]5. If value is coded as '1', then associated Immigr Status (ELG.003.042) value must equal '8'6. Value must be 1 character7. Mandatory

1. Value must be in Restricted Benefits Code List (VVL)2. (Restricted Benefits) if value is "3 and Dual Eligible Code (ELG.005.085) value is "05", then Eligibility Group (ELG.005.087) m be "24"3. (Restricted Benefits) if value is "3" and Dual Eligible Code (ELG.005.085) value is "06", then Eligibility Group (ELG.005.087) must be "26"4. (Restricted Benefits) if value is " and Dual Eligible Code (ELG.005.085) value is "02", then Eligibility Group (ELG.005.087) m be "23"5. (Restricted Benefits) if value is "1" and Dual Eligible Code (ELG.005.085) value is "04", then Eligibility Group (ELG.005.087) must be "25"6. (Restricted Benefits) if value is " then Dual Eligible Code (ELG.005.085) cannot be "00"7. Mandatory8. If value is populated, Eligibility Group (ELG.005.087) must be populated.9. If value is "6" then Eligibility Group(ELG.DE.087) must be in ("35", "70")10. If value is "1" or "7" then Eligibility Group (EGL.DE.087) must be in ("72", "73", "74", "75") and State Plan Option Type (ELG.DE.163) equal to "06"11. (Restricted Pregnancy-Related) if value is "4", then associated Sex (ELG.002.023) value must be "F"12. (Non-Citizen) if value is "2", then associated Citizensh Indicator (ELG.003.040) value must not be equal to "1"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 segment14. Value must be 1 character15. (Restricted Benefits) value is "3" and Dual Eligible Code (ELG.005.085) value is "01", then Eligibility Group (ELG.005.087) must be "23"16. (Restricted Benefits) if value is "3" and Dual Eligible Code (ELG.005.085) value is "03", then Eligibility Group (ELG.005.087) must be "25"17. (Restrict Benefits) if value is "G", then Dual Eligible Code (ELG.005.085) must be in (‘01’, ‘03', ‘06’)
Value must be in Restricted Benefits Code List (VVL)2. (Restricted Benefits) if value is "3" a Dual Eligible Code (ELG.005.085) value is "05", then Eligibility Group (ELG.005.087) must b "24"3. (Restricted Benefits) if value is "3" and Dual Eligible Code (ELG.005.085) value is "0 then Eligibility Group (ELG.005.087) must be "26"4. (Restricted Benefits) if value is "1" and Dual Eligible Code (ELG.005.085) value is "02", then Eligibility Group (ELG.005.087) must b "23"5. (Restricted Benefits) if value is "1" and Dual Eligible Code (ELG.005.085) value is "0 then Eligibility Group (ELG.005.087) must be "25"6. (Restricted Benefits) if value is "3", the Dual Eligible Code (ELG.005.085) cannot be "00"7. Mandatory8. If value is populated, then Eligibility Group (ELG.005.087) must be populated.9. If value is "6" then Eligibility Group(ELG.DE.087) must be in ("35", "70")10. If value is "1" or "7" then Eligibility Group (EGL.DE.087) must be in ("72", "73", "74", "75") and State Plan Option Type (ELG.DE.163) equal to "06"11. (Restricted Pregnancy-Related) if value is "4", then associated Sex (ELG.002.023) value must be "F"12. (Non-Citizen) if value is "2", then associated Citizensh Indicator (ELG.003.040) value must not be equal to "1"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 segment14. Value must be 1 character15. (Restricted Benefits) value is "3" and Dual Eligible Code (ELG.005.085) value is "01", then Eligibility Group (ELG.005.087) must be "23"16. (Restricted Benefits) if value is "3" and Dual Eligible Code (ELG.005.085) value is "03", then Eligibility Group (ELG.005.087) must be "25"17. (Restrict Benefits) if value is "G", then Dual Eligible Code (ELG.005.085) must be in (‘01’, ‘03', ‘06’)

1. Value must be 3 characters2. Conditional3. Must be a 3 digit value from the Type-of-Ser valid value list
1. Mandatory2. Value must be 20 characters or less3. When Type of Claim not in (4, D, X, Z V, Y, W), value must match MSIS Identification Number (ELG.021.251) and the Admission D (CIP.002.094) must be between Enrollment Effective Date (ELG.021.253) and Enrollment E Date (ELG.021.254)4. When Type of Claim (CIP.002.100) equals 4, D or X (lump sum paym value must begin with an '&'
1. Mandatory2. Value must be 20 characters or less3. When Type of Claim (CIP.002.100) = or X (lump sum payment) value must begin with an '&'
1. Mandatory2. Value must be 20 characters or less3. Populated value must begin with an when TYPE-OF-CLAIM = 4, D or X (lump sum payment)4. The Beginning Date of Service on claim must fall between (ELG.021.253) enrollment effective and (ELG.021.253) end date
1. Mandatory2. Value must be 20 characters or less3. When Type of Claim (CLT.002.052) equals 4, D or X (lump sum payment) value must begin with an '&'
1. Mandatory2. Value must be 20 characters or less3. Populated value must begin with an when Type of Claim (COT.002.037) = 4, D or X (lump sum payment)4. Value must match M Identification Number (ELG.021.251) and the Beginning Date of Service (COT.002.033) mu between Enrollment Effective Date (ELG.021.253) and Enrollment End Date (ELG.021.254)
1. Mandatory2. Value must be 20 characters or less3. When Type of Claim (COT.002.037) equals 4, D or X (lump sum payment) value must begin with an '&'
1. Mandatory2. Value must be 20 characters or less3. The Prescription Fill Date (CRX.002.0 on the claim must fall between Enrollment Timespan Effective Date (ELG.021.253) and Enrollment Timespan End Date (ELG.021.253)
1. Mandatory2. Value must be 20 characters or less3. When TYPE-OF-CLAIM = 4, D or X (lu sum payment), value must begin with an '&'

1. Mandatory2. Value must be 20 characters or less
1. Mandatory2. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eli individual's SSN3. Value must be 20 characters or less
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DE No|DE Name|Coding Requirement|CIP022|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|CIP022|MSIS-IDENTIFICATION-NUM||
DE NO| DATA ELEMENT NAME COMPUTING|CODING REQUIREMENT|CIP194|DRG-OUTLIER-A Value must be populated when Outlier Code (CIP.002.197) is '01' ,'02' or '10'|
DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|CODING REQUIREMENT|CIP202| REMITTANCE-NUM|The Remittance Advice Number is a sequential number that identifies th current Remittance Advice (RA) produced for a provider. The number is incremented by or each time a new RA is generated. The RA is the detailed explanation of the reason for the payment amount.||
DE No|DE Name|Coding Requirement|CIP234|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|CIP234|MSIS-IDENTIFICATION-NUM||

DE No|DE Name|Coding Requirement|CLT022|MSIS-IDENTIFICATION-NUM||

DE No|DE Name|Coding Requirement|CLT022|MSIS-IDENTIFICATION-NUM||

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|CODING REQUIREMENT|CLT144|
REMITTANCE-NUM|The Remittance Advice Number is a sequential number that identifies th
current Remittance Advice (RA) produced for a provider. The number is incremented by or
each time a new RA is generated. The RA is the detailed explanation of the reason for the
payment amount.||

DE No|DE Name|Coding Requirement|CLT187|MSIS-IDENTIFICATION-NUM||

DE No|DE Name|Coding Requirement|CLT187|MSIS-IDENTIFICATION-NUM||

DE No|DE Name|Coding Requirement|COT022|MSIS-IDENTIFICATION-NUM||

DE No|DE Name|Coding Requirement|COT022|MSIS-IDENTIFICATION-NUM||

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|CODING REQUIREMENT|COT126|
REMITTANCE-NUM|The Remittance Advice Number is a sequential number that identifies th
current Remittance Advice (RA) produced for a provider. The number is incremented by or
each time a new RA is generated. The RA is the detailed explanation of the reason for the
payment amount.||

DE No|DE Name|Coding Requirement|COT157|MSIS-IDENTIFICATION-NUM||

DE No|DE Name|Coding Requirement|COT157|MSIS-IDENTIFICATION-NUM||

DE No|DE Name|Coding Requirement|CRX022|MSIS-IDENTIFICATION-NUM||

DE No|DE Name|Coding Requirement|CRX022|MSIS-IDENTIFICATION-NUM||

DE NO| DATA ELEMENT NAME COMPUTING|DEFINITION|CODING REQUIREMENT|CRX081|
REMITTANCE-NUM|The Remittance Advice Number is a sequential number that identifies th
current Remittance Advice (RA) produced for a provider. The number is incremented by or
each time a new RA is generated. The RA is the detailed explanation of the reason for the
payment amount.||

DE No|DE Name|Coding Requirement|CRX111|MSIS-IDENTIFICATION-NUM||

DE No|DE Name|Coding Requirement|CRX111|MSIS-IDENTIFICATION-NUM||
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), re the income that applies to their primary eligibility group.A beneficiary’s income is applicab unless it is not required by the eligibility group for which they were determined eligible. Fo 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 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.
This data element provides the beneficiary's or their household's income as a percentage the federal poverty level. Used to assign the beneficiary to the eligibility group that covere 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 eligib group.A beneficiary’s income is applicable unless it is not required by the eligibility group f 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 eligibilit individuals needing treatment for breast or cervical cancer do not have a Medicaid income Additionally, for individuals receiving SSI, states with section 1634 agreements with the So Security Administration (SSA) and states that use SSI financial methodologies for Medicaid determinations do not conduct separate Medicaid financial eligibility for this group.
1. Mandatory2. Value must be 20 characters or less
DE No|DE Name|Coding Requirement|ELG019|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG019|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG033|MSIS-IDENTIFICATION-NUM||

DE No|DE Name|Definition|ELG038|INCOME-CODE|A code indicating the federal poverty lev range in which the family income falls.If the beneficiary's income was assessed using mult methodologies (MAGI and Non-MAGI), report the income that applies to their primary eligib group.A beneficiary’s income is applicable unless it is not required by the eligibility group f 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 eligibilit individuals needing treatment for breast or cervical cancer do not have a Medicaid income Additionally, for individuals receiving SSI, states with section 1634 agreements with the So Security Administration (SSA) and states that use SSI financial methodologies for Medicaid determinations do not conduct separate Medicaid financial eligibility for this group.
DE NO| DATA ELEMENT NAME COMPUTING|CODING REQUIREMENT|ELG040|CITIZENSHIP-IN Value must be in [0, 1, 2] or not populated|
DE No|DE Name|Coding Requirement|ELG064|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG064|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG082|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG082|MSIS-IDENTIFICATION-NUM||
DE NO| DATA ELEMENT NAME COMPUTING|CODING REQUIREMENT|ELG097|RESTRICTED-BENEFITS-CODE|(Restricted Benefits) if value is "G", then Dual Eligible Code (ELG.005.085) must be in (‘01’, ‘03', ‘06’)|
DE No|DE Name|Coding Requirement|ELG106|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG106|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG117|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG117|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG129|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG129|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG139|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG139|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG149|MSIS-IDENTIFICATION-NUM||

DE No|DE Name|Coding Requirement|ELG149|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG162|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG162|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG171|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG171|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG181|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG181|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG191|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG191|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG203|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG203|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG212|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG212|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG223|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG223|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG232|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG232|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG241|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG241|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG251|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG251|MSIS-IDENTIFICATION-NUM||

DE No|DE Name|Coding Requirement|ELG260|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|ELG260|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Definition|ELG269|ELIGIBLE-FEDERAL-POVERTY-LEVEL-PERCENTAGE|This element provides the beneficiary's or their household's income as a percentage of the fede poverty level. Used to assign the beneficiary to the eligibility group that covered their Med or CHIP benefits. If the beneficiary's income was assessed using multiple methodologies (M and Non-MAGI), report the income that applies to their primary eligibility group.A beneficia 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 assistanc foster care, or guardianship care under title IV-E and optional eligibility for individuals neec treatment for breast or cervical cancer do not have a Medicaid income test. Additionally, fo 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.
DE NO| DATA ELEMENT NAME COMPUTING|CODING REQUIREMENT|ELG270|LOCKED-IN-SRV Must be a 3 digit value from the Type-of-Service valid value list|
DE No|DE Name|Coding Requirement|TPL019|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|TPL019|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|TPL032|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|TPL032|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|TPL066|MSIS-IDENTIFICATION-NUM||
DE No|DE Name|Coding Requirement|TPL066|MSIS-IDENTIFICATION-NUM||
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in 1115A Demonstration Indicator List (VVL)4. Conditional5. When value equals '0', is invalid not populated, then the associated 1115A Demonstration Indicator (ELG.018.233) must eq '0', is invalid or not populated
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in Other Insurance Indicator List (VVL)4. Conditional
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in Fixed Payment Indicator List (VVL)4. Conditional

1. Value must be in Medicare Combined Deductible Indicator List (VVL)2. Value must be 1 character3. Value must be in [0, 1] or not populated4. If value equals '1', then Total Medica Coinsurance amount must not be populated.5. If value equals '0', then Crossover Indicator must equals '0'6. If value equals '1', then Crossover Indicator must equals '1'7. Conditional
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in Forced Claim Indicator List (VVL)4. Conditional
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in Healthcare Acquired Condition Indicator List (VVL).4. Conditional
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in Border State Indicator List (VVL)4. Conditional
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in 1115A Demonstration Indicator List (VVL)4. Conditional5. When value equals '0', is invalid not populated, the associated 1115A Demonstration Indicator (ELG.018.233) must equal '0 invalid or not populated
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in Other Insurance Indicator List (VVL)4. Conditional
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1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in Pregnancy Indicator List (VVL)4. Conditional
1. Value must be in Primary Eligibility Group Indicator List (VVL)2. Value must be 1 charact Value must be in [0, 1]4. Mandatory
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in American Indian Alaskan Native Indicator List (VVL)4. Conditional
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in 1115A Demonstration Indicator List (VVL)4. Conditional
1. Value must be in Adjustment Indicator List (VVL)2. If associated Type of Claim value is in 3, 5, A, C, E, U, W, Y], then value must be in [0, 1, 4]3. If associated Type of Claim value D, X', then value must be in [5, 6]4. Value must be 1 character5. Mandatory

1. Value must be in Claim Denied Indicator List (VVL)2. If value is '0', then Claim Status Category must equal "F2"3. Value must be 1 character4. Mandatory
1. Value must be in Line Adjustment Indicator List (VVL)2. If associated Type of Claim valu [1, 3, 5, A, C, E, U, W, Y], then value must be in [0, 1, 4]3. If associated Type of Claim va in [4, D, X], then value must be in [5, 6]4. Value must be 1 character5. Conditional6. If associated Line Adjustment Number is populated, then value must be populated
1. Value must be in Adjustment Indicator List (VVL)2. If associated Type of Claim value is i 3, 5, A, C, E, U, W, Y], then value must be in [0, 1, 4]3. If associated Type of Claim value D, X', then value must be in [5, 6]4. Value must be 1 character5. Mandatory
1. Value must be in Claim Denied Indicator List (VVL)2. If value is '0', then Claim Status Category must equal "F2"3. Value must be 1 character4. Mandatory
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8/9/2023
A code to indicate what type of payment is covered in this claim.For sub-capitated encoun from a sub-capitated entity or sub-capitated network provider, report TYPE-OF-CLAIM = '3' Medicaid sub-capitated encounter record or “C” for an S-CHIP sub-capitated encounter rec
8/9/2023

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 provi report a SOURCE-LOCATION = '22' to indicate that the sub-capitated entity paid a provider the service to the enrollee on a FFS basis.For sub-capitated encounters from a sub-capitat 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 th service directly to the enrollee.
8/9/2023
The total amount billed for this claim at the claim header level as submitted by the provide For encounter records, when Type of Claim value is [3, C, or W], then value must equal amount the provider billed to the managed care plan. Total Billed Amount is not expected financial transactions.For sub-capitated encounters from a sub-capitated entity that is not 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-capi network provider.For sub-capitated encounters from a sub-capitated network provider, if th sub-capitated network provider directly employs the provider that renders the service to th enrollee, report a null value in this field.
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8/9/2023
The claim header level maximum amount determined by the payer as being 'allowable' un the provisions of the contract prior to the determination of actual payment. On FFS claims Allowed Amount is determined by the state's MMIS. On managed care encounters the Allow Amount is determined by the managed care organization.For sub-capitated encounters fro sub-capitated entity that is not a sub-capitated network provider, report the total amount t the sub-capitated entity allowed for the service. Report a null value in this field if the provi is a sub-capitated network provider.For sub-capitated encounters from a sub-capitated net provider, if the sub-capitated network provider directly employs the provider that renders service to the enrollee, report a null value in this field.
8/9/2023

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8/9/2023
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 rec Type of Claim = 3, C, or W, this field should be populated with the amount that the provide billed to the managed care plan.For sub-capitated encounters from a sub-capitated entity 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 sub-capitated network provider.For sub-capitated encounters from a sub-capitated networ provider, if the sub-capitated network provider directly employs the provider that renders service to the enrollee, report a null value in this field.
8/9/2023
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8/9/2023
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8/9/2023

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8/9/2023
The total amount paid by Medicaid/CHIP or the managed care plan on this claim or adjustm at the claim header level, which is the sum of the amounts paid by Medicaid or the manag care plan at the detail level for the claim.For sub-capitated encounters from a sub-capitate 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 prov is a sub-capitated network provider.For sub-capitated encounters from a sub-capitated net provider, if the sub-capitated network provider directly employs the provider that renders service to the enrollee, report a null value in this field.
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8/9/2023
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8/9/2023
For services received during a single encounter with a provider, the date the service cover 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 serv covered by this claim began. For capitation premium payments, the date on which the per 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.For sub-capitation payments, this represents the first date of the period the sub-capitation payme covers.

For services received during a single encounter with a provider, the date the service cover 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 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, popu with the last day of the time period covered by this financial transaction.For sub-capitation payments, this represents the last date of the period the sub-capitation payment covers.

8/9/2023

A code to indicate what type of payment is covered in this claim.For sub-capitated encount from a sub-capitated entity or sub-capitated network provider, report TYPE-OF-CLAIM = '3' Medicaid sub-capitated encounter record or “C” for an S-CHIP sub-capitated encounter rec

8/9/2023

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 provi report a SOURCE-LOCATION = '22' to indicate that the sub-capitated entity paid a provider the service to the enrollee on a FFS basis.For sub-capitated encounters from a sub-capitate 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-capitation payments, report a SOURCE-LOCATION of '20', indicating the managed care plan is the source of payment.

8/9/2023

The total amount billed for this claim at the claim header level as submitted by the provide For encounter records, when Type of Claim value is [3, C, or W], then value must equal amount the provider billed to the managed care plan. Total Billed Amount is not expected financial transactions.For sub-capitated encounters from a sub-capitated entity that is not 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-capi network provider.For sub-capitated encounters from a sub-capitated network provider, if th sub-capitated network provider directly employs the provider that renders the service to th enrollee, report a null value in this field.

8/9/2023

The claim header level maximum amount determined by the payer as being 'allowable' un the provisions of the contract prior to the determination of actual payment. On FFS claims Allowed Amount is determined by the state's MMIS. On managed care encounters the Allow Amount is determined by the managed care organization.For sub-capitated encounters fro sub-capitated entity that is not a sub-capitated network provider, report the total amount t the sub-capitated entity allowed for the service. Report a null value in this field if the provi is a sub-capitated network provider.For sub-capitated encounters from a sub-capitated net provider, if the sub-capitated network provider directly employs the provider that renders t service to the enrollee, report a null value in this field.

8/9/2023
The total amount paid by Medicaid/CHIP or the managed care plan on this claim or adjustm at the claim header level, which is the sum of the amounts paid by Medicaid or the manag care plan at the detail level for the claim.For sub-capitated encounters from a sub-capitate 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 prov is a sub-capitated network provider.For sub-capitated encounters from a sub-capitated net provider, if the sub-capitated network provider directly employs the provider that renders t service to the enrollee, report a null value in this field.For sub-capitation payments, this represents the amount paid by the managed care plan to the sub-capitated entity.
A unique number assigned by the state which represents a distinct comprehensive manag 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 a sub-capitated entity or sub-capitated network provider, report the PLAN-ID-NUMBER for t MCP (MCO, PIHP, or PAHP that has a contract with a state) that is making the payment to t sub-capitated entity or sub-capitated network provider.For sub-capitated encounters from 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.
8/9/2023
A unique identification number assigned by the state to a provider or capitation plan. This element should represent the entity billing for the service. For encounter records, if associ Type of Claim value equals 3, C, or W, then value must be the state identifier of the provid entity (billing or reporting) to the managed care plan.For sub-capitation payments, report t state-assigned provider identifier for the sub-capitated entity, when available or required.
8/9/2023
The National Provider ID (NPI) of the billing entity responsible for billing a patient for health services. The billing provider can also be servicing, referring, or prescribing provider. Can b admitting provider except for Long Term Care.For sub-capitation payments, report the nat provider identifier (NPI) for the sub-capitated entity if the provider has one.
8/9/2023
8/6/2023
For services received during a single encounter with a provider, the date the service cover 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 serv covered by this claim began. For capitation premium payments, the date on which the per 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.For sub-capitation payments, this represents the first date of the period the sub-capitation paymen covers.

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For services received during a single encounter with a provider, the date the service cover 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 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, popu with the last day of the time period covered by this financial transaction.For sub-capitation payments, this represents the last date of the period the sub-capitation payment covers.
8/9/2023
The amount billed at the claim detail level as submitted by the provider. For encounter rec Type of Claim = 3, C, or W, this field should be populated with the amount that the provide billed the managed care plan.For sub-capitated encounters from a sub-capitated entity tha 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 sub-capitated network provider.For sub-capitated encounters from a sub-capitated networ provider, if the sub-capitated network provider directly employs the provider that renders service to the enrollee, report a null value in this field.
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8/9/2023
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The total amount billed for this claim at the claim header level as submitted by the provide For encounter records, when Type of Claim value is [3, C, or W], then value must equal amount the provider billed to the managed care plan. Total Billed Amount is not expected financial transactions.For sub-capitated encounters from a sub-capitated entity that is not 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-capi network provider.For sub-capitated encounters from a sub-capitated network provider, if th sub-capitated network provider directly employs the provider that renders the service to th enrollee, report a null value in this field.
8/9/2023
The claim header level maximum amount determined by the payer as being 'allowable' un the provisions of the contract prior to the determination of actual payment. On FFS claims Allowed Amount is determined by the state's MMIS. On managed care encounters the Allow Amount is determined by the managed care organization.For sub-capitated encounters fro sub-capitated entity that is not a sub-capitated network provider, report the total amount t the sub-capitated entity allowed for the service. Report a null value in this field if the provi is a sub-capitated network provider.For sub-capitated encounters from a sub-capitated net provider, if the sub-capitated network provider directly employs the provider that renders t service to the enrollee, report a null value in this field.
8/9/2023
The total amount paid by Medicaid/CHIP or the managed care plan on this claim or adjustm at the claim header level, which is the sum of the amounts paid by Medicaid or the manag care plan at the detail level for the claim.For sub-capitated encounters from a sub-capitate 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 prov is a sub-capitated network provider.For sub-capitated encounters from a sub-capitated ent that is not a sub-capitated network provider, report the total amount that the sub-capitate entity paid the provider for the service. Report a null value in this field if the provider is a s capitated network provider.
8/9/2023

The amount billed at the claim detail level as submitted by the provider. For encounter rec Type of Claim = 3, C, or W, this field should be populated with the amount that the provide billed the managed care plan.For sub-capitated encounters from a sub-capitated entity tha 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 sub-capitated network provider.For sub-capitated encounters from a sub-capitated networ provider, if the sub-capitated network provider directly employs the provider that renders service to the enrollee, report a null value in this field.
8/9/2023
The maximum amount displayed at the claim line level as determined by the payer as bein 'allowable' under the provisions of the contract prior to the determination of actual payme On Fee for Service claims the Allowed Amount is determined by the state's MMIS (or PBM). 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 netw 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.
8/9/2023
The amount paid by Medicaid/CHIP agency or the managed care plan on this claim or adjustment at the claim detail level.For sub-capitated encounters from a sub-capitated ent that is not a sub-capitated network provider, report the amount that the sub-capitated ent paid the provider at the claim line detail level. Report a null value in this field if the provide a sub-capitated network provider.For sub-capitated encounters from a sub-capitated netwo provider, if the sub-capitated network provider directly employs the provider that renders service to the enrollee, report a null value in this field.
8/9/2023
A free-form text field to describe the type of living arrangement used for the eligibility determination process.
8/9/2023

The reason for a complete loss/termination in an individual's eligibility for Medicaid and CH The end date of the segment in which the value is reported must represent the date that t 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. I a single termination in eligibility for a single individual there are multiple distinct co-occurr 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' (Othe '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 stat 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 o 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.
The reason for a complete loss/termination in an individual's eligibility for Medicaid and CH The end date of the segment in which the value is reported must represent the date that t 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. I a single termination in eligibility for a single individual there are multiple distinct co-occurr 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' (Othe '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 stat 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 o 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.|
8/9/2023
The start date of the managed care contract period with the state.
8/9/2023
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.
8/10/23
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 coinsurance.
8/10/2023

The total deductible amount on a claim the beneficiary is obligated to pay for covered serv This amount is the total Medicaid or contract negotiated beneficiary deductible liability mi previous beneficiary payments that went toward their deductible. Do not subtract out any payments for the given claim that went toward the deductible.
8/10/2023
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 coinsurance.
8/10/2023
The total deductible amount on a claim the beneficiary is obligated to pay for covered serv This amount is the total Medicaid or contract negotiated beneficiary deductible liability mi previous beneficiary payments that went toward their deductible. Do not subtract out any payments for the given claim that went toward the deductible.
8/10/2023
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 coinsurance.
8/10/2023
The total deductible amount on a claim the beneficiary is obligated to pay for covered serv This amount is the total Medicaid or contract negotiated beneficiary deductible liability mi previous beneficiary payments that went toward their deductible. Do not subtract out any payments for the given claim that went toward the deductible.
CRX - CLAIM PHARMACY
8/10/2023
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 coinsurance.
8/10/2023
The total deductible amount on a claim the beneficiary is obligated to pay for covered serv This amount is the total Medicaid or contract negotiated beneficiary deductible liability mi previous beneficiary payments that went toward their deductible. Do not subtract out any payments for the given claim that went toward the deductible.
8/11/2023
A code to indicate what type of payment is covered in this claim.For sub-capitated encoun from a sub-capitated entity or sub-capitated network provider, report TYPE-OF-CLAIM = '3' Medicaid sub-capitated encounter record or “C” for an S-CHIP sub-capitated encounter record.For sub-capitation payments, report TYPE-OF-CLAIM = '6' or “F”.
CRX - CLAIM PHARMACY

1. Value of the CC component must be "20"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 yea never April 31st or Sept 31st)4. Value must be less than current date5. Value must be equ or after the value of associated End of Time Period6. Mandatory
1. Value of the CC component must be "20"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 yea never April 31st or Sept 31st)4. Value must be equal to or earlier than associated Date File Created5. Value must be before associated End of Time Period6. Mandatory
1. Value must be 8 characters in the form "CCYYMMDD"2. Value of the CC component mus "20"3. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never A 31st or Sept 31st)4. Value must be equal to or earlier than associated Date File Created5. Value must be equal to or after associated Start of Time Period6. Mandatory
1. Value must be unique within record segment over all records associated with a given Re ID2. Value must be 11 digits or less3. Mandatory
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Value must be le than or equal to associated Discharge Date value in the claim header.4. Value must be gre than or equal to associated eligible Date of Birth value.5. Value must be less than or equal associated eligible Date of Death value.6. Mandatory7. Value must be between Enrollment Effective Date (ELG.021.253) and Enrollment End Date (ELG.021.254)8. (capitated payme 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' value must be before Adjudication Date (CIP.003.286)
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Value must be le than or equal to associated Adjudication Date value.4. Value must be greater than or equa associated Admission Date value.5. Value must be greater than or equal to associated elig Date of Birth value.6. Value must be less than or equal to associated eligible Date of Death value.7. Conditional8. If associated Adjustment Indicator (CIP.002.026) does not equal "1" denied claims) and Patient Status (CIP.002.199) is not equal to "30" value must be populat When populated, Discharge Hour (CIP.002.097) must be populated
1. Value must be a positive integer2. Value must be between 0:9999 (inclusive)3. Value m not include commas or other non-numeric characters4. Value must be equal to the numbe claim lines (e.g. Original Claim Line Number or Adjustment Claim Line Number instances) reported in the associated claim record being reported5. Value must be 4 characters or les Mandatory
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Must have an associated Occurrence Code4. Must be greater than or equal to Occurrence Code Effective Date5. Conditional

1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Must have an associated Occurrence Code4. Must be greater than or equal to Occurrence Code Effective Date5. Conditional
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1. Value must be unique within record segment over all records associated with a given Re ID2. Value must be 11 digits or less3. Mandatory
1. Value of the CC component must be "20"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 yea never April 31st or Sept 31st)4. Value must be less than current date5. Value must be equ or after the value of associated End of Time Period6. Mandatory
1. Value of the CC component must be "20"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 yea never April 31st or Sept 31st)4. Value must be equal to or earlier than associated Date File Created5. Value must be before associated End of Time Period6. Mandatory

1. Value must be 8 characters in the form "CCYYMMDD"2. Value of the CC component mus "20"3. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never A 31st or Sept 31st)4. Value must be equal to or earlier than associated Date File Created5. Value must be equal to or after associated Start of Time Period6. Mandatory
1. Value must be unique within record segment over all records associated with a given Re ID2. Value must be 11 digits or less3. Mandatory
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Value must be les than or equal to associated Discharge Date value in the claim header.4. Value must be gre than or equal to associated eligible Date of Birth value.5. Value must be less than or equal associated eligible Date of Death value.6. Mandatory7. When associated Type of Claim (CLT.002.052) is not '2','B' or 'V' (capitated payment) value must be before Adjudication Da (CLT.002.050)8. When associated Type of Claim (CLT.002.052) is not '2','B' or 'V' (capitate payment) and Type of Service (CLT.003.211) is not '119, '120', '121', 122' value must be b Adjudication Date (CLT.003.233)
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Value must be les than or equal to associated Adjudication Date value.4. Value must be greater than or equa associated Admission Date value.5. Value must be greater than or equal to associated elig Date of Birth value.6. Value must be less than or equal to associated eligible Date of Death value.7. Conditional8. When populated, Discharge Hour (CLT.002.047) must be populated
1. Value must be a positive integer2. Value must be between 0:9999 (inclusive)3. Value m not include commas or other non-numeric characters4. Value must be equal to the numbe claim lines (e.g. Original Claim Line Number or Adjustment Claim Line Number instances) reported in the associated claim record being reported5. Value must be 4 characters or les Mandatory
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Must have an associated Occurrence Code4. Must be greater than or equal to Occurrence Code Effective Date5. Conditional
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Must have an associated Occurrence Code4. Must be greater than or equal to Occurrence Code Effective Date5. Conditional
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1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Must have an associated Occurrence Code4. Must be greater than or equal to Occurrence Code Effective Date5. Conditional
1. Value must be unique within record segment over all records associated with a given Re ID2. Value must be 11 digits or less3. Mandatory
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. If associated Type of Claim value equals C, W', then value is mandatory and must be provided4. Conditional
1. Value of the CC component must be "20"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 yea never April 31st or Sept 31st)4. Value must be less than current date5. Value must be equ or after the value of associated End of Time Period6. Mandatory
1. Value of the CC component must be "20"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 yea never April 31st or Sept 31st)4. Value must be equal to or earlier than associated Date File Created5. Value must be before associated End of Time Period6. Mandatory

1. Value must be 8 characters in the form "CCYYMMDD"2. Value of the CC component mus "20"3. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never A 31st or Sept 31st)4. Value must be equal to or earlier than associated Date File Created5. Value must be equal to or after associated Start of Time Period6. Mandatory
1. Value must be unique within record segment over all records associated with a given Re ID2. Value must be 11 digits or less3. Mandatory
1. Value must be a positive integer2. Value must be between 0:9999 (inclusive)3. Value m not include commas or other non-numeric characters4. Value must be equal to the numbe claim lines (e.g. Original Claim Line Number or Adjustment Claim Line Number instances) reported in the associated claim record being reported5. Value must be 4 characters or les Mandatory
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Must have an associated Occurrence Code4. Must be greater than or equal to Occurrence Code Effective Date5. Conditional
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Must have an associated Occurrence Code4. Must be greater than or equal to Occurrence Code Effective Date5. Conditional
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Must have an associated Occurrence Code4. Must be greater than or equal to Occurrence Code Effective Date5. Conditional
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Must have an associated Occurrence Code4. Must be greater than or equal to Occurrence Code Effective Date5. Conditional
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1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Must have an associated Occurrence Code4. Must be greater than or equal to Occurrence Code Effective Date5. Conditional

1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Must have an associated Occurrence Code4. Must be greater than or equal to Occurrence Code Effective Date5. Conditional
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Must have an associated Occurrence Code4. Must be greater than or equal to Occurrence Code Effective Date5. Conditional
1. Value must be unique within record segment over all records associated with a given Re ID2. Value must be 11 digits or less3. Mandatory
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. If associated Type of Claim value equals C, W', then value is mandatory and must be provided4. Conditional
1. Value must be 60 characters or less2. Value must not be equal to associated Address Li or Address Line 3 value(s)3. Value must not contain a pipe or asterisk symbols4. Condition
1. Value must be 60 characters or less2. Value must not be equal to associated Address Li or Address Line 3 value(s)3. There must be an Address Line 1 in order to have an Address 24. Value must not contain a pipe or asterisk symbols5. Conditional
1. Value must be 60 characters or less2. Value must not be equal to associated Address Li or Address Line 3 value(s)3. Value must not contain a pipe or asterisk symbols4. Condition
1. Value must be 60 characters or less2. Value must not be equal to associated Address Li or Address Line 3 value(s)3. There must be an Address Line 1 in order to have an Address 24. Value must not contain a pipe or asterisk symbols5. Conditional
1. Value of the CC component must be "20"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 yea never April 31st or Sept 31st)4. Value must be less than current date5. Value must be equ or after the value of associated End of Time Period6. Mandatory
1. Value of the CC component must be "20"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 yea never April 31st or Sept 31st)4. Value must be equal to or earlier than associated Date File Created5. Value must be before associated End of Time Period6. Mandatory
1. Value must be 8 characters in the form "CCYYMMDD"2. Value of the CC component mus "20"3. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never A 31st or Sept 31st)4. Value must be equal to or earlier than associated Date File Created5. Value must be equal to or after associated Start of Time Period6. Mandatory
1. Value must be unique within record segment over all records associated with a given Re ID2. Value must be 11 digits or less3. Mandatory

1. Value must be a positive integer2. Value must be between 0:9999 (inclusive)3. Value m not include commas or other non-numeric characters4. Value must be equal to the numbe claim lines (e.g. Original Claim Line Number or Adjustment Claim Line Number instances) reported in the associated claim record being reported5. Value must be 4 characters or les Mandatory
1. Value must be unique within record segment over all records associated with a given Re ID2. Value must be 11 digits or less3. Mandatory
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. If associated Type of Claim value equals C, W', then value is mandatory and must be provided4. Conditional
1. Value of the CC component must be "20"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 yea never April 31st or Sept 31st)4. Value must be less than current date5. Value must be equ or after the value of associated End of Time Period6. Mandatory
1. Value of the CC component must be "20"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 yea never April 31st or Sept 31st)4. Value must be equal to or earlier than associated Date File Created5. Value must be before associated End of Time Period6. Mandatory
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1. Value must be unique within record segment over all records associated with a given Re ID2. Value must be 11 digits or less3. Mandatory
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Children enrolled the Separate CHIP prenatal program option should have a date of birth missing or a date o birth equal to the pregnant mother's date of birth4. When Conception to Birth Indicator (ELG.005.094) does not equal '1' and Eligibility Group (ELG.005.087) does not equal '64' va must be less than or equal to associated End of Time Period value5. Value must be less tha equal to associated Date File Created (ELG.001.008) value6. Mandatory7. When Conceptio Birth Indicator (ELG.005.094) does not equal '1' and Eligibility Group (ELG.005.087) does n equal '64' value minus Start of Time Period (ELG.001.10) must be less than 125 years
1. Value must be unique within record segment over all records associated with a given Re ID2. Value must be 11 digits or less3. Mandatory
1. Value must be unique within record segment over all records associated with a given Re ID2. Value must be 11 digits or less3. Mandatory
1. Value must be 60 characters or less2. Value must not be equal to associated Address Li or Address Line 3 value(s)3. Value must not contain a pipe or asterisk symbols4. Mandator When populated, the associated Address Type is required

1. Value must be 60 characters or less2. Value must not be equal to associated Address Li or Address Line 3 value(s)3. There must be an Address Line 1 in order to have an Address 24. Value must not contain a pipe or asterisk symbols5. Conditional
1. Value must be 60 characters or less2. Value must not be equal to associated Address Li or Address Line 2 value(s)3. If Address Line 2 is not populated, then value should not be populated4. Value must not contain a pipe or asterisk symbols5. Conditional
1. Value must be unique within record segment over all records associated with a given Re ID2. Value must be 11 digits or less3. Mandatory
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1. Value of the CC component must be "20"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 yea never April 31st or Sept 31st)4. Value must be less than current date5. Value must be equ or after the value of associated End of Time Period6. Mandatory
1. Value of the CC component must be "20"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 yea never April 31st or Sept 31st)4. Value must be equal to or earlier than associated Date File Created5. Value must be before associated End of Time Period6. Mandatory
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1. Value must be unique within record segment over all records associated with a given Re ID2. Value must be 11 digits or less3. Mandatory
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1. Value must be unique within record segment over all records associated with a given Re ID2. Value must be 11 digits or less3. Mandatory
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1. Value must be 60 characters or less2. Value must not be equal to associated Address Li or Address Line 3 value(s)3. There must be an Address Line 1 in order to have an Address 24. Value must not contain a pipe or asterisk symbols5. Conditional
1. Value must be 60 characters or less2. Value must not be equal to associated Address Li or Address Line 2 value(s)3. If Address Line 2 is not populated, then value should not be populated4. Value must not contain a pipe or asterisk symbols5. Conditional
1. Value must be unique within record segment over all records associated with a given Re ID2. Value must be 11 digits or less3. Mandatory
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1. Value must be 8 characters in the form "CCYYMMDD"2. Value of the CC component mus "20"3. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never A 31st or Sept 31st)4. Value must be equal to or earlier than associated Date File Created5. Value must be equal to or after associated Start of Time Period6. Mandatory

1. Value must be unique within record segment over all records associated with a given Re ID2. Value must be 11 digits or less3. Mandatory
1. Value must be 60 characters or less2. Value must not be equal to associated Address Li or Address Line 3 value(s)3. Value must not contain a pipe or asterisk symbols4. Optional5 When populated, the associated Address Type is required
1. Value must be 60 characters or less2. Value must not be equal to associated Address Li or Address Line 3 value(s)3. There must be an Address Line 1 in order to have an Address 24. Value must not contain a pipe or asterisk symbols5. Conditional
1. Value must be 60 characters or less2. Value must not be equal to associated Address Li or Address Line 2 value(s)3. If Address Line 2 is not populated, then value should not be populated4. Value must not contain a pipe or asterisk symbols5. Conditional
Value must be in Adjustment Indicator List (VVL)2. If associated Type of Claim value is in [5, A, C, E, U, W, Y], then value must be in [0, 1, 4]3. If associated Type of Claim value is ' X', then value must be in [5, 6]4. Value must be 1 character5. Mandatory6. If value is in [‘5’, ‘6’], then associated Adjustment ICN must not be populated7. If value is in [‘4’, ‘1’] the Adjustment ICN must be populated8. Value must equal ‘1’, when associated Claim Status equals ‘686’
1. Value must be in Diagnosis Code Flag List(VVL)2. Value must be 1 character3. Condition
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Value must be less than associated Tota Billed Amount - (Total Medicare Coinsurance Amount + Total Medicare Deductible Amount Conditional
1. Value must be associated with a populated Waiver Type2. Value must be 20 characters less3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associate Claim Waiver Type value must be 01 or in [21-30]4. (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. Conditional
1. Value must be 10 digits2. Conditional3. Value must have an associated Provider Identifi Type equal to '2'4. Value must exist in the NPPES NPI File
1. Value must be in Revenue Code List (VVL)2. A Revenue Code value requires an associat Revenue Charge3. Value must be 4 characters or less4. Mandatory
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Value must be less than or equal to associated Total Billed Amount value4. When populated, associated claim line Revenue Ch must be populated5. Conditional
Value must be in Adjustment Indicator List (VVL)2. If associated Type of Claim value is in [5, A, C, E, U, W, Y], then value must be in [0, 1, 4]3. If associated Type of Claim value is ' X', then value must be in [5, 6]4. Value must be 1 character5. Mandatory6. If value is in [‘5’, ‘6’], then associated Adjustment ICN must not be populated7. If value is in [‘4’, ‘1’] the Adjustment ICN must be populated8. Value must equal ‘1’, when associated Claim Status equals ‘686’

1. Value must be in Diagnosis Code Flag List(VVL)2. Value must be 1 character3. Condition
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Value must be less than associated Tota Billed Amount - (Total Medicare Coinsurance Amount + Total Medicare Deductible Amount Conditional
1. Value must be associated with a populated Waiver Type2. Value must be 20 characters less3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associate Claim Waiver Type value must be 01 or in [21-30]4. (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. Conditional
1. Value must be 10 digits2. Value must have an associated Provider Identifier Type equal '2'3. Conditional4. Value must exist in the NPPES data file
1. Value must be in Revenue Code List (VVL)2. A Revenue Code value requires an associat Revenue Charge3. Value must be 4 characters or less4. Mandatory
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres 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 Cl must be populated5. Conditional
Value must be in Adjustment Indicator List (VVL)2. If associated Type of Claim value is in [5, A, C, E, U, W, Y], then value must be in [0, 1, 4]3. If associated Type of Claim value is ' X', then value must be in [5, 6]4. Value must be 1 character5. Mandatory6. If value is in [‘5’, ‘6’], then associated Adjustment ICN must not be populated7. If value is in [‘4’, ‘1’] the Adjustment ICN must be populated8. Value must equal ‘1’, when associated Claim Status equals ‘686’
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Value must be less than associated Tota Billed Amount- (Total Medicare Coinsurance Amount + Total Medicare Deductible Amount) Conditional
1. Value must be associated with a populated Waiver Type2. Value must be 20 characters less3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associate Claim Waiver Type value must be 01 or in [21-30]4. (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. Conditional
1. Value must be 10 digits2. Value must have an associated Provider Identifier Type (PRV.005.007) equal to '2'3. Conditional4. Value must exist in the NPPES NPI data file
1. Value must be in Revenue Code List (VVL)2. A Revenue Code value requires an associat Revenue Charge3. Value must be 4 characters or less4. Conditional
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Conditional4. When Type of Claim is in ['A'}, Medicaid Paid Amount (COT.003.177) is less than or equal to the value submitted

Value must be in Adjustment Indicator List (VVL)2. If associated Type of Claim value is in [5, A, C, E, U, W, Y], then value must be in [0, 1, 4]3. If associated Type of Claim value is ' X', then value must be in [5, 6]4. Value must be 1 character5. Mandatory6. If value is in [‘5’, ‘6’], then associated Adjustment ICN must not be populated7. If value is in [‘4’, ‘1’] the Adjustment ICN must be populated8. Value must equal ‘1’, when associated Claim Status equals ‘686’
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Value must be less than associated Tota Billed Amount - (Total Medicare Coinsurance Amount + Total Medicare Deductible Amount Conditional
1. Value must be associated with a populated Waiver Type2. Value must be 20 characters less3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associate Claim Waiver Type value must be 01 or in [21-30]4. (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. Conditional
1. Value must be 3 characters2. Conditional3. Must be a 3 digit value from the Type-of-Ser (VVL)
1. Value must be associated with a populated Waiver Type2. Value must be 20 characters less3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associate Claim Waiver Type value must be 01 or in [21-30]4. (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. Value must have a corresponding value in Waiver Type (ELG.012.173)6. Mandatory
1. Value must be 10-digit number2. Situational
1. Must contain the '@' symbol2. May contain uppercase and lowercase Latin letters A to Z a to z3. May contain digits 0-94. Must contain a dot '.' that is not the first or last character provided that it does not appear consecutively5. Value must be 60 characters or less6. Situational
1. Value must be unique within record segment over all records associated with a given Re ID2. Value must be 11 digits or less3. Mandatory
1. Value must be unique within record segment over all records associated with a given Re ID2. Value must be 11 digits or less3. Mandatory
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1. Value must be unique within record segment over all records associated with a given Re ID2. Value must be 11 digits or less3. Mandatory

1. Value must be 30 characters or less2. Conditional3. When Type of Claim not in ('Z','3','C','W',"2","B","V"," 4","D","X") then value may match (PRV.002.019) Submitting Sta Provider ID or4. When Type of Claim not in ('Z','3','C','W',"2","B","V"," 4","D","X") then valu may match (PRV.005.081) Provider Identifier where the Provider Identifier5. Discharge Dat (CIP.002.096) may be between Provider Attributes Effective Date (PRV.002.020) and Provi Attributes End Date (PRV.002.021) or6. Discharge Date (CIP.002.096) may be between Pro Identifier Effective Date (PRV.005.079) and Provider Identifier End Date (PRV.005.080)7. Discharge Date (CIP.002.096) may be between Provider Attributes Effective Date (PRV.002 and Provider Attributes End Date (PRV.002.021) or8. Discharge Date (CIP.002.096) may be between Provider Identifier Effective Date (PRV.005.079) and Provider Identifier End Date (PRV.005.080)
1.Value must be 10 digits2. Value must have an associated Provider Identifier Type equal t '2'3. Value must exist in the NPPES NPI data file4. Conditional5. When populated, value mu match Provider Identifier (PRV.005.081) and Facility Group Individual Code (PRV.002.028) equal '01'6. When Type of Claim is in ['1','3','A','C'], then value must be populated7. NPPES Entity Type Code associated with this NPI must equal ‘2’ (Organization)
Value must be 10 digits2. Value must have an associated Provider Identifier Type equal to Value must exist in the NPPES NPI data file 4. Conditional5. When populated, value must m Provider Identifier (PRV.005.081) and Facility Group Individual Code (PRV.002.028) must e '01'6. When Type of Claim is in ['1','3','A','C'], then value must be populated 7. NPPES Entity Type Code associated with this NPI must equal ‘2’ (Organization)
1. Value must be in CMS 64 Category for Federal Reimbursement List (VVL)2. Value must b characters3. (Federal Funding under Title XXI) if value equals '02', then the eligible's CHIP (ELG.003.054) must be in ['2', '3']4. (Federal Funding under Title XIX) if value equals '01' th the eligible's CHIP Code (ELG.003.054) must be '1'5. Conditional6. If Type of Claim is in ['1','2','5','A','B','E','U','V','Y'] and the Total Medicaid Paid Amount is populated on the corresponding claim header, then value must be reported7. If Type of Claim is in ['4','D'] a the Service Tracking Payment Amount on the relevant record is populated, then value mus reported8. When Type of Claim is in [‘1’,‘A’], value must be populated
1. Value must be in CMS 64 Category for Federal Reimbursement List (VVL)2. Value must b characters3. (Federal Funding under Title XXI) if value equals '02', then the eligible's CHIP (ELG.003.054) must be in ['2', '3']4. (Federal Funding under Title XIX) if value equals '01' th the eligible's CHIP Code (ELG.003.054) must be '1'5. Conditional6. If Type of Claim is in ['1','2','5','A','B','E','U','V','Y'] and the Total Medicaid Paid Amount is populated on the corresponding claim header, then value must be reported7. If Type of Claim is in ['4','D'] a the Service Tracking Payment Amount on the relevant record is populated, then value mus reported8. When Type of Claim is in [‘1’, ‘A’], value must be populated

Value must be in CMS 64 Category for Federal Reimbursement List (VVL)2. Value must be characters3. (Federal Funding under Title XXI) if value equals '02', then the eligible's CHIP (ELG.003.054) must be in ['2', '3']4. (Federal Funding under Title XIX) if value equals '01' th the eligible's CHIP Code (ELG.003.054) must be '1'5. Conditional6. If Type of Claim is in ['1','2','5','A','B','E','U','V','Y'] 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'] a the Service Tracking Payment Amount on the relevant record is populated, then value mus reported.8. When Type of Claim is in [‘1’, ‘A’], value must be populated
1. Value must be 30 characters or less2. Conditional3. When Type of Claim not in ('Z','3','C','W","2","B","V"," 4","D","X") then value may match (PRV.002.019) Submitting Sta Provider ID or4. When Type of Claim not in ('Z','3','C','W","2","B","V"," 4","D","X") then valu may match (PRV.005.081) Provider Identifier where the Provider Identifier5. Ending Date o Service (CLT.002.049) may be between Provider Attributes Effective Date (PRV.002.020) a Provider Attributes End Date (PRV.002.021) or6. Ending Date of Service (CLT.002.049) may between Provider Identifier Effective Date (PRV.005.079) and Provider Identifier End Date (PRV.005.080)7. Ending Date of Service (CLT.002.049) may be between Provider Attributes Effective Date (PRV.002.020) and Provider Attributes End Date (PRV.002.021) or8. Ending of Service (CLT.002.049) may be between Provider Identifier Effective Date (PRV.005.079) Provider Identifier End Date (PRV.005.080)
1. Value must be 10 digits 2. Value must have an associated Provid Identifier Type (PRV.005.007) equal to '2' 3. Value must exist in the N NPI data file 4. Conditional 5. When populate value must match Provider Identifier (PRV.005.081) and Facility Group Individual Code (PRV.002.028) must equal '01' 6. When Type of Claim is in ['1','3','A' then value must be populated 7. When Type of Claim not in ('3','C','V then value must match Provider Identifier (PRV.002.081) 8. NPPES E Type Code associated with this NPI must equal ‘2’ (Organization)
1. Value must be 30 characters or less2. Conditional3. When Type of Claim not in ('Z','3','C','W","2","B","V"," 4","D","X") then value may match (PRV.002.019) Submitting Sta Provider ID or4. When Type of Claim not in ('Z','3','C','W","2","B","V"," 4","D","X") then valu may match (PRV.005.081) Provider Identifier where the Provider Identifier Type (PRV.005.0 equal to '1' 5. When Type of Claim is in ['1','3','A','C'], then value must be populated6. Whe Type of Claim in ('1','3','A','C’) then associated Provider Medicaid Enrollment Status Code (PRV.007.100) must be in ['01', '02', '03', '04', '05', '06'] (active)7. Must have an enrollmen where the Ending Date of Service (COT.003.167) may be between Provider Attributes Effec Date (PRV.002.020) and Provider Attributes End Date (PRV.002.021) or8. Must have an enrollment where the Ending Date of Service (COT.003.167) may be between Provider Iden Effective Date (PRV.005.079) and Provider Identifier End Date (PRV.005.080)9. When Type Service (COT.003.186) is not in ['119', ‘120’, ‘122’], value must be reported in Provider Identifier (PRV.005.080) with an associated Provider Identifier Type (PRV.005.081) equal to

1. Value must be 30 characters or less2. Conditional3. When Type of Claim not in ('Z','3','C','W","2","B","V"," 4","D","X") then value may match (PRV.002.019) Submitting Sta Provider ID or4. When Type of Claim not in ('Z','3','C','W","2","B","V"," 4","D","X") then valu may match (PRV.005.081) Provider Identifier where the Provider Identifier Type (PRV.005.0 equal to '1' 5. When Type of Claim is in ['1','3','A','C'], then value mu populated 6. When Type of Claim in ('1','3','A','C') then associated Provider Medicaid Enrollment Status Code (PRV.007.100) must be in ['01', '02', '03', '04', '0 '06'] (active)7. Must have an enrollment where the Ending Date of Service (COT.003.167) m be between Provider Attributes Effective Date (PRV.002.020) and Provider Attributes End D (PRV.002.021) or8. Must have an enrollment where the Ending Date of Service (COT.003.1 may be between Provider Identifier Effective Date (PRV.005.079) and Provider Identifier En Date (PRV.005.080) 9. When Type of Service (COT.003.186) is not in ['119', '120', '122'], value must be reported in Provider Identifier (PRV.005.080) with an associated Provider Identifier Type (PRV.005.081) equal to '1'
1. Situational2. Value must be between -99999999999.99 and 99999999999.993. Value m be expressed as a number with 2-digit precision (e.g. 100.50)4. Value must be 11 digits o left of the decimal i.e. 9999999999 99
1. Situational2. Value must be between -99999999999.99 and 99999999999.993. Value m be expressed as a number with 2-digit precision (e.g. 100.50)
1. Value must be 30 characters or less2. Conditional3. When Type of Claim not in ('Z','3','C','W","2","B","V"," 4","D","X") then value may match (PRV.002.019) Submitting Sta Provider ID or4. When Type of Claim not in ('Z','3','C','W","2","B","V"," 4","D","X") then valu may match (PRV.005.081) Provider Identifier where the Provider Identifier Type (PRV.005.0 equal to '1' 5. When Type of Claim is in ['1','3','A','C'], then value mu be populated 6. When Type of Claim in ('1','3','A','C') then associated Provider Medicaid Enrollment Status Code (PRV.007.100) must be in ['01', '02', '03', '04', '0 '06'] (active)7. Prescription Fill Date (CRX.002.085) may be between Provider Attributes Effective Date (PRV.002.020) and Provider Attributes End Date (PRV.002.021) or 8. Prescription Fill Date (CRX.002.085) may be between Provider Identifier Effectiv Date (PRV.005.079) and Provider Identifier End Date (PRV.005.080)
1. Value must be 10 digits2. Value must have an associated Provider Identifier Type (PRV.005.007) equal to '2'3. Value must exist in the NPPES NPI data file4. Conditional5. Wh populated, value must match Provider Identifier (PRV.005.081) and Facility Group Individua Code (PRV.002.028) must equal '01'6. When Type of Claim is in ['1','3','A','C'], then value m be populated7. When Type of Claim not in ('3','C','W') then value must match Provider Iden (PRV.002.081) 8. NPPES Entity Type Code associated with this NPI must equal '2' (Organiza

1. Value must be 10 digits 2. Value must have an associated Provide Identifier Type (PRV.005.007) 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 Individua Code (PRV.002.028) must equal '01' 6. When Type of Claim is in ['1','3','A','C'], then value must be populated 7. When Type of Claim in ('3','C','W') then value must match Provider Identifier (PRV.002.081) NPPES Entity Type Code associated with this NPI must equal ‘2’ (Organization)
1. Value must be 1 character2. Value must be in Citizenship Indicator List (VVL)3. If value i coded as '0', then associated Immigration Status (ELG.003.042) value must be in [1, 2, 3] value is coded as '1', then associated Immigration Status (ELG.003.042) value must equal Mandatory
1. Value must be in Conception to Birth Indicator List (VVL)2. Value must be 1 character3. must be in [0, 1] or not populated4. If the value is equal to "1", then the Eligibility Group (ELG.005.087) must equal "64"5. If the value is equal to "1", then any associated claims m indicate the Program Type = '14' (State Plan CHIP)6. If the value is equal to "1", then CHIP (ELG.003.054) must equal "3" (Individual was not Medicaid Expansion CHIP eligible, but wa included in a separate title XXI CHIP Program)7. Conditional
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"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 CF 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 mem of a tribe, band, or other organized group of Indians, including those tribes, bands, or grou terminated since 1940 and those recognized now or in the future by the State in which the 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 an Indian for any purpose; or iv. Is determined to be an Indian under regulations promulga by the Secretary of Health and Human Services; c. Is considered by the Secretary of the In 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 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/Alaska Native. Are you a member of a federally recognized tribe? Has this person ever gotten a se from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Situational
Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calendar (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. When populated, valu must have an associated Third Party Coinsurance Amount 4. Conditional
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Situational
Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calendar (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. When populated, must have an associated Third Party Copayment Amount 4. Situational
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Must have an associated Third Party Copayment Amount4. Situational
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Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calendar (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. When populated, mus have an associated Third Party Copayment Amount 4. Situational
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Must have an associated Third Party Copayment Amount4. Situational
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Situational
Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calendar (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. When populated, valu must have an associated Third Party Coinsurance Amount 4. Conditional
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1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Situational
Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calendar (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. When populated, mus have an associated Third Party Copayment Amount 4. Situational
1. Value must be 10 characters or less2. Value must be in the Data Dictionary Version List (VVL)3. Mandatory
Situational
Value must be 50 characters or less2. Value must not contain a pipe or asterisk symbols3. associated Adjustment Indicator value is 0, then value must not be populated4. Conditiona associated Adjustment Indicator value is in [‘4’, ‘1’] then value must be populated
1. Value must be in Crossover Indicator List (VVL)2. Value must be 1 character3. Value mu in [0, 1] or not populated4. If Crossover Indicator value is "1", the associated Dual Eligible (ELG.005.085) value must be in "01", "02", "04", "08", "09", or "10" for the same time peri (by date of service)5. If the Type of Claim value is in ["1", "3", "A", "C"], then value is mandatory and must be reported6. Conditional

1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres 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 claim4. Conditional5. When associated Type of Claim ['1', '3', 'A', 'C'], value must be populated6. (individual line item payments) when populate and Payment Level Indicator (CIP.002.132) equals = '2' value must be greater than or equ the sum of all claim line Revenue Charges (CIP.003.251)
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Must have an associated Medicaid Paid Date4. If Total Medicare Coinsurance Amount and Total Medicare Deductible Amount is reported it must equal Total Medicaid Paid Amount5. When Payment Level Indicator equals value must equal the sum of line level Medicaid Paid Amounts.6. Conditional7. Value must populated, when Type of Claim is in ['1', 'A']8. Value must not be populated or equal to '0. when associated Claim Status is in ['26', '026', '87', '087', '542', '585', '654']9. Value shoul be populated, when associated Type of Claim value is in ['4', 'D'] 10. must be populated when the associated Type of Claim (CIP.002.100) is in ['5', 'E']11. Value must not be greater than Total Allowed Amount (CIP.002.113)
1. Value must be in Health Home Provider Indicator List (VVL)2. Value must be 1 character Value must be in [0, 1] or not populated4. If there is an associated Health Home Entity Nar value, then value must be "1"5. Conditional
1. Value must be associated with a populated Waiver Type2. Value must be 20 characters less3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associate Claim Waiver Type value must be 01 or in [21-30]4. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", then the value must include slash "/" in the 11th position followed by a version number [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]6. Conditional
1. Value must be 10 digits2. Value must have an associated Provider Identifier Type equal '2'3. Value must exist in the NPPES NPI data file4. Conditional
Situational
1. Value must be in Copay Waived Indicator List (VVL)2. Value must be 1 character3. Value must be in [0, 1] or not populated4. Situational
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Conditional4. When Type of Claim is in ['D', 'X'], value must not be populated
1. Value must be 10 digits2. Value must have an associated Provider Identifier Type (PRV.005.007) equal to '2' 3. Value must exist in the NPPES NPI data fil Conditional
Situational

Value must be 50 characters or less2. Value must not contain a pipe or asterisk symbols3. associated Adjustment Indicator value is 0, then value must not be populated4. Conditiona associated Adjustment Indicator value is in [‘4’, ‘1’] then value must be populated
1. Value must be in XIX MBESCBES Category of Service List (VVL)2. Value must be 5 chara or less3. Conditional4. (Medicaid Claim) if the associated CMS-64 Category for Federal Reimbursement value is '01', then a valid value is mandatory and must be reported5. If va 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
1. Value must be in XXI MBESCBES Category of Service List (VVL)2. Conditional3. (CHIP Cla the associated CMS-64 Category for Federal Reimbursement value is '02', then a valid valu mandatory and must be reported4. If XIX MBESCBES Category of Service is populated ther value must not be populated5. Value must be 3 characters or less
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1. Value must be 1 character2. Value must be in [0, 1]3. Mandatory
1. Value must be 10 characters or less2. Value must be in the Data Dictionary Version List (VVL)3. Mandatory
Value must be 10 characters or less2. Value must be in the Data Dictionary Version List (V Mandatory
Situational
1. Value must be 50 characters or less2. Value must not contain a pipe or asterisk symbols associated Adjustment Indicator value is 0, then value must not be populated4. Conditiona associated Adjustment Indicator value is in [‘4’, ‘1’] then value must be populated
1. Value must be in Crossover Indicator List (VVL)2. Value must be 1 character3. Value mu in [0, 1] or not populated4. If Crossover Indicator value is "1", the associated Dual Eligible (ELG.005.085) value must be in "01", "02", "04", "08", "09", or "10" for the same time peri (by date of service)5. If the Type of Claim value is in ["1", "3", "A", "C"], then value is mandatory and must be reported.6. Conditional
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres 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 claim4. Conditional5. When associated Type of Claim [‘1’, ’3’, ’A’, ’C’], value must be populated 6. Value should not be populated when assoc Type of Claim (CLT.002.052) is equal to '4', 'D' or 'X'7. (individual line item payments) whe populated and Payment Level Indicator (CLT.002.082) equals = '2' value must be greater t or equal to the sum of all claim line Revenue Charges (CLT.003.204)

1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Must have an associated Medicaid Paid Date4. If Total Medicare Coinsurance Amount and Total Medicare Deductible Amount is reported it must equal Total Medicaid Paid Amount5. When Payment Level Indicator equals value must equal the sum of line level Medicaid Paid Amounts.6. Conditional7. Value must be greater than Total Allowed Amount8. Value must be populated, when Type of Claim is i 'A']9. Value must not be populated or equal to '0.00' when associated Claim Status is in ['2 '026', '87', '087', '542', '585', '654']10. Value should not be populated, when associated Ty Claim value is in ['4', 'D'] 11. Value must be less than Total Allowed Amount11. Value mus populated when the associated Type of Claim (CLT.002.052) is in ['5', 'E']
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Must have an associated Medicaid Paid Date4. If Total Medicare Coinsurance Amount and Total Medicare Deductible Amount is reported it must equal Total Medicaid Paid Amount5. When Payment Level Indicator equals value must equal the sum of line level Medicaid Paid Amounts.6. Conditional7. Value must be greater than Total Allowed Amount8. Value must be populated, when Type of Claim is i 'A']9. Value must not be populated or equal to '0.00' when associated Claim Status is in ['2 '026', '87', '087', '542', '585', '654']10. Value should not be populated, when associated Ty Claim value is in ['4', 'D'] 11. Value must be less than Total Allowed Amount12. Value must be populated when the associated Type of Claim (CLT.002.052) is i ['5', 'E']
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. If associated Crossover Indicator value i (not a crossover claim), then value should not be populated.4. Conditional5. When populat value must be less than or equal to Total Billed Amount
1. Value must be in Health Home Provider Indicator List (VVL)2. Value must be 1 character Value must be in [0, 1] or not populated4. If there is an associated Health Home Entity Nar value, then value must be "1"5. Conditional
1. Value must be associated with a populated Waiver Type2. Value must be 20 characters less3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associate Claim Waiver Type value must be 01 or in [21-30]4. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", then the value must include slash "/" in the 11th position followed by a version number [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]6. Conditional
1. Value must be 10 digits2. Value must have an associated Provider Identifier Type equal '2'3. Value must exist in the NPPES NPI data file4. Conditional
Situational

1. Value must be in Copay Waived Indicator List (VVL)2. Value must be 1 character3. Value must be in [0,1] or not populated4. Situational
1. Value must be 10 digits2. Value must have an associated Provider Identifier Type (PRV.005.007) equal to '2'3. Value must exist in the NPPES NPI data file4. Conditional
Situational
Value must be 50 characters or less2. Value must not contain a pipe or asterisk symbols3. associated Adjustment Indicator value is 0, then value must not be populated4. Conditiona associated Adjustment Indicator value is in [‘4’, ‘1’] then value must be populated
1. Value must be in XIX MBESCBES Category of Service List (VVL)2. Value must be 5 chara or less3. Conditional4. (Medicaid Claim) if the associated CMS-64 Category for Federal Reimbursement value is '01', then a valid value is mandatory and must be reported5. If va 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
1. Value must be in XXI MBESCBES Category of Service List (VVL)2. Conditional3. (CHIP Cla the associated CMS-64 Category for Federal Reimbursement value is '02', then a valid valu mandatory and must be reported4. If XIX MBESCBES Category of Service is populated ther value must not be populated5. Value must be 3 characters or less
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Situational
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1. Value must be in Crossover Indicator List (VVL)2. Value must be 1 character3. Value mu in [0, 1] or not populated4. If Crossover Indicator value is "1", the associated Dual Eligible (ELG.005.085) value must be in "01", "02", "04", "08", "09", or "10" for the same time peri (by date of service)5. If the Type of Claim value is in ["1", "3", "A", "C"], then value is mandatory and must be reported.6. Conditional
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres 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 claim4. Conditional5. When associated Type of Claim [‘1’, ’3’, ’A’, ’C’], value must be populated

1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Must have an associated Medicaid Paid Date4. If Total Medicare Coinsurance Amount and Total Medicare Deductible Amount is reported it must equal Total Medicaid Paid Amount5. When Payment Level Indicator equals value must equal the sum of line level Medicaid Paid Amounts.6. Conditional7. Value must populated, when Type of Claim is in [‘1’, ‘A’]8. Value must not be populated or equal to ‘0. when associated Claim Status is in ['26', '026', '87', '087', '542', '585', '654']9. Value shoul be populated, when associated Type of Claim value is in [‘4’, ‘D’] 10 Value must not be greater than Total Allowed Amount (COT.002.049) Value must be populated, when Type of Claim (COT.002.037) is in [‘2’, '5', ‘B’, 'E']
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Must have an associated Medicaid Paid Date4. If Total Medicare Coinsurance Amount and Total Medicare Deductible Amount is reported it must equal Total Medicaid Paid Amount5. When Payment Level Indicator equals value must equal the sum of line level Medicaid Paid Amounts.6. Conditional7. Value must be greater than Total Allowed Amount (COT.002.049)8. Value must not be populated or eq to ‘0.00’ when associated Claim Status is in ['26', '026', '87', '087', '542', '585', '654']9. Val should not be populated, when associated Type of Claim value is in [‘4’, ‘D’] 10. Value must not be greater than Total Allowed Amount (COT.002.049) 11. Value must be populated, when Type of Claim (COT.002.037) is in [‘2’, '5', ‘B’, 'E']
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1. Value must be 10 digits2. Value must have an associated Provider Identifier Type equal '2'3. Value must be in the NPPES NPI data file4. Conditional

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 Medicaid MCO copayment waived decisions.
Situational
1. Value must be in Copayment Waived Indicator List (VVL)2. Value must be 1 character3. Value must be in [0, 1]4. Situational
1. Value must not contain a pipe or asterisk symbols2. Value must 50 characters or less3. Conditional4. Value must be populated when an associated Type of Service (COT.003.186) equals ‘138’ (payment for health home services)5. Value must be populated when an associated claim line has a XIX MBESCBES Category of Service (COT.003.211) equals ‘45’ (health homes for substance use services)
1. Value must be 10 digits2. Value must have an associated Provider Identifier Type equal '2'3. Conditional4. When Type of Service (COT.003.186) equals '121', value must not be populated5. Value must exist in the NPPES NPI data file
Value must be 10 digits2. Value must have an associated Provider Identifier Type equal to Conditional4. When Type of Service (COT.003.186) equals '121', value must not be popula Value must exist in the NPPES NPI data file
Situational
1. Value must be 50 characters or less2. Value must not contain a pipe or asterisk symbols associated Adjustment Indicator value is 0, then value must not be populated4. Conditiona associated Adjustment Indicator value is in [‘4’, ‘1’] then value must be populated
1. Value must be in XIX MBESCBES Category of Service List (VVL)2. Value must be 5 chara or less3. Conditional4. (Medicaid Claim) if the associated CMS-64 Category for Federal Reimbursement value is '01', then a valid value is mandatory and must be reported5. If va 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
1. Value must be in XXI MBESCBES Category of Service List (VVL)2. Conditional3. (CHIP Cla the associated CMS-64 Category for Federal Reimbursement value is '02', then a valid valu mandatory and must be reported4. If XIX MBESCBES Category of Service is populated ther value must not be populated5. Value must be 3 characters or less
Situational
1. Value must be 1 character2. Value must be in [0, 1]3. Mandatory
1. Value must be 10 characters or less2. Value must be in the Data Dictionary Version List (VVL)3. Mandatory
Situational
1. Value must be 50 characters or less2. Value must not contain a pipe or asterisk symbols associated Adjustment Indicator value is 0, then value must not be populated4. Conditiona associated Adjustment Indicator value is in [‘4’, ‘1’] then value must be populated

1. Value must be in Crossover Indicator List (VVL)2. Value must be 1 character3. Value mu in [0, 1] or not populated4. If Crossover Indicator value is "1", the associated Dual Eligible (ELG.005.085) value must be in "01", "02", "04", "08", "09", or "10" for the same time peri (by date of service)5. If the Type of Claim value is in ["1", "3", "A", "C"], then value is mandatory and must be reported.6. Conditional
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres 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 claim4. Conditional5. When associated Type of Claim ['1', '3', 'A', 'C'], value must be populated
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Must have an associated Medicaid Paid Date4. If Total Medicare Coinsurance Amount and Total Medicare Deductible Amount is reported it must equal Total Medicaid Paid Amount5. When Payment Level Indicator equals value must equal the sum of line level Medicaid Paid Amounts.6. Conditional7. Value must populated, when Type of Claim is in ['1', 'A']8. Value must not be populated or equal to '0. when associated Claim Status is in ['26', '026', '87', '087', '542', '585', '654']9. Value shoul be populated, when associated Type of Claim value is in ['4', 'D']
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. If associated Crossover Indicator value i (not a crossover claim), then value should not be populated.4. Conditional5. When populat value must be less than or equal to Total Billed Amount
1. Value must be in Health Home Provider Indicator List (VVL)2. Value must be 1 character Value must be in [0, 1] or not populated4. If there is an associated Health Home Entity Nar value, then value must be "1"5. Conditional
1. Value must be associated with a populated Waiver Type2. Value must be 20 characters less3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associate Claim Waiver Type value must be 01 or in [21-30]4. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", then the value must include slash "/" in the 11th position followed by a version number [0-9] in the 12th position 5. (1915(b) or 1915(c) waivers) If v begins with the two-letter state abbreviation followed by a period (.), the associated Claim Waiver Type value must be in [02-20, 32, 33]6. Conditional
Situational
1. Value must be in Copay Waived Indicator List (VVL)2. Value must be 1 character3. Value must be in [0,1] or not populated4. Situational
1. Value must be 10 digits2. Value must have an associated Provider Identifier Type (PRV.005.007) equal to '2'3. When Type of Claim not in ('3','C','W') then value must match Provider Identifier (PRV.005.081)4. Mandatory5. Value must exist in the NPPES NPI data file Nppes Entity Type Code associate with this NPI must equal '1' (Individual)

1. Value must be 10 digits2. Value must have an associated Provider Identifier Type equal '2'3. Conditional4. Value must exist in the NPPES NPI data file
Situational
1. Value must be 50 characters or less2. Value must not contain a pipe or asterisk symbols associated Adjustment Indicator value is 0, then value must not be populated4. Conditiona associated Adjustment Indicator value is in [‘4’, ‘1’] then value must be populated
Situational
1. Situational2. Value must be 5 digits or less left of the decimal i.e. 99999.99
1. Value must be in XIX MBESCBES Category of Service List (VVL)2. Value must be 5 chara or less3. Conditional4. (Medicaid Claim) if the associated CMS-64 Category for Federal Reimbursement value is '01', then a valid value is mandatory and must be reported5. If va 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
1. Value must be in XXI MBESCBES Category of Service List (VVL)2. Conditional3. (CHIP Cla the associated CMS-64 Category for Federal Reimbursement value is '02', then a valid valu mandatory and must be reported4. If XIX MBESCBES Category of Service is populated ther value must not be populated5. Value must be 3 characters or less
Situational
1. Value must be 1 character2. Value must be in [0, 1]3. Mandatory
1. Value must be 10 characters or less2. Value must be in the Data Dictionary Version List (VVL)3. Mandatory
Situational
Situational
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be ir Veteran Indicator List (VVL)4. Conditional5. Value must be populated when Immigration St (ELG.003.042) is in ['1', '2', '3']
Situational
1. Value must be 10-digit number2. Conditional3. If Eligible Address Type (ELG.004.065) = then value is mandatory and must be provided
Situational
Value must be in Eligibility Group List (VVL)2. If value is "26", then Dual Eligible Code value must be "06"3. Conditional4. 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 [" "73", "74", "75"], then associated Restricted Benefits Code value must equal "1" or "7" an State Plan Option Type must equal "06"6. If associated CHIP Code value is "2", then value 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 characters9. If value is "23", the 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 If value is "26", then Dual Eligible Code value must be "06"
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1. Value must be 30 characters or less2. Mandatory3. Value must match a corresponding Provider Identifier (PRV.005.081)
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1. Value must have a corresponding value in Waiver Type (ELG.012.173)2. Value must be characters or less3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", associated Claim Waiver Type value must be 01 or in [21-30]4. (1115 demonstration waive value begins with "11-W-" or "21-W-", then the value must include slash “/” in the 11th pos followed by a version number [0-9] in the 12th position5. (1915(b) or 1915(c) waivers) If va begins with the two-letter state abbreviation followed by a period (.), the associated Claim Waiver Type value must be in [02-20, 32, 33]6. Mandatory
1. Value must have a corresponding value in Waiver Type (ELG.012.173)2. Value must be characters or less3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", associated Claim Waiver Type value must be 01 or in [21-30]4. (1115 demonstration waive value begins with "11-W-" or "21-W-", then the value must include slash “/” in the 11th pos followed by a version number [0-9] in the 12th position 5. (1915(b) or 1915(c) waivers) If v begins with the two-letter state abbreviation followed by a period (.), the associated Claim Waiver Type value must be in [02-20, 32, 33]6. Value must have a corresponding value in Waiver Type (ELG.012.173)7. Mandatory
Value must have a corresponding value in Waiver Type (ELG.012.173)2. Value must be 20 characters or less3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", associated Claim Waiver Type value must be 01 or in [21-30]4. (1115 demonstration waive value begins with "11-W-" or "21-W-", then the value must include slash “/” in the 11th pos followed by a version number [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]6. Value must have a corresponding va in Waiver Type (ELG.012.173)7. Mandatory
1. Value must have a corresponding value in Waiver Type (ELG.012.173)2. Value must be characters or less3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", associated Claim Waiver Type value must be 01 or in [21-30]4. (1915(b) or 1915(c) waiver 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. Value must have a corresponding va in Waiver Type (ELG.012.173)6. Mandatory
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1. Value must be 30 characters or less2. Mandatory3. Value must match a corresponding Provider Identifier (PRV.005.081)
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1. Value must be 25 characters or less2. If associated Ethnicity Code (ELG.015.204) is in [" then value must be populated. 3. Conditional
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1. Value must be 20 characters or less2. Mandatory3. Must not contain a pipe or asterisk symbol
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1. Value must be 10 characters or less2. Value must be in the Data Dictionary Version List (VVL)3. Mandatory
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1. Value must be 10-digit number2. Situational
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1. Must contain the '@' symbol2. May contain uppercase and lowercase Latin letters A to Z a to z3. May contain digits 0-94. Must contain a dot '.' that is not the first or last character provided that it does not appear consecutively5. Value must be 60 characters or less6. Situational
Must contain the '@' symbol2. May contain uppercase and lowercase Latin letters A to Z a to z3. May contain digits 0-94. Must contain a dot '.' that is not the first or last character a provided that it does not appear consecutively5. Value must be 60 characters or less6. Situational
Situational
1. Value must be a 10-digit number2. Situational
1. Value must be 10 characters or less2. Value must be in the Data Dictionary Version List (VVL)3. Mandatory
1. Value must be in Facility Group Individual Code List (VVL)2. Value must be 2 characters Mandatory4. (individual) if value equals '03', then Provider First Name (PRV.002.028) must populated5. (organization) if value does not equal '03', then Provider Middle Initial (PRV.002.029) must not be populated6. (individual) if value equals '03', then Provider Last Name (PRV.002.030) must be populated7. (individual) if value equals '03', then Provider Se (PRV.002.031) must be populated8. (individual) if value equals '03', then Provider Date of (PRV.002.034) must be populated9. (organization) if value equals '01' or '02', then Provide Date of Death (PRV.002.035) must not be populated10. (individual) if value equals '03', the there must be one Provider Identifier (PRV.005.081) populated with an associated Provider Identifier Type (PRV.005.077) equal to ‘2’ (NPI)

1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. Conditional4. Wh populated, value must be on or after individual's Date of Birth5. Value must be less than o equal to associated End of Time Period (PRV.001.010)6. There can only be one value on all records when the value is populated7. When populated, the difference between value and of Birth (PRV.002.034) must be 18 years or greater
1. Value must be 10 characters or less2. Value must be in the Data Dictionary Version List (VVL)3. Mandatory
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in Health Insurance Coverage Indicator List (VVL)4. Mandatory5. 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.
Situational
1. Value must be 28 characters or less2. Value must not contain a pipe or asterisk symbols Situational
Situational
1. Value must be in State Code List (VVL)2. Value must be 2 characters3. Situational
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1. Value may only be 5 digits (0-9) (Example: 91320) or 9 digits (0-9) (Example: 91320001 Situational
Situational
1. Value must be 10-digit number2. Situational
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1. Value must be 10 characters or less2. Value must not contain a pipe or asterisk symbols Situational
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1. Value must be 30 characters or less2. Value must not contain a pipe or asterisk symbols Situational
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Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calendar (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. When populated, must have an associated Third Party Copayment Amount4. Situational

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1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. If associated Crossover Indicator value i then the value must not be populated.4. Conditional5. If value is populated, Crossover Indi must be equal to "1"
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Conditional4. Value should not be popul or equal to zero, when associated Claim Line Status is in ['26', '026', '87', '087', '542', '585 '654']
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. If associated Type of Claim value equals C, W', then value is mandatory and must be provided4. Conditional
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. If associated Crossover Indicator value i then the value must not be populated.4. Conditional5. If value is populated, Crossover Indi must be equal to "1"
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Conditional4. Value should not be popul or equal to zero, when associated Claim Line Status is in ['26', '026', '87', '087', '542', '585 '654']

1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. Conditional4. Value should not be popul or equal to zero, when associated Claim Line Status is in ['26', '026', '87', '087', '542', '585 '654']
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. If associated Crossover Indicator value i then the value must not be populated.4. Conditional5. If value is populated, Crossover Indi must be equal to "1"
1. Value must be 12 digits or less2. Value must be a valid National Drug Code3. Mandatory Value must have an associated Dtl Metric Decimal Quantity (CRX.003.144)5. Value must h an associated Unit of Measure (CRX.003.133)
Value must be between -99999999999.99 and 99999999999.992. Value must be expresse a number with 2-digit precision (e.g. 100.50)3. Conditional4. If associated Crossover Indica value is '0' (not a crossover claim), value should not be populated5. If value is greater than then Crossover Indicator must be '1'
1. Value must be between -99999999999.99 and 99999999999.992. Value must be expres as a number with 2-digit precision (e.g. 100.50)3. If associated Crossover Indicator value i then the value must not be populated.4. Conditional5. If value is populated, Crossover Indi must be equal to "1"
A data element to capture the version of the T-MSIS data dictionary that was used to build file.
A data element to capture the version of the T-MSIS data dictionary that was used to build file.
The second line of the street address of the destination point to which a patient is transpor either from home or Long term care facility to a health care provider for healthcare service vice versa. For transportation claims only. Required if state has captured this information, otherwise it is conditional.
A data element to capture the version of the T-MSIS data dictionary that was used to build file.
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A data element to capture the version of the T-MSIS data dictionary that was used to build file.
The amount the beneficiary or his or her representative (e.g., their guardian) paid towards coinsurance for the covered services on the claim. Do not include coinsurance payments m by a third party/ies on behalf of the beneficiary.
The amount the beneficiary or his or her representative (e.g., their guardian) paid towards copayment for the covered services on the claim. Do not include copayment payments ma by a third party/ies on behalf of the beneficiary.

The amount the beneficiary or his or her representative (e.g., their guardian) paid towards deductible for the covered services on the claim. Do not include deductible payments mad a third party/ies on behalf of the beneficiary.
The amount the beneficiary or his or her representative (e.g., their guardian) paid towards coinsurance for the covered services on the claim. Do not include coinsurance payments n by a third party/ies on behalf of the beneficiary.
The amount the beneficiary or his or her representative (e.g., their guardian) paid towards copayment for the covered services on the claim. Do not include copayment payments ma by a third party/ies on behalf of the beneficiary.
The amount the beneficiary or his or her representative (e.g., their guardian) paid towards copayment for the covered services on the claim. Do not include copayment payments ma by a third party/ies on behalf of the beneficiary.
The amount the beneficiary or his or her representative (e.g., their guardian) paid towards coinsurance for the covered services on the claim. Do not include coinsurance payments n by a third party/ies on behalf of the beneficiary.
The amount the beneficiary or his or her representative (e.g., their guardian) paid towards copayment for the covered services on the claim. Do not include copayment payments ma by a third party/ies on behalf of the beneficiary.
The amount the beneficiary or his or her representative (e.g., their guardian) paid towards deductible for the covered services on the claim. Do not include deductible payments mad a third party/ies on behalf of the beneficiary.
The quantity of a service or product that is rendered for a specific date of service or billing span as reported by revenue code or procedure code on the claim line. For use with CLAIM and CLAIMRX claims. For CLAIMIP and CLAIMOT claims/encounter records, use the Service Quantity Actual field. 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/ that were filled.
The maximum allowable quantity of a service that may be rendered per date of service or month. For use with CLAIMOT and CLAIMRX claims. For CLAIMIP and CLAIMOT claims/encou records, use the Revenue center -quantity Allowed field. NOTE: One prescription for 100 25 milligram tablets results in Prescription 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 number of units of a prescription/refill that were filled. For prescriptions/refills, use the Med 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 value in Prescription Quantity allowed must correspond with the value in Unit of measure.

The maximum allowable quantity of a service that may be rendered per date of service or month. For use with CLAIMOT and CLAIMRX claims. For CLAIMIP and CLAIMOT claims/encou records, use the Revenue center -quantity Allowed field. NOTE: One prescription for 100 25 milligram tablets results in Prescription Quantity allowed=100.This field is only applicable 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 Med 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 value in Prescriptio Quantity allowed must correspond with the value in Unit of measure.
A code to categorize the services provided to a Medicaid or CHIP enrollee. For sub-capitati payments, report a TYPE-OF-SERVICE value 119, 120, or 122.
The amount the beneficiary or his or her representative (e.g., their guardian) paid towards coinsurance for the covered services on the claim. Do not include coinsurance payments m by a third party/ies on behalf of the beneficiary.
The amount the beneficiary or his or her representative (e.g., their guardian) paid towards copayment for the covered services on the claim. Do not include copayment payments ma by a third party/ies on behalf of the beneficiary.
The amount the beneficiary or his or her representative (e.g., their guardian) paid towards deductible for the covered services on the claim. Do not include deductible payments mad a third party/ies on behalf of the beneficiary.
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. When populated, must have an associated Third Party Copayment Amount4. Situational
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. When populated, must have an associated Third Party Copayment Amount4. Situational
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. When populated, must have an associated Third Party Copayment Amount4. Situational
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. When populated, must have an associated Third Party Copayment Amount4. Situational
1. Value must be in SSN Indicator List (VVL)2. Value must be 1 character3. Mandatory4. W populated, value must equal SSN Indicator (ELG.001.012)
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in Claim Indicator List (VVL).4. Conditional

1. Value must be 30 characters or less2. Conditional3. When Type of Claim not in ('Z','3','C','W","2","B","V"," 4","D","X") then value may match (PRV.005.081) Provider Identi or4. When Type of Claim not in ('Z','3','C','W","2","B","V"," 4","D","X") then value may matc (PRV.002.019) Submitting State Provider ID5. When Type of Claim in ['1','3','A','C’] then associated Provider Medicaid Enrollment Status Code (PRV.007.100) must be in ['01', '02', '04', '05', '06'] (active)
1. Value must be 10 digits2. Value must have an associated Provider Identifier Type equal '2'3. Conditional4. Value must exist in the NPPES NPI data file5. When Type of Claim is in ['1','3','A','C'], then value must be populated
1. Value must be 10 digits2. Value must have an associated Provider Identifier Type equal '2'3. Conditional4. Value must exist in the NPPES NPI data file
1. Value must be in SSN Indicator List (VVL)2. Value must be 1 character3. Mandatory4. W populated, value must equal SSN Indicator (ELG.001.012)
1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in Claim Indicator List (VVL).4. Conditional
1. Value must be 30 characters or less2. Conditional3. When Type of Claim not in ('Z','3','C','W","2","B","V"," 4","D","X") then value may match (PRV.005.081) Provider Identi or4. When Type of Claim not in ('Z','3','C','W","2","B","V"," 4","D","X") then value may matc (PRV.002.019) Submitting State Provider ID5. When Type of Claim in ['1','3','A','C’] then associated Provider Medicaid Enrollment Status Code (PRV.007.100) must be in ['01', '02', '04', '05', '06'] (active)
1. Value must be 10 digits2. Value must have an associated Provider Identifier Type equal '2'3. Conditional4. When Type of Claim (CLT.002.052) not in ('3','C','W') then value must m Provider Identifier (PRV.005.081)5. Value must exist in the NPPES NPI data file
1. Value must be in SSN Indicator List (VVL)2. Value must be 1 character3. Mandatory4. W populated, value must equal SSN Indicator (ELG.001.012)
1. Value must be 30 characters or less2. Conditional3. When Type of Claim not in ("Z","3","C",'W',"2","B","V","4","D","X") then value may match (PRV.005.081) Provider Iden or4. When Type of Claim not in ("Z","3","C",'W',"2","B","V","4","D","X") then value may ma (PRV.002.019) Submitting State Provider ID5. When Type of Claim in ["1","3","A","C"] then associated Provider Medicaid Enrollment Status Code (PRV.007.100) must be in "01", "02", "03", "04", "05", "06"] (active)
1. Value must be 10 digits2. Value must have an associated Provider Identifier Type equal '2'3. Conditional4. When Type of Claim (COT.002.037) not in ('3','C','W') then value must m Provider Identifier (PRV.005.081)5. Value must exist in the NPPES NPI data file
1. Value must be in SSN Indicator List (VVL)2. Value must be 1 character3. Mandatory4. W populated, value must equal SSN Indicator (ELG.001.012)
1. Value must be 10 digits2. Value must have an associated Provider Identifier Type equal '2'3. Mandatory4. Value must exist in the NPPES NPI data file5. NPPES Entity Type Code associate with this NPI must equal ‘1’ (Individual)

1. Value must be 1 character2. Value must be in [0, 1] or not populated3. Value must be in SSDI Indicator List (VVL)4. Conditional
1. Value must be in SSI State Supplement Status Code List (VVL)2. Value must be 3 characters3. (individual not receiving Federal SSI)If value is "001" or "002", then SSI Status (ELG.005.092) must be "001" or "002"4. (Individual not receiving Federal SSI)If value is "00 "002", then SSI Indicator (ELG.005.090) must be "1"5. Value must not be populated or mus "000" when SSI Status (ELG.005.092) is not populated or is "000"
1. Value must be in SSN Indicator List (VVL)2. Value must be 1 character3. Mandatory4. W populated, value must equal SSN Indicator (ELG.001.012)
4
1. Value must be in Adjustment Indicator List (VVL)2. If associated Type of Claim value is in 3, 5, A, C, E, U, W, Y], then value must be in [0, 1, 4]3. If associated Type of Claim value D, X', then value must be in [5, 6]4. Value must be 1 character5. Mandatory6. If value is i [‘0’, ‘5’, ‘6’], then associated Adjustment ICN must not be populated7. If value is in [‘4’, ‘1 then Adjustment ICN must be populated8. Value must equal ‘1’, when associated Claim St equals ‘686’
4
1. Value must be in Adjustment Indicator List (VVL)2. If associated Type of Claim value is in 3, 5, A, C, E, U, W, Y], then value must be in [0, 1, 4]3. If associated Type of Claim value D, X', then value must be in [5, 6]4. Value must be 1 character5. Mandatory6. If value is i [‘0’, ‘5’, ‘6’], then associated Adjustment ICN must not be populated7. If value is in [‘4’, ‘1 then Adjustment ICN must be populated8. Value must equal ‘1’, when associated Claim St equals ‘686’
4
1. Value must be in Adjustment Indicator List (VVL)2. If associated Type of Claim value is in 3, 5, A, C, E, U, W, Y], then value must be in [0, 1, 4]3. If associated Type of Claim value D, X', then value must be in [5, 6]4. Value must be 1 character5. Mandatory6. If value is i [‘0’, ‘5’, ‘6’], then associated Adjustment ICN must not be populated7. If value is in [‘4’, ‘1 then Adjustment ICN must be populated8. Value must equal ‘1’, when associated Claim St equals ‘686’
4
1. Value must be in Adjustment Indicator List (VVL)2. If associated Type of Claim value is in 3, 5, A, C, E, U, W, Y], then value must be in [0, 1, 4]3. If associated Type of Claim value D, X', then value must be in [5, 6]4. Value must be 1 character5. Mandatory6. If value is i [‘0’, ‘5’, ‘6’], then associated Adjustment ICN must not be populated7. If value is in [‘4’, ‘1 then Adjustment ICN must be populated8. Value must equal ‘1’, when associated Claim St equals ‘686’
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. When populated, value must have an associated Third Party Coinsurance Amount4. Conditional
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. When populated, value must have an associated Third Party Coinsurance Amount4. Conditional

1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. When populated, value must have an associated Third Party Coinsurance Amount4. Conditional
1. Value must be 8 characters in the form "CCYYMMDD"2. The date must be a valid calend date (i.e. Feb 29th only on the leap year, never April 31st or Sept 31st)3. When populated, value must have an associated Third Party Coinsurance Amount4. Conditional
A data element to capture the version of the T-MSIS data dictionary that was used to build file.
N/A
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COT284|COT.004.284|DIAGNOSIS-CODE|Diagnosis Code|Mandatory|ICD-9 or ICD-10 diagnc codes used as a tool to group and identify diseases, disorders, symptoms, poisonings, adv effects of drugs and chemicals, injuries and other reasons for patient encounters. Diagnosi codes should be passed through to T-MSIS exactly as they were submitted by the provider 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. If associated Diagno Code Flag value is '1' (ICD-9), then value must be in ICD-9 Diagnosis Code List (VVL) 2. If associated Diagnosis Code Flag value is '2' (ICD-10), then value must be in ICD-10 Diagnosis Code List (VVL) 3. Value must be a minimum of 3 characters 4. Value must not contain a decimal point 5. Mandatory
COT285|COT.004.285|STATE-NOTATION|State Notation|Optional|A free text field for the submitting state to enter whatever information it chooses.|N/A|COT00004|CLAIM-DX-OT|X(12|142|641|1. Value must be 500 characters or less 2. Value must not contain a pipe or asterisk symbols 3. Optional

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident
MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity
data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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-blog/entry/4757
|N/A|CRX00002|CLAIM-HEADER-RECORD-RX|X(20)|7|134|153|1. Mandatory
2. Value must be 20 characters or less
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|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. Value m
be in Crossover Indicator List (VVL)
2. Value must be 1 character
3. Value must be in [0, 1] or not populated
4. If Crossover Indicator value is "1", the associated Dual Eligible Code (ELG.005.085) valu
must be in "01", "02", "04", "08", "09", or "10" for the same time period (by date of service
5. Value must be 1 character
6. Mandatory

CRX025|CRX.002.025|ADJUSTMENT-IND|Adjustment Indicator|Mandatory|Indicates the type
adjustment record.
|ADJUSTMENT-IND|CRX00002|CLAIM-HEADER-RECORD-RX|X(1)|10|156|156|1. Value must b
Adjustment Indicator List (VVL).
2. Value must be in [0, 1, 4].
3. Value must be 1 character.
4. Mandatory

CRX039|CRX.002.039|TOT-BILLED-AMT|Total Billed Amount|Conditional|The total amount b for this claim at the claim header level as submitted by the provider. For encounter record when Type of Claim value is in [3, C, W], then value must equal amount the provider billed the managed care plan. For sub-capitated encounters from a sub-capitated entity that is n 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-capi network provider. For sub-capitated encounters from a sub-capitated network provider, if t sub-capitated network provider directly employs the provider that renders the service to th 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 betwe 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
N/A
N/A

CRX056|CRX.002.056|PLAN-ID-NUMBER|Plan ID Number|Conditional|A unique number assi
by the state which represents a distinct comprehensive managed care plan, prepaid healt
plan, primary care case management program, a program for all-inclusive care for the eld
entity, or other approved plans.
|N/A|CRX00002|CLAIM-HEADER-RECORD-RX|X(12)|37|330|341|1. Value must be 12 charact
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].
7. When Type of Claim in [3, C, W] value must have a Managed Care Enrollment (ELG.014)
the beneficiary where the Prescription Fill Date (CRX.002.085) occurs between the manage
care plan enrollment eff/end dates (ELG.014.197/198).
8. When Type of Claim in [3, C, W] value must have a Managed Care Main Record (MCR.00
for the plan where the Prescription Fill Date (CRX.002.085) occurs between the managed c
contract eff/end dates (MCR.002.020/021).

CRX070|CRX.002.070|BILLING-PROV-NUM|Billing Provider Number|Conditional|A unique
identification number assigned by the state to a provider or managed care plan. This data
element should represent the entity billing for the service. For encounter records, if associ
Type of Claim value equals 3, C, or W, then value must be the state identifier of the provid
entity (billing or reporting) to the managed care plan.|N/A|CRX00002|CLAIM-HEADER-RECO
RX|X(30)|50|462|491|1. Value must be 30 characters or less.
2. Conditional
3. When Type of Claim not in ('3','C','W') then value may match (PRV.002.019) Submitting
Provider ID or
4. When Type of Claim not in ('3','C','W') then value may match (PRV.005.081) Provider
Identifier where the Provider Identifier.
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).

CRX085|CRX.002.085|PRESCRIPTION-FILL-DATE|Prescription Fill Date|Mandatory|Date the device, or supply was dispensed by the provider.
|N/A|CRX00002|CLAIM-HEADER-RECORD-RX|9(8)|60|607|614|1. Value must be 8 characters the form 'CCYYMMDD'.
2. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April or Sept 31st).
3. Value must be on or before associated End of Time Period (CRX.001.010).
4. Value must be on or after associated Start of Time Period (CRX.001.009).
5. Value must be on or after associated Date Prescribed (CRX.002.084).
6. Value must be on or after associated eligible party's Date of Birth (ELG.002.024).
7. Value must be on or before associated eligible party's Date of Death (ELG.002.025).
8. Value must be populated when Adjustment Indicator (CRX.002.025) does not equal '1'.
9. Mandatory

CRX156|CRX.002.156|DISPENSING-PRESCRIPTION-DRUG-PROV-NUM|Dispensing Prescriptio Drug Provider Number|Mandatory|The state-specific provider id of the provider who actual dispensed the prescription medication.|N/A|CRX00002|CLAIM-HEADER-RECORD-RX|X(30)|7 805|834|1. Value must be 30 characters or less.
2. When Type of Claim not in ('3','C','W') then value may match Submitting State Provider (PRV.002.019) or
3. When Type of Claim not in ('3','C','W') then value may match Provider Identifier (PRV.005.081) where the Provider Identifier Type (PRV.005.077) = '1'.
4. 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 fund cover part of their care before Medicaid funds can be utilized.|N/A|CRX00002|CLAIM-HEADI 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 code indicating the format in which the provider submitted their claim. Very few if any clai 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 Tex
Conditional|A free-form text field where a state can identify the "other" claim form used by
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 r
than 50 characters long.
2. Conditional
3. Value is mandatory when corresponding Provider Claim Form Code is 'Other'

CRX176|CRX.002.176|TOT-GME-AMOUNT-PAID|Total GME Amount Paid|Conditional|The am
included in the Total Medicaid Amount (CRX.002.041) that is attributable to a Graduate Me
Education (GME) payment, when the state makes GME payments by claim.|N/A|CRX00002
CLAIM-HEADER-RECORD-IP|S9(11)V99|89|959|971|1. Value must be between -999999999
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 Amou
Conditional|The component (in dollar and cents) of the total allowed amount that represen
the difference between what would have been the managed care plan's typical contractua
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
(1)(iii).|N/A|CRX00002|CLAIM-HEADER-RECORD-IP|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 t
difference between what would have been the managed care plan's typical contractual pa
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
CRX00002|CLAIM-HEADER-RECORD-IP|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

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident
MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity
data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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-blog/entry/4757
|N/A|CRX00003|CLAIM-LINE-RECORD-RX|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less.

CRX116|CRX.003.116|LINE-ADJUSTMENT-IND|Line Adjustment Indicator|Conditional|A code
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. Value must b
Line Adjustment Indicator List (VVL)
2. Value must be in [0, 1, 4]
3. Value must be 1 character
4. Conditional
5. If associated Line Adjustment Number is populated, then value must be populated

CRX131|CRX.003.131|PRESCRIPTION-QUANTITY-ALLOWED|Prescription Quantity Allowed|
Conditional|The maximum allowable quantity of a drug or service that may be dispensed p
prescription per date of service or per month. Quantity limits are applied to medications w
the majority of appropriate clinical utilizations will be addressed within the quantity allowe
For use with CLAIMOT and CLAIMRX claims. For CLAIMIP and CLAIMLT claims/encounter rec
use the Revenue Center Quantity Actual field.
One prescription for 100 250 milligram tablets results in Prescription Quantity Allowed =10
N/A|CRX00003|CLAIM-LINE-RECORD-RX|S9(9)V(9)|23|290|307|1. Value may include up to 9
digits to the left of the decimal point, and 9 digits to the right e.g. 123456789.123456789
2. When populated, corresponding Unit of Measure must be populated
3. Conditional

CRX132|CRX.003.132|PRESCRIPTION-QUANTITY-ACTUAL|Prescription Quantity Actual| Mandatory|The quantity of a drug that is dispensed for a prescription as reported ny Natio Drug Code on the claim line. For use with CLAIMOT and CLAIMRX claims. For CLAIMIP and CLAIMLT claims/encounter records, use the Revenue Center Quantity Actual field.|N/A| CRX00003|CLAIM-LINE-RECORD-RX|S9(9)V(9)|24|308|325|1. Value may include up to 9 dig to the left of the decimal point, and 9 digits to the right e.g. 123456789.123456789 2. Mandatory 3. When populated, corresponding Unit of Measure must be populated
N/A
N/A
CRX149|CRX.003.149|CATEGORY-FOR-FEDERAL-REIMBURSEMENT|Category for Federal Reimbursement|Conditional|A code to indicate the Federal funding source for the payment CATEGORY-FOR-FEDERAL-REIMBURSEMENT|CRX00003|CLAIM-LINE-RECORD-RX|X(2)|39|38 388|1. Value must be in Category for Federal Reimbursement List (VVL). 2. Value must be 2 characters. 3. (Federal Funding under Title XXI) if value equals '02', then the eligible's CHIP Code (ELG.003.054) must be in ['2', '3']. 4. (Federal Funding under Title XIX) if value equals '01' then the eligible's CHIP Code (ELG.003.054) must be '1'. 5. Conditional 6. If Type of Claim is in ['1','A','U'] and the Total Medicaid Paid Amount is populated on the corresponding claim header, then value must be reported.

N/A
N/A
CRX172|CRX.003.172|IHS-SERVICE-IND|IHS Service Indicator|Mandatory|To indicate Servic 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 [0, 1] 3. Mandatory
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 and 830.|N/A|CRX00003|CLAIM-LINE-RECORD-RX|X(76)|50|497|572|1. Value must not be m than 76 characters long. 2. Conditional

CRX180|CRX.003.180|MBESCBES-CATEGORY-OF-SERVICE|MBES or CBES Category of Servi
Conditional|A code indicating the category of service for the paid claim. The category of se
is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM
21, 64.9 WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS) that states use to report
expenditures and request federal financial participation.|MBESCBES-CATEGORY-OF-SERVIC
(XIX), MBESCBES-CATEGORY-OF-SERVICE (XXI)|CRX00003|CLAIM-LINE-RECORD-RX|X(5)|51
577|1. Value must not be more than 5 characters
2. Value must be in MBES or CBES Category of Service Code List (VVL)
3. Value must be populated on all FFS claim lines with a paid amount greater than $0
4. Conditional

CRX181|CRX.003.181|MBESCBES-FORM|MBES or CBES Form|Conditional|The MBES or CBES
form to which the expenditured will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21,
WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS). This should be determined by th
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.|MBESCBE
FORM|CRX00003|CLAIM-LINE-RECORD-RX|X(50)|52|578|627|1. Value must be 50 character
less
2. Value must be in MBES or CBES Form Code List (VVL)
3. Value must be populated on all FFS claim lines with a paid amount greater than $0
4. Conditional

CRX182|CRX.003.182|PROCEDURE-CODE|Procedure Code|Conditional|The procedure code
CPT, HCPCS, or other procedure code that is not an NDC or UDI) reported by a pharmacy o
their NDPCP transaction.|N/A|CRX00003|CLAIM-LINE-RECORD-RX|X(6)|53|628|633|1. Value
not be more than 6 characters.
2. Value must be in Procedure Code List (VVL)
3. Conditional

CRX183|CRX.003.183|PROCEDURE-CODE-MODIFIER-1|Procedure Code Modifier 1|Condition
The first modifier associated with the procedure code (or if procedure code is missing, then
modifier may be associated with an NDC or Unique Device Identifier).|N/A|CRX00003|CLAIM
LINE-RECORD-RX|X(2)|54|634|635|1. Value must be 2 characters.
2. Conditional

CRX184|CRX.003.184|PROCEDURE-CODE-MODIFIER-2|Procedure Code Modifier 2|Condition
The second modifier associated with the procedure code (or if procedure code is missing, t
the modifier may be associated with an NDC or Unique Device Identifier).|N/A|CRX00003|
CLAIM-LINE-RECORD-RX|X(2)|55|636|637|1. Value must be 2 characters.
2. Conditional

CRX185|CRX.003.185|PROCEDURE-CODE-MODIFIER-3|Procedure Code Modifier 3|Condition
The third modifier associated with the procedure code (or if procedure code is missing, the
modifier may be associated with an NDC or Unique Device Identifier).|N/A|CRX00003|CLAIM
LINE-RECORD-RX|X(2)|56|638|639|1. Value must be 2 characters.
2. Conditional

CRX186|CRX.003.186|PROCEDURE-CODE-MODIFIER-4|Procedure Code Modifier 4|Condition
The fourth modifier associated with the procedure code (or if procedure code is missing, th
the modifier may be associated with an NDC or Unique Device Identifier).|N/A|CRX00003|
CLAIM-LINE-RECORD-RX|X(2)|57|640|641|1. Value must be 2 characters.
2. Conditional

CRX187|CRX.003.187|PROCEDURE-CODE-MODIFIER-5|Procedure Code Modifier 5|Condition
The fifth modifier associated with the procedure code (or if procedure code is missing, ther
modifier may be associated with an NDC or Unique Device Identifier).|N/A|CRX00003|CLAIM
LINE-RECORD-RX|X(2)|58|642|643|1. Value must be 2 characters.
2. Conditional

CRX188|CRX.003.188|PROCEDURE-CODE-MODIFIER-6|Procedure Code Modifier 6|Condition
The sixth modifier associated with the procedure code (or if procedure code is missing, the
the modifier may be associated with an NDC or Unique Device Identifier).|N/A|CRX00003|
CLAIM-LINE-RECORD-RX|X(2)|59|644|645|1. Value must be 2 characters.
2. Conditional

CRX189|CRX.003.189|PROCEDURE-CODE-MODIFIER-7|Procedure Code Modifier 7|Condition
The seventh modifier associated with the procedure code (or if procedure code is missing,
the modifier may be associated with an NDC or Unique Device Identifier).|N/A|CRX00003|
CLAIM-LINE-RECORD-RX|X(2)|60|646|647|1. Value must be 2 characters.
2. Conditional

CRX190|CRX.003.190|PROCEDURE-CODE-MODIFIER-8|Procedure Code Modifier 8|Condition
The eighth modifier associated with the procedure code (or if procedure code is missing, th
the modifier may be associated with an NDC or Unique Device Identifier).|N/A|CRX00003|
CLAIM-LINE-RECORD-RX|X(2)|61|648|649|1. Value must be 2 characters.
2. Conditional

CRX191|CRX.003.191|PROCEDURE-CODE-MODIFIER-9|Procedure Code Modifier 9|Condition
The ninth modifier associated with the procedure code (or if procedure code is missing, the
the modifier may be associated with an NDC or Unique Device Identifier).|N/A|CRX00003|
CLAIM-LINE-RECORD-RX|X(2)|62|650|651|1. Value must be 2 characters
2. Conditional

CRX192|CRX.003.192|PROCEDURE-CODE-MODIFIER-10|Procedure Code Modifier 10|Condit
The tenth modifier associated with the procedure code (or if procedure code is missing, th
the modifier may be associated with an NDC or Unique Device Identifier).|N/A|CRX00003|
CLAIM-LINE-RECORD-RX|X(2)|63|652|653|1. Value must be 2 characters.
2. Conditional

CRX193|CRX.003.193|GME-AMOUNT-PAID|GME Amount Paid|Conditional|The amount inclu
in the Medicaid Amount (CRX.003.125) that is attributable to a Graduate Medical Educatio
(GME) payment, when the state makes GME payments by claim.|N/A|CRX00003|CLAIM-LIN
RECORD-RX|S9(11)V99|64|654|666|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|Condit
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 amou
and the enhanced allowed amount for this specific claim as defined by the State's SPA, wa
or demonstration for a State Directed Payment model per 42 CFR 438.6(c)(1)(iii).|N/A|
CRX00003|CLAIM-LINE-RECORD-IP|S9(11)V99|65|667|679|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 betwee
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|CRX000
CLAIM-LINE-RECORD-IP|S9(11)V99|66|680|692|1. Value must be between -99999999999.9
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
segment being reported. The Record ID communicates how the contents of a given row of
should be interpreted depending on which segment type the Record ID represents. Each t
of segment collects different data elements so each segment type has a distinct layout. Th
first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th
segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).|N/A|CRX00
CLAIM-DX-RX|X(8)|1|1|8|1. Mandatory
2. Value must be 8 characters
3. Value must be in Record ID List (VVL)

CRX197|CRX.004.197|SUBMITTING-STATE|Submitting State|Mandatory|A code that uniquel
identifies the U.S. State or Territory from which T-MSIS system data resources were receiv
STATE|CRX00004|CLAIM-DX-RX|X(2)|2|9|10|1. Value must be in State Code List (VVL)
2. Value must be 2 characters
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 recor
within the submission file.|N/A|CRX00004|CLAIM-DX-RX|9(11)|3|11|21|1. Value must be un
within record segment over all records associated with a given Record ID (CE)
2. Value must be 11 digits or less
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|CLA
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 assigne
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 o
2. Value must not contain a pipe or asterisk symbols
3. If associated Adjustment Indicator value is 0, then value must not be populated
4. Conditional

CRX201|CRX.004.201|ADJUSTMENT-IND|Adjustment Indicator|Mandatory|Indicates the type
adjustment record.|LINE-ADJUSTMENT-IND|CRX00004|CLAIM-DX-RX|X(1)|6|122|122|1. Valu
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 [
4]
3. If associated Type of Claim value is '4, D, X', then value must be in [5, 6]
4. Value must be 1 character
5. Mandatory

CRX202|CRX.004.202|ADJUDICATION-DATE|Adjudication Date|Mandatory|The date on whic
payment status of the claim was finally adjudicated by the state. For Encounter Records (
of Claim = 3, C, W), use date the encounter was processed by the state.|N/A|CRX00004|CL
DX-RX|9(8)|7|123|130|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
or Sept 31st)
3. Value should be on or before End of Time Period value found in associated T-MSIS File
Header Record
4. Mandatory

CRX203|CRX.004.203|DIAGNOSIS-TYPE|Diagnosis Type|Mandatory|Indicates the context of
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 o
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 in [D]
4. Mandatory

CRX204|CRX.004.204|DIAGNOSIS-SEQUENCE-NUMBER|Diagnosis Sequence Number|Manda
The order in which the diagnosis occurred on the provider's claim for a given type of diagn
code (e.g., an NCPDP claim can have up to 5 diagnosis codes).|N/A|CRX00004|CLAIM-DX-R
9(2)|9|132|133|1. Value must be between 1 and 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 in Diagnosis Code
List (VVL)
2. Value must be 1 character
3. Mandatory

CRX206|CRX.004.206|DIAGNOSIS-CODE|Diagnosis Code|Mandatory|ICD-9 or ICD-10 diagnc
codes used as a tool to group and identify diseases, disorders, symptoms, poisonings, adv
effects of drugs and chemicals, injuries and other reasons for patient encounters. Diagnosi
codes should be passed through to T-MSIS exactly as they were submitted by the provider
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. If associated Diagno
Code Flag value is '1' (ICD-9), then value must be in ICD-9 Diagnosis Code List (VVL)
2. If associated Diagnosis Code Flag value is '2' (ICD-10), then value must be in ICD-10
Diagnosis Code List (VVL)
3. Value must be a minimum of 3 characters
4. Value must not contain a decimal point
5. Mandatory

CRX207|CRX.004.207|STATE-NOTATION|State Notation|Optional|A free text field for the
submitting state to enter whatever information it chooses.|N/A|CRX00004|CLAIM-DX-RX|X(
12|142|641|1. Value must be 500 characters or less
2. Value must not contain a pipe or asterisk symbols
3. Optional

ELG272|ELG.001.272|FILE-SUBMISSION-METHOD|File Submission Method|Mandatory|The fi
submission method (e.g., TFFR, RHFR, IT, or CSO) used by the state to build and submit th
This should correspond with the state's declared file submission method for the same file t
and time period.|FILE-SUBMISSION-METHOD|ELG00001|FILE-SUBMISSION-METHOD|X(2)|14
80|1. Value must be in File Submission Method List (VVL)
2. Value must be 2 characters
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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident
MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity
data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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-blog/entry/4757
|N/A|ELG00002|PRIMARY-DEMOGRAPHICS-ELIGIBILITY|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
|N/A|ELG00003|VARIABLE-DEMOGRAPHICS-ELIGIBILITY|X(20)|4|22|41|1. Mandatory
2. For Non-SSN States (i.e. SSN Indicator = 0), value must not be equal to eligible individua SSN
3. Value must be 20 characters or less

ELG046|ELG.003.046|PREFERRED-LANGUAGE-CODE|Primary Language Code|Conditional|A indicating the language that is the individuals' preferred spoken or written language.| PREFERRED-LANGUAGE-CODE|ELG00003|VARIABLE-DEMOGRAPHICS-ELIGIBILITY|X(3)|17|1 122|1. Value must be in Primary Language Code List (VVL)
2. Value must be 3 characters
3. Conditional

ELG273|ELG.003.273|APPLICATION-SIGNATURE-DATE|Application Signature Date|Condition The date that a beneficiary signed their Medicaid or CHIP application. If the beneficiary wa deemed eligible via an administrative determination then a signature may not be applicable/available. |N/A|ELG00003|VARIABLE-DEMOGRAPHICS-ELIGIBILITY|9(8)|26|170|17
Value must be a valid date
2. Conditional
3. Value must be less than the VARIABLE-DEMOGRAPHIC-ELEMENT-END-DATE

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757 |N/A|ELG00004|ELIGIBLE-CONTACT-INFORMATION|X(20)|4|22|41|1. Mandatory 2. Value must be 20 characters or less
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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757 |N/A|ELG00005|ELIGIBILITY-DETERMINANTS|X(20)|4|22|41|1. Mandatory 2. Value must be 20 characters or less
N/A

ELG095|ELG.005.095|ELIGIBILITY-TERMINATION-REASON|Eligibility Termination Reason| Conditional|The reason for a complete loss/termination in an individual's eligibility for Medi and CHIP. The end date of the segment in which the value is reported must represent the d that the complete loss/termination of Medicaid and CHIP eligibility occurred. The reason fo termination represents the reason that the segment in which it was reported was closed. I a single termination in eligibility for a single individual there are multiple distinct co-occurr 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'; (Oth '22'; (Unknown), then the state should not report the co-occurring value '21'; and/or '22'; t MSIS. If there are multiple co-occurring distinct values between '01'; and '19', then the sta should choose whichever is first in the state's system. Of the values that could logically co occur in the range of '01'; throug '19', CMS does not currently have a preference for any or 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-TERMINATION-REASON|ELG00005|ELIGIBILITY-DETERMINANTS|X(2)|16|77|78|1 Value must be in Eligibility Change Reason List (VVL) 2. Value must be 2 characters 3. Conditional
N/A
ELG274|ELG.005.274|ELIGIBILITY-REDETERMINTATION-DATE|Eligibility Redetermination Da Conditional|The date by which a person's Medicaid or CHIP eligiblity must be redetermined 1915(i)(1)(I), 42 CFR 435.916, 435.926, any other applicable regulations, or waiver of thes regulations. This is effectively the "expiration date" of the eligiblity characteristics with wh 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 21|97|104|1. Value must be a valid date 2. Conditional 3. Value must be greater than the ELIGIBLITY-DETERMINANTS-EFF-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 should correspond to the eligibility characteristics, including eligibility redetermination dat with which the code is being reported.|ELIGIBILITY-EXTENSION-CODE|ELG00005|ELIGIBILIT DETERMINANTS|X(3)|22|105|107|1. Value must not be more than 3 characters
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 23|108|157|1. Value must not be more than 50 characters long
2. Conditional
3. Value is mandatory when corresponding Eligibility Extension Code is 'Other'

ELG277|ELG.005.277|CONTINUOUS-ELIGIBILITY-CODE|Continuous Eligibility Code|Condition code to identify the authority used to provide continuous eligibility during the period of coverage|CONTINUOUS-ELIGIBILITY-CODE|ELG00005|ELIGIBILITY-DETERMINANTS|X(3)|24|1 160|1. Value must not be more than 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 Te 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|21 Value must not be more than 50 characters long
2. Conditional
3. Value is mandatory when corresponding Continuous Eligibility Code is 'Other'

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 not be more than 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 u 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. Va must not be more than 50 characters long.
2. Conditional
3. Value is mandatory when corresponding Income Standard Code is 'Other'

ELG281|ELG.005.281|ELIGIBILITY-TERMINATION-REASON-OTHER-TYPE-TEXT|Eligibility Termination Reason Other Type Text|Conditional|Value must be populated with a state-spe 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 less
2. Value must not be populated when Eligibility Termination Reason = 22 (Other)
3. Value must be populated when Eligibility Termination Reason <> 22 (Other)
3. Conditional

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
|N/A|ELG00006|HEALTH-HOME-SPA-PARTICIPATION-INFORMATION|X(20)|4|22|41|1. Mandat
2. Value must be 20 characters or less

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
|N/A|ELG00007|HEALTH-HOME-SPA-PROVIDERS|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
|N/A|ELG00008|HEALTH-HOME-CHRONIC-CONDITIONS|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
|N/A|ELG00009|LOCK-IN-INFORMATION|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
|N/A|ELG00010|MFP-INFORMATION|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
|N/A|ELG00011|STATE-PLAN-OPTION-PARTICIPATION|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
|N/A|ELG00012|WAIVER-PARTICIPATION|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
|N/A|ELG00013|LTSS-PARTICIPATION|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident
MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity
data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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-blog/entry/4757
|N/A|ELG00014|MANAGED-CARE-PARTICIPATION|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident
MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity
data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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-blog/entry/4757
|N/A|ELG00015|ETHNICITY-INFORMATION|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident
MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity
data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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-blog/entry/4757
|N/A|ELG00016|RACE-INFORMATION|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
|N/A|ELG00017|DISABILITY-INFORMATION|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
|N/A|ELG00018|1115A-DEMONSTRATION-INFORMATION|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
|N/A|ELG00020|HCBS-CHRONIC-CONDITIONS-NON-HEALTH-HOME|X(20)|4|22|41|1. Mandat
2. Value must be 20 characters or less

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
|N/A|ELG00021|ENROLLMENT-TIME-SPAN-SEGMENT|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique 'key' value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
|N/A|ELG00022|ELG-IDENTIFIERS|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

FTX001|FTX.001.001|RECORD-ID|Record ID|Mandatory|The Record ID represents the type
segment being reported. The Record ID communicates how the contents of a given row of
should be interpreted depending on which segment type the Record ID represents. Each t
of segment collects different data elements so each segment type has a distinct layout. Th
first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th
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 exactly 8 characters
2. Value must be in RECORD-ID list (VVL)
3. Value must equal "FTX00001"
4. Mandatory

FTX002|FTX.001.002|DATA-DICTIONARY-VERSION|Data Dictionary Version|Mandatory|A da
element to capture the version of the T-MSIS data dictionary that was used to build the file
the version number specified on the Cover Sheet of the data dictionary".|N/A|FTX00001|FIL
HEADER-RECORD-FTX|X(10)|2|9|18|1. Value must be 10 characters or less
2. Value must not include the pipe ("|") symbol
3. 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 ed
rejects.|SUBMISSION-TRANSACTION-TYPE|FTX00001|FILE-HEADER-RECORD-FTX|X(1)|3|19|1
Value must be in SUBMISSION-TRANSACTION-TYPE list (VVL)
2. Value must be 1 character
3. Mandatory

FTX004|FTX.001.004|FILE-ENCODING-SPECIFICATION|File Encoding Specification|Mandator
Denotes which supported file encoding standard was used to create the file.|FILE-ENCODIN
SPECIFICATION|FTX00001|FILE-HEADER-RECORD-FTX|X(3)|4|20|22|1. Value must be in FILE
ENCODING-SPECIFICATION list (VVL)
2. Value must be 3 characters
3. Mandatory

FTX005|FTX.001.005|DATA-MAPPING-DOCUMENT-VERSION|Data Mapping Document Versio
Mandatory|Identifies the version of the T-MSIS data mapping document used to build a sta
submission file. Use the version number specified on the title page of the data mapping
document|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 t
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 C
Plan Information,
Inpatient, Long-Term Care, Other, and Pharmacy Claim).|FILE-NAME|FTX00001|FILE-HEADE
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 receiv
STATE|FTX00001|FILE-HEADER-RECORD-FTX|X(2)|7|40|41|1. Value must be in State Code l
(VVL)
2. Value must be 2 characters
3. Mandatory

FTX008|FTX.001.008|DATE-FILE-CREATED|Date File Created|Mandatory|The date on which
file was created.|N/A|FTX00001|FILE-HEADER-RECORD-FTX|9(8)|8|42|49|1. Value of the CC
component must be "20"
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
or Sept 31st)
4. Value must be less than current date
5. Mandatory

FTX009|FTX.001.009|START-OF-TIME-PERIOD|Start of Time Period|Mandatory|newly acquir
SSN for at least one monthly submission of the Eligible File so that T-MSIS can associated t
temporary MSIS Identification Number and the social security number.|N/A|FTX00001|FILE-
HEADER-RECORD-FTX|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. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April
or Sept 31st)
4. Value must be equal to or earlier than associated Date File Created
5. Value must be before associated END-OF-TIME-PERIOD
6. Mandatory

FTX010|FTX.001.010|END-OF-TIME-PERIOD|End of Time Period|Mandatory|This value must
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. Value must be 8 characters in the form "CCYYMMD
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
or Sept 31st)
4. Value must be equal to or earlier than associated Date File Created
5. Value must be equal to or after associated START-OF-TIME-PERIOD
6. 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-INDICA
FTX00001|FILE-HEADER-RECORD-FTX|X(1)|11|66|66|1. For production files, value must be to 'P'
2. Value must be in File Status Indicator list (VVL)
3. Value must be 1 character
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 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 in SSN-INDICATOR list (VVL)
2. Value must be 1 character
3. Mandatory

FTX013|FTX.001.013|TOT-REC-CNT|Total Record Count|Mandatory|A count of all records in file except for the file header record. This count will be used as a control total to help assu 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 a positive integer
2. Value must be between 0:99999999999 (inclusive)
3. Value must be 11 digits or less
4. Value must equal the number of records included in the file submission except for the fi header record.
5. Mandatory

FTX014|FTX.001.014|SEQUENCE-NUMBER|Sequence Number|Mandatory|To enable states t sequentially number files, when related, follow-on files are necessary (i.e. update files, rep files). This should begin with 1 for the
original Create submission type and be incremented by one for each Replacement or Upda 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 between 1 ar 9999
2. Value must be equal to the largest of any prior values for the same reporting period and type, plus 1 (i.e. incremented by 1)
3. Value must not contain a pipe symbol
4. Value must be 4 characters or less
5. Mandatory

FTX015|FTX.001.015|STATE-NOTATION |State Notation |Optional|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. Optional

FTX017|FTX.002.017|RECORD-ID|Record ID|Mandatory|The Record ID represents the type
segment being reported. The Record ID communicates how the contents of a given row of
should be interpreted depending on which segment type the Record ID represents. Each t
of segment collects different data elements so each segment type has a distinct layout. Th
first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th
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 exactly 8 characters
2. Value must be in RECORD-ID list (VVL)
3. Value must equal "FTX00002"
4. Mandatory

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 receive
STATE|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(2)|2|9|10|1. Value must be in State Cod
(VVL)
2. Value must be 2 characters
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 recor
within the submission file.|N/A|FTX00002|INDIVIDUAL-CAPITATION-PMPM|9(11)|3|11|21|1. V
must be unique within record segment over all records associated with a given Record ID
2. Value must be 11 digits or less
3. Mandatory

FTX020|FTX.002.020|ICN-ORIG|ICN Orig|Conditional|A unique item control number assigne
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
2. Value must not contain a pipe or asterisk symbols
3. If UNIQUE-TRANSACTION-ID is populated, ICN-ORIG must not be populated
4. Conditional

FTX021|FTX.002.021|ICN-ADJ|ICN Adj|Conditional|A unique claim/transaction number assig
by the state’s payment system that identifies the adjustment claim/transaction for an orig
item control number.|N/A|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(50)|5|72|121|1. Valu
must be 50 characters or less
2. Value must not contain a pipe or asterisk symbols
3. If UNIQUE-TRANSACTION-ID is populated, ICN-ADJ must not be populated
4. Conditional

FTX022|FTX.002.022|UNIQUE-TRANSACTION-ID|Unique Transaction ID|Conditional|For transactions that are not assigned an ICN-ORIG or ICN-ADJ in the MMIS, this unique transac ID distinguishes this transaction from all other transactions in T-MSIS.|N/A|FTX00002| INDIVIDUAL-CAPITATION-PMPM|X(50)|6|122|171|1. Value must be 50 characters or less
2. If ICN-ORIG or ICN-ADJ are populated, UNIQUE-TRANSACTION-ID must not be populated
3. Conditional

FTX023|FTX.002.023|ADJUSTMENT-IND|Adjustment Ind|Conditional|Indicates the type of adjustment record.|ADJUSTMENT-IND|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(1)|7|172
1. Value must be 1 character
2. Value must be in ADJUSTMENT-IND list (VVL)
3. If UNIQUE-TRANSACTION-ID is populated, ADJUSTMENT-IND must not be populated
4. Conditional

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)|8|173|180|1. Value must be 8 characters in form “CCYYMMDD”
2. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April or Sept 31st)
3. Value of the CC component must be in ['19', '20']
4. Mandatory

FTX025|FTX.002.025|PAYMENT-OR-RECOUPMENT-AMOUNT|Payment Or Recoupment Amou 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|9|181|193|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 Eff Date|Conditional|The date a check is issu 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)|10|194|201|1. Value must be 8 digits in the "CCYYMMDD"
2. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April or Sept 31st)
3. Must have an associated Check Number
4. Conditional

FTX027|FTX.002.027|CHECK-NUM|Check Num|Conditional|The check or electronic funds transfer number.|N/A|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(15)|11|202|216|1. Value 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

FTX028|FTX.002.028|PAYER-ID|Payer ID|Mandatory|This is the identifier that corresponds w the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking th action of either making a payment or taking a recoupment, as opposed to the payee who i object of the transaction. The payer is the entity that is either making a payment or recoup a payment from another entity or individual. The payee is the individual or entity that is ei 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)|12|217|246|1. Value must be 30 characters or less
2. If PAYER-ID-TYPE = '01' then PAYER-ID = SUBMITTING-STATE (FTX00001)
3. If PAYER-ID-TYPE = '02' then PAYER-ID = STATE-PLAN-ID-NUM (MCR00002)
4. If PAYER-ID-TYPE = '04' then PAYER-ID = SUBMITTING-STATE-PROV-ID (PRV00002)
5. Mandatory

FTX029|FTX.002.029|PAYER-ID-TYPE|Payer ID Type|Mandatory|This is a qualifier that indica what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted a submitting state code.|PAYER-ID-TYPE|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(2)|13|24 248|1. Value must be 2 characters
2. Value must be in PAYER-ID-TYPE list (VVL)
3. Mandatory

FTX030|FTX.002.030|PAYER-ID-TYPE-OTHER-TEXT|Payer ID Type Other Text|Conditional|Th a description of what the payer ID represents when the payer ID was reported with a paye type of "Other".|N/A|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(100)|14|249|348|1. Value be 100 characters or less
2. PAYER-ID-TYPE must = '95'
3. Conditional

FTX031|FTX.002.031|PAYER-MCR-PLAN-TYPE|Payer MCR Plan Type|Conditional|This describ
the type of managed care plan or care coordination model of the payer, when applicable. T
valid value list is comprised of the standard managed care plan type list from the MCR and
files and a complementary list of care coordination models.|MANAGED-CARE-PLAN-TYPE|
FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(2)|15|349|350|1. Value must be 2 characters
2. Value must be in MANAGED-CARE-PLAN-TYPE list (VVL)
3. If PAYER-ID-TYPE is '02' then PAYER-MCR-PLAN-TYPE must be populated
4. If PAYER-ID-TYPE is not '02' then PAYER-MCR-PLAN-TYPE 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 m
the payer ID was reported with a PAYER-MCR-PLAN-OR-OTHER-TYPE of "Other".|N/A|FTX00
INDIVIDUAL-CAPITATION-PMPM|X(100)|16|351|450|1. Value must be 100 characters or less
2. PAYER-MCR-PLAN-TYPE must = '95'
3. Conditional

FTX033|FTX.002.033|PAYEE-ID|Payee ID|Mandatory|This is the identifier that corresonds w
the payee's role in relation to the Medicaid/CHIP system.The payee is the individual or enti
that is either receiving a payment or having a previous payment recouped. The payee is th
object of the transaction, as opposed to the payer who is the subject taking the action of e
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)|17|451|480|1. Value must be 30 characters or less
2. If PAYEE-ID-TYPE = '01' then PAYEE-ID = SUBMITTING-STATE (FTX00001)
3. If PAYEE-ID-TYPE = '02' then PAYEE-ID = STATE-PLAN-ID-NUM (MCR00002)
4. If PAYEE-ID-TYPE = '04' or '05' then PAYEE-ID = SUBMITTING-STATE-PROV-ID (PRV0002)
6. If PAYEE-ID-TYPE = '06' then PAYEE-ID = PROV-IDENTIFIER where PROV-IDENTIFIER-TYPE
(PRV00005)
7. If PAYEE-ID-TYPE = '07' then PAYEE-ID = INSURANCE-CARRIER-ID-NUM (TPL00006)
8. If PAYER-ID-TYPE = '08' then PAYEE-ID = MSIS-IDENTIFICATION-NUM (ELG00002)
9. Mandatory

FTX034|FTX.002.034|PAYEE-ID-TYPE |Payee ID Type|Mandatory|This is a qualifier that indic
what type of ID the payee ID is. For example, if the payee ID represents a provider ID, then
payee ID type will indicate that the payee ID should be interpreted as a provider ID.|PAYEE
TYPE |FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(2)|18|481|482|1. Value must be 2 chara
2. Value must be in PAYEE-ID-TYPE list (VVL)
3. Mandatory

FTX035|FTX.002.035|PAYEE-ID-TYPE-OTHER-TEXT|Payee ID Type Other Text|Conditional|Th
a description of what the PAYEE-ID-TYPE represents when the PAYEE-ID-TYPE was reported
a payee ID type of "Other".|N/A|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(100)|19|483|5
Value must be 100 characters or less
2. PAYEE-ID-TYPE must = '95'
3. Conditional

FTX036|FTX.002.036|PAYEE-MCR-PLAN-TYPE|Payee MCR Plan Type |Conditional|This descri
the type of managed care plan or care coordination model of the payee, when applicable.
valid value code set is comprised of the standard managed care plan type list from the MC
and ELG files and a complementary list of care coordination models.|MANAGED-CARE-PLAN
TYPE|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(2)|20|583|584|1. Value must be 2 charac
2. Value must be in MANAGED-CARE-PLAN-TYPE list (VVL)
3. If PAYEE-ID-TYPE is '02' or ‘03’ then PAYEE-MCR-PLAN-TYPE must be populated
4. If PAYEE-ID-TYPE is not '02' or ‘03’ then PAYEE-MCR-PLAN-TYPE must not be populated
5. Conditional

FTX037|FTX.002.037|PAYEE-MCR-PLAN-TYPE-OTHER-TEXT|Payee MCR Plan Type Other Tex
Conditional|This is a description of what type of managed care plan or care coordination m
the payee ID was reported with a payee MCR plan or other care coordination model type o
"Other".|N/A|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(100)|21|585|684|1. Value must b
characters or less
2. PAYEE-MCR-PLAN-TYPE must = '95'
3. Conditional

FTX038|FTX.002.038|PAYEE-TAX-ID|Payee Tax ID|Mandatory|This is the identifier that
corresonds 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 recou
The payee is the object of the transaction, as opposed to the payer who is the subject taki
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)|22|685|714|1. Value must be 12 character
less
2. Mandatory

FTX039|FTX.002.039|PAYEE-TAX-ID-TYPE|Payee Tax ID Type|Mandatory|This is a qualifier t
indicates what type of tax ID the payee tax ID is. For example, if the payee tax ID represen
SSN, then the payee tax ID type will indicate that the payee tax ID should be interpreted a
SSN.|PAYEE-TAX-ID-TYPE|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(2)|23|715|716|1. Valu
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 PAYE
TAX-ID-TYPE was reported with a payee tax ID type of "Other".|N/A|FTX00002|INDIVIDUAL-
CAPITATION-PMPM|X(100)|24|717|816|1. Value must be 100 characters or less
2. PAYEE-TAX-ID-TYPE must = '95'
3. Conditional

FTX041|FTX.002.041|CONTRACT-ID|Contract ID|Conditional| Managed care plan contract ID
FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(100)|25|817|916|1. Value must be 100 charac
or less
2. Value must be populated if SUBCAPITATION-IND = '01'
3. Conditional

FTX042|FTX.002.042|MSIS-IDENTIFICATION-NUM|MSIS Identification Number|Mandatory|A s
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 da
distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for informatio
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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-blog/entry/4757
N/A|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(20)|26|917|936|1. Value must be 20 chara
or less
2. Mandatory

FTX043|FTX.002.043|CAPITATION-PERIOD-START-DATE|Capitation Period Start Date|Manda
The date representing the beginning of the period covered by the capitation or sub-capitat
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 no
beneficiary actually receives services during that month).|N/A|FTX00002|INDIVIDUAL-
CAPITATION-PMPM|9(8)|27|937|944|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
or Sept 31st)
3. Value must be before or the same as the associated CAPITATION-PERIOD-END-DATE

4. Value of the CC component must be in ['19', '20']
5. Mandatory

FTX044|FTX.002.044|CAPITATION-PERIOD-END-DATE|Capitation Period End Date|Mandator
date representing the end of the period covered by the capitation or sub-capitation payme
recoupment; for example, the last day of the calendar month of beneficiary enrollment in t
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-PMP
9(8)|28|945|952|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
or Sept 31st)
3. Value must be after or the same as the associated CAPITATION-PERIOD-START-DATE

4. Value of the CC component must be in ['19', '20']
5. Mandatory

FTX045|FTX.002.045|CATEGORY-FOR-FEDERAL-REIMBURSEMENT|Category For Federal
Reimbursement|Conditional|A code to indicate the Federal funding source for the payment
CATEGORY-FOR-FEDERAL-REIMBURSEMENT|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(2)
953|954|1. Value must be 2 characters
2. Value must be in CATEGORY-OF-FEDERAL-REIMBURSEMENT list (VVL)
3. Value must be populated if SUBCAPITATION-IND = '01'
4. Conditional

FTX046|FTX.002.046|MBESCBES-CATEGORY-OF-SERVICE|MBES or CBES Category of Servic
Conditional|A code indicating the category of service for the paid claim. The category of se
is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM
21, 64.9 WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS) that states use to report
expenditures and request federal financial participation.|MBESCBES-CATEGORY-OF-SERVIC
(XIX), MBESCBES-CATEGORY-OF-SERVICE (XXI)|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X
30|955|959|1. Value must be in XIX-MBESCBES-CATEGORY-OF-SERVICE or XXI-MBESCBES-
CATEGORY-OF-SERVICE lists (VVLs)
2. Value must be 5 characters or less
3. Value must be populated if SUBCAPITATION-IND = '01'
4. Conditional

FTX047|FTX.002.047|MBESCBES-FORM|MBES or CBES Form|Conditional|The MBES or CBES
to which the expenditured will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, 64.9
WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS). This should be determined by th
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.|MBESCBE
FORM|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(50)|31|960|1009|1. Value must be 50
characters or less
2. Value must be in MBES or CBES Form list (VVL)
3. Value must be populated if SUBCAPITATION-IND = '01'
4. Conditional

FTX048|FTX.002.048|MBESCBES-FORM-GROUP|MBES or CBES Form Group|Conditional|Indi
group of MBES/CBES forms that this payment applies to.|MBESCBES-FORM-GROUP|FTX000
INDIVIDUAL-CAPITATION-PMPM|X(1)|32|1010|1010|1. Value must be one character
2. Value must be in MBESCBES-FORM-GROUP list (VVL)
3. Value must be populated if SUBCAPITATION-IND = '01'
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 wa
ID number assigned during the state submission and CMS approval process. Waiver IDs sh
actually only be the "core" part of the waiver IDs, without including suffixes for renewals o
amendments.|N/A|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(20)|33|1011|1030|1. Value
be associated with a populated WAIVER-TYPE
2. Value must be 20 characters or less
3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associated Cl
Waiver Type value must be 01 or in [21-30]
4. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation follow
by a period (.), the associated Claim Waiver Type value must be in [02-20, 32, 33]
5. Value must match Eligible Waiver ID (ELG.012.172) for the enrollee for the same time p
6. Conditional

FTX050|FTX.002.050|WAIVER-TYPE|Waiver Type|Conditional|A code for specifying waiver t
under which the eligible individual is covered during the month and receiving services/und
which transaction is submitted.|WAIVER-TYPE|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(
34|1031|1032|1. Value must have a corresponding value in WAIVER-ID

2. Value must be in WAIVER-TYPE list (VVL)
3. Value must be 2 characters
4. Value must match ELIGIBLE-WAIVER-TYPE (ELG.012.173) for the enrollee for the same ti
period
5. Conditional

FTX051|FTX.002.051|FUNDING-CODE|Funding Code|Conditional|A code to indicate the sou
non-federal share funds.
|FUNDING-CODE|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(2)|35|1033|1034|1. Value mu
in FUNDING-CODE list (VVL)
2. Value must be 2 character
3. Value must be populated if SUBCAPITATION-IND = '01'
4. Conditional

FTX052|FTX.002.052|FUNDING-SOURCE-NONFEDERAL-SHARE|Funding Source Nonfederal Share|Mandatory|A code to indicate the type of non-federal share used by the state to fina its expenditure to the provider. In the event of two sources, states are to report the portio which represents the largest proportion not funded by the Federal government.|FUNDING-SOURCE-NONFEDERAL-SHARE|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(2)|36|1035|103
Value must be in FUNDING-SOURCE-NONFEDERAL-SHARE list (VVL)
2. Value must be 2 characters
3. Value must be populated if SUBCAPITATION-IND = '01'
4. Mandatory

FTX053|FTX.002.053|SDP-IND|State Directed Payment Indicator|Mandatory|Indicates whet the financial transaction from an MC plan plan to a provider or other entity is a type of Sta Directed Payment.|SDP-IND|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(1)|37|1037|1037|1
Value must be 1 character
2. Value must be in SPD-IND 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)|38|1038|103
Value must be in SOURCE-LOCATION list (VVL)
2. Value must be 2 characters
3. Mandatory

FTX055|FTX.002.055|SPA-NUMBER|SPA Number|Conditional|State plan amendment (SPA) I 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 th 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 optional entry for specific SPA types|N/A|FTX00002|INDIVIDUAL-CAPITATION-PM X(15)|39|1040|1054|1. Value must be 15 characters or less
2. Conditional

FTX056|FTX.002.056|SUBCAPITATION-IND|Subcapitation Ind|Mandatory|Indicates whethe t 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 be between a sub-capitated entity and another sub-capitated entity or sub-capitated netw provider. |SUBCAPITATION-IND|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(1)|40|1055|105
Value must be 1 characters
2. Value must be in SUBCAPITATION-IND list (VVL)
3. Mandatory

FTX057|FTX.002.057|PAYMENT-CAT-XREF|Payment Cat Xref|Conditional|Cross-reference to applicable payment category in the managed care plan's contract with the state Medicaid/ agency or their fiscal intermediary.|N/A|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(50)|41 1056|1105|1. Value must be 50 characters or less
2. Value must be populated if SUBCAPITATION-IND = '01'
3. Conditional

FTX058|FTX.002.058|RATE-CELL-DESCRIPTION-TEXT|Rate Cell Description Text|Conditional is the description of the rate cell from the rate setting process that applies to the capitatio payment. For example, a rate cell may represent the monthly capitation rate paid for adul with chronic conditions who live in a rural area. If the rate paid for this capitation payment based on the rate cell for adults with chronic conditions who live in a rural area, then the r cell description could be "Adults with chronic conditions living in a rural area."|N/A|FTX000 INDIVIDUAL-CAPITATION-PMPM|X(100)|42|1106|1205|1. Value must be 100 characters or le
2. Conditional

FTX059|FTX.002.059|EXPENDITURE-AUTHORITY-TYPE|Expenditure Authority Type|Condition This is the federal statute or regulation under which the expenditure is authorized/justified federal statute or regulation is usually referenced in either the Medicaid or CHIP State Plan waiver documentation. For waivers, do not reference the federal statute or regulation bein waived by the waiver. For waivers, referring to the waiver authority is sufficient. If the fed statute or regulation is not available in the list of valid values, choose the value for "Other" report the authority in the Expenditure Authority Type Text.|EXPENDITURE-AUTHORITY-TYP FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(2)|43|1206|1207|1. Value must be 2 character
2. Value must be in EXPENDITURE-AUTHORITY-TYPE list (VVL)
3. Value must be populated if SUBCAPITATION-IND = '01'
4. Conditional

FTX060|FTX.002.060|EXPENDITURE-AUTHORITY-TYPE-OTHER-TEXT|Expenditure Authority T Other Text|Conditional|This field is only to be used if EXPENDITURE-AUTHORITY-TYPE "Othe valid value is selected. Enter a specific text description of the "Other" expenditure authori type.|N/A|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(100)|44|1208|1307|1. Value must be characters or less
2. EXPENDITURE-AUTHORITY-TYPE must = '95'
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)|45|1308|1807|1. Value must be 500 characters or le
2. Conditional

FTX062|FTX.002.062|STATE-NOTATION|State Notation |Optional|A free text field for the submitting state to enter whatever information it chooses.|N/A|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(500)|46|1808|2307|1. Value must be 500 characters or less
2. Value must not contain a pipe or asterisk symbols
3. Optional

FTX064|FTX.003.064|RECORD-ID|Record ID|Mandatory|The Record ID represents the type segment being reported. The Record ID communicates how the contents of a given row of should be interpreted depending on which segment type the Record ID represents. Each t of segment collects different data elements so each segment type has a distinct layout. Th first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th 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 b exactly 8 characters
2. Value must be in RECORD-ID list (VVL)
3. Value must equal "FTX00003"
4. Mandatory

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 receiv STATE|FTX00003|INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT|X(2)|2|9|10|1. Value must be in State Code list (VVL)
2. Value must be 2 characters
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 recor within the submission file.|N/A|FTX00003|INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYM 9(11)|3|11|21|1. Value must be unique within record segment over all records associated w given Record ID
2. Value must be 11 digits or less
3. Mandatory

FTX067|FTX.003.067|ICN-ORIG|ICN Orig|Conditional|A unique item control number assigne 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 mu 50 characters or less
2. Value must not contain a pipe or asterisk symbols
3. If UNIQUE-TRANSACTION-ID is populated, ICN-ORIG must not be populated
4. Conditional

FTX068|FTX.003.068|ICN-ADJ|ICN Adj|Conditional|A unique claim/transaction number assig
by the state’s payment system that identifies the adjustment claim/transaction for an orig
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 UNIQUE-TRANSACTION-ID is populated, ICN-ADJ must not be populated
4. Conditional

FTX069|FTX.003.069|UNIQUE-TRANSACTION-ID|Unique Transaction ID|Conditional|For
transactions that are not assigned an ICN-ORIG or ICN-ADJ in the MMIS, this unique transac
ID distinguishes this transaction from all other transactions in T-MSIS.|N/A|FTX00003|
INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT|X(50)|6|122|171|1. Value must be 50
characters or less
2. If ICN-ORIG or ICN-ADJ are populated, UNIQUE-TRANSACTION-ID must not be populated
3. Conditional

FTX070|FTX.003.070|ADJUSTMENT-IND|Adjustment Ind|Conditional|Indicates the type of
adjustment record.|ADJUSTMENT-IND|FTX00003|INDIVIDUAL-HEALTH-INSURANCE-PREMIUM
PAYMENT|X(1)|7|172|172|1. Value must be 1 character
2. Value must be in ADJUSTMENT-IND list (VVL)
3. If UNIQUE-TRANSACTION-ID is populated, ADJUSTMENT-IND must not be populated
4. Conditional

FTX071|FTX.003.071|PAYMENT-OR-RECOUPMENT-DATE|Payment Date|Mandatory|The date
the payment or recoupment was executed by the payer. |N/A|FTX00003|INDIVIDUAL-HEALT
INSURANCE-PREMIUM-PAYMENT|9(8)|8|173|180|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
or Sept 31st)
3. Value of the CC component must be in ['19', '20']
4. Mandatory

FTX072|FTX.003.072|PAYMENT-AMOUNT|Payment Amount|Mandatory|The dollar amount b
paid to the payee.|N/A|FTX00003|INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT|
S9(11)V99|9|181|193|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 Eff Date|Conditional|The date a check is issu
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)|10|194|201|1. Value r
be 8 digits in the form "CCYYMMDD"
2. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April
or Sept 31st)
3. Must have an associated Check Number
4. Conditional

FTX074|FTX.003.074|CHECK-NUM|Check Num|Conditional|The check or electronic funds
transfer number.|N/A|FTX00003|INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT|X(15
202|216|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

FTX075|FTX.003.075|PAYER-ID|Payer ID|Mandatory|This is the identifier that corresponds w
the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking th
action of either making a payment or taking a recoupment, as opposed to the payee who i
object of the transaction. The payer is the entity that is either making a payment or recoup
a payment from another entity or individual. The payee is the individual or entity that is ei
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)|12|217|246|1. Value must be 30 characters
less
2. If PAYER-ID-TYPE = '01' then PAYER-ID = SUBMITTING-STATE (FTX00001)
3. Mandatory

FTX076|FTX.003.076|PAYER-ID-TYPE|Payer ID Type|Mandatory|This is a qualifier that indica
what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid
CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted a
submitting state code.|PAYER-ID-TYPE|FTX00003|INDIVIDUAL-HEALTH-INSURANCE-PREMIU
PAYMENT|X(2)|13|247|248|1. Value must be 2 characters
2. Value must be in PAYER-ID-TYPE list (VVL)
3. Mandatory

FTX077|FTX.003.077|PAYER-ID-TYPE-OTHER-TEXT|Payer ID Type Other Text|Conditional|Th
a description of what the payer ID represents when the payer ID was reported with a paye
type of "Other".|N/A|FTX00003|INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT|X(100
249|348|1. Value must be 100 characters or less
2. PAYER-ID-TYPE must = '95'
3. Conditional

FTX078|FTX.003.078|PAYEE-ID|Payee ID|Mandatory|This is the identifier that corresonds w
the payee's role in relation to the Medicaid/CHIP system.The payee is the individual or enti
that is either receiving a payment or having a previous payment recouped. The payee is th
object of the transaction, as opposed to the payer who is the subject taking the action of e
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)|15|349|378|1. Value must be 30 characters
less
2. If PAYEE-ID-TYPE = '01' then PAYEE-ID = SUBMITTING-STATE (FTX00001)
3. If PAYEE-ID-TYPE = '02' then PAYEE-ID = STATE-PLAN-ID-NUM (MCR00002)
4. If PAYEE-ID-TYPE = '04' or '05' then PAYEE-ID = SUBMITTING-STATE-PROV-ID (PRV0002)
6. If PAYEE-ID-TYPE = '06' then PAYEE-ID = PROV-IDENTIFIER where PROV-IDENTIFIER-TYPE
(PRV00005)
7. If PAYEE-ID-TYPE = '07' then PAYEE-ID = INSURANCE-CARRIER-ID-NUM (TPL00006)
8. If PAYER-ID-TYPE = '08' then PAYEE-ID = MSIS-IDENTIFICATION-NUM (ELG00002)
9. Mandatory

FTX079|FTX.003.079|PAYEE-ID-TYPE |Payee ID Type|Mandatory|This is a qualifier that indic
what type of ID the payee ID is. For example, if the payee ID represents a provider ID, ther
payee ID type will indicate that the payee ID should be interpreted as a provider ID.|PAYEE
TYPE |FTX00003|INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT|X(2)|16|379|380|1. V
must be 2 characters
2. Value must be in PAYEE-ID-TYPE list (VVL)
3. Mandatory

FTX080|FTX.003.080|PAYEE-ID-TYPE-OTHER-TEXT|Payee ID Type Other Text|Conditional|Th
a description of what the PAYEE-ID-TYPE represents when the PAYEE-ID-TYPE was reported
a payee ID type of "Other".|N/A|FTX00003|INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-
PAYMENT|X(100)|17|381|480|1. Value must be 100 characters or less
2. PAYEE-ID-TYPE must = '95'
3. Conditional

FTX081|FTX.003.081|PAYEE-TAX-ID|Payee Tax ID|Mandatory|This is the identifier that corresonds 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 recou The payee is the object of the transaction, as opposed to the payer who is the subject taki 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)|18|481|510|1. Value must be 12 characters or less
2. Mandatory

FTX082|FTX.003.082|PAYEE-TAX-ID-TYPE|Payee Tax ID Type|Mandatory|This is a qualifier t indicates what type of tax ID the payee tax ID is. For example, if the payee tax ID represer SSN, then the payee tax ID type will indicate that the payee tax ID should be interpreted a SSN.|PAYEE-TAX-ID-TYPE|FTX00003|INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT|X 19|511|512|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 PAYE TAX-ID-TYPE was reported with a payee tax ID type of "Other".|N/A|FTX00003|INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT|X(100)|20|513|612|1. Value must be 100 charact less
2. PAYEE-TAX-ID-TYPE must = '95'
3. Conditional

FTX084|FTX.003.084|INSURANCE-CARRIER-ID-NUM|Insurance Carrier ID Num|Mandatory| The state-assigned identification number of the Third Party Liability (TPL) Entity.|N/A|FTX0 INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT|X(12)|21|613|624|1. Value must be 1 characters or less
2. Value must not contain a pipe or asterisk symbols
3. Mandatory

FTX085|FTX.003.085|INSURANCE-PLAN-ID|Insurance Plan ID|Conditional|The ID number iss 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)|22|625|644|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 s
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 da
distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for informatio
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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-blog/entry/4757
N/A|FTX00003|INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT|X(20)|23|645|664|1. V
must be 20 characters or less
2. Mandatory

FTX087|FTX.003.087|MEMBER-ID|Member ID|Conditional|Member identification number as
appears on the card issued by the TPL insurance carrier.|N/A|FTX00003|INDIVIDUAL-HEALT
INSURANCE-PREMIUM-PAYMENT|X(20)|24|665|684|1. Value must be 20 characters or less
2. Conditional

FTX088|FTX.003.088|PREMIUM-PERIOD-START-DATE|Premium Period Start Date|Mandatory
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 th
insurance plan that the payment is intended to cover (whether or not the beneficiary actua
receives services during that month).|N/A|FTX00003|INDIVIDUAL-HEALTH-INSURANCE-
PREMIUM-PAYMENT|9(8)|25|685|692|1. Value must be 8 characters in the form “CCYYMMD

2. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April
or Sept 31st)
3. Value must be before or the same as the associated PREMIUM-PERIOD-END-DATE

4. Value of the CC component must be in ['19', '20']
5. Mandatory

FTX089|FTX.003.089|PREMIUM-PERIOD-END-DATE|Premium Period End Date|Mandatory|Th
date representing the end of the period covered by the premium payment or recoupment;
example, the last day of the calendar month of beneficiary coverage in the insurance plan
the payment is intended to cover (whether or not the beneficiary actually receives service
during that month).|N/A|FTX00003|INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT|9(
26|693|700|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
or Sept 31st)
3. Value must be after or the same as the associated PREMIUM-PERIOD-START-DATE

4. Value of the CC component must be in ['19', '20']
5. 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)|27|701|702|1. Value must be 2 characters
2. Value must be in CATEGORY-OF-FEDERAL-REIMBURSEMENT list (VVL)
3. Mandatory

FTX091|FTX.003.091|MBESCBES-CATEGORY-OF-SERVICE|MBES or CBES Category of Servic
Mandatory|A code indicating the category of service for the paid claim. The category of se
is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM
21, 64.9 WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS) that states use to report
expenditures and request federal financial participation.|MBESCBES-CATEGORY-OF-SERVIC
(XIX), MBESCBES-CATEGORY-OF-SERVICE (XXI)|FTX00003|INDIVIDUAL-HEALTH-INSURANCE
PREMIUM-PAYMENT|X(5)|28|703|707|1. Value must be in XIX-MBESCBES-CATEGORY-OF-SERVICE or XXI-MBESCBES-CATEGORY-OF-SERVICE lists (VVLs)
2. Value must be 5 characters or less
3. Mandatory

FTX092|FTX.003.092|MBESCBES-FORM|MBES or CBES Form|Mandatory|The MBES or CBES
to which the expenditured will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, 64.9
WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS). This should be determined by th
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.|MBESCBE
FORM|FTX00003|INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT|X(50)|29|708|757|1.
Value must be 50 characters or less
2. Value must be in MBES or CBES Form list (VVL)
3. Mandatory

FTX093|FTX.003.093|MBESCBES-FORM-GROUP|MBES or CBES Form Group|Mandatory|Indic
group of MBES/CBES forms that this payment applies to.|MBESCBES-FORM-GROUP|FTX000
INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT|X(1)|30|758|758|1. Value must be on
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 wa ID number assigned during the state submission and CMS approval process. Waiver IDs sh actually only be the "core" part of the waiver IDs, without including suffixes for renewals o amendments.|N/A|FTX00003|INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT|X(20)|3 759|778|1. Value must be associated with a populated WAIVER-TYPE
2. Value must be 20 characters or less
3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associated Cl Waiver Type value must be 01 or in [21-30]
4. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation follow by a period (.), the associated Claim Waiver Type value must be in [02-20, 32, 33]
5. Value must match Eligible Waiver ID (ELG.012.172) for the enrollee for the same time p
6. Conditional

FTX095|FTX.003.095|WAIVER-TYPE|Waiver Type|Conditional|A code for specifying waiver t under which the eligible individual is covered during the month and receiving services/und which transaction is submitted.|WAIVER-TYPE|FTX00003|INDIVIDUAL-HEALTH-INSURANCE- PREMIUM-PAYMENT|X(2)|32|779|780|1. Value must have a corresponding value in WAIVER-

2. Value must be in WAIVER-TYPE list (VVL)
3. Value must be 2 characters
4. Value must match ELIGIBLE-WAIVER-TYPE (ELG.012.173) for the enrollee for the same ti period
5. Conditional

FTX096|FTX.003.096|FUNDING-CODE|Funding Code|Mandatory|A code to indicate the sour non-federal share funds.
|FUNDING-CODE|FTX00003|INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT|X(2)|33|7 782|1. Value must be in FUNDING-CODE list (VVL)
2. Value must be 2 character
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 fina its expenditure to the provider. In the event of two sources, states are to report the portio which represents the largest proportion not funded by the Federal government.|FUNDING- SOURCE-NONFEDERAL-SHARE|FTX00003|INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYM X(2)|34|783|784|1. Value must be in FUNDING-SOURCE-NONFEDERAL-SHARE list (VVL)
2. Value must be 2 characters
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-PAYM
X(2)|35|785|786|1. Value must be in SOURCE-LOCATION list (VVL)
2. Value must be 2 characters
3. Mandatory

FTX099|FTX.003.099|SPA-NUMBER|SPA Number|Conditional|State plan amendment (SPA) I
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 th
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 optional entry for specific SPA types|N/A|FTX00003|INDIVIDUAL-HEALTH-INSURA
PREMIUM-PAYMENT|X(15)|36|787|801|1. Value must be 15 characters or less
2. Conditional

FTX100|FTX.003.100|EXPENDITURE-AUTHORITY-TYPE|Expenditure Authority Type|Mandato
This is the federal statute or regulation under which the expenditure is authorized/justified
federal statute or regulation is usually referenced in either the Medicaid or CHIP State Plan
waiver documentation. For waivers, do not reference the federal statute or regulation bein
waived by the waiver. For waivers, referring to the waiver authority is sufficient. If the fed
statute or regulation is not available in the list of valid values, choose the value for "Other"
report the authority in the Expenditure Authority Type Text.|EXPENDITURE-AUTHORITY-TYP
FTX00003|INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT|X(2)|37|802|803|1. Value m
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 T
Other Text|Conditional|This field is only to be used if EXPENDITURE-AUTHORITY-TYPE "Othe
valid value is selected. Enter a specific text description of the "Other" expenditure authori
type.|N/A|FTX00003|INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT|X(100)|38|804|9
Value must be 100 characters or less
2. EXPENDITURE-AUTHORITY-TYPE must = '95'
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)|39|904|1403|1. Value must be
characters or less
2. Conditional

FTX103|FTX.003.103|STATE-NOTATION |State Notation |Optional|A free text field for the submitting state to enter whatever information it chooses.|N/A|FTX00003|INDIVIDUAL-HEA INSURANCE-PREMIUM-PAYMENT|X(500)|40|1404|1903|1. Value must be 500 characters or
2. Value must not contain a pipe or asterisk symbols
3. Optional

FTX105|FTX.004.105|RECORD-ID|Record ID|Mandatory|The Record ID represents the type segment being reported. The Record ID communicates how the contents of a given row of should be interpreted depending on which segment type the Record ID represents. Each t of segment collects different data elements so each segment type has a distinct layout. Th first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).|RECORD-I FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X(8)|1|1|8|1. Value must be exactly 8 characters
2. Value must be in RECORD-ID list (VVL)
3. Value must equal "FTX00004"
4. Mandatory

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 receiv STATE|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X(2)|2|9|10|1. Value must be in Code list (VVL)
2. Value must be 2 characters
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 recor within the submission file.|N/A|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|9(11)|3|1 21|1. Value must be unique within record segment over all records associated with a given Record ID
2. Value must be 11 digits or less
3. Mandatory

FTX108|FTX.004.108|ICN-ORIG|ICN Orig|Conditional|A unique item control number assigne 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. If UNIQUE-TRANSACTION-ID is populated, ICN-ORIG must not be populated
4. Conditional

FTX109|FTX.004.109|ICN-ADJ|ICN Adj|Conditional|A unique claim/transaction number assig
by the state’s payment system that identifies the adjustment claim/transaction for an orig
item control number.|N/A|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X(50)|5|72|12
Value must be 50 characters or less
2. Value must not contain a pipe or asterisk symbols
3. If UNIQUE-TRANSACTION-ID is populated, ICN-ADJ must not be populated
4. Conditional

FTX110|FTX.004.110|UNIQUE-TRANSACTION-ID|Unique Transaction ID|Conditional|For
transactions that are not assigned an ICN-ORIG or ICN-ADJ in the MMIS, this unique transac
ID distinguishes this transaction from all other transactions in T-MSIS.|N/A|FTX00004|GROU
INSURANCE-PREMIUM-PAYMENT|X(50)|6|122|171|1. Value must be 50 characters or less
2. If ICN-ORIG or ICN-ADJ are populated, UNIQUE-TRANSACTION-ID must not be populated
3. Conditional

FTX111|FTX.004.111|ADJUSTMENT-IND|Adjustment Ind|Conditional|Indicates the type of
adjustment record.|ADJUSTMENT-IND|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X
172|172|1. Value must be 1 character
2. Value must be in ADJUSTMENT-IND list (VVL)
3. If UNIQUE-TRANSACTION-ID is populated, ADJUSTMENT-IND must not be populated
4. Conditional

FTX112|FTX.004.112|PAYMENT-DATE|Payment Date|Mandatory|The date that the payment
recoupment was executed by the payer. |N/A|FTX00004|GROUP-INSURANCE-PREMIUM-
PAYMENT|9(8)|8|173|180|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
or Sept 31st)
3. Value of the CC component must be in ['19', '20']
4. Mandatory

FTX113|FTX.004.113|PAYMENT-AMOUNT|Payment Amount|Mandatory|The dollar amount b
paid to the payee.|N/A|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|S9(11)V99|9|181
193|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 Eff Date|Conditional|The date a check is issu
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)|10|194|201|1. Value must be 8 dig
the form "CCYYMMDD"
2. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April
or Sept 31st)
3. Must have an associated Check Number
4. Conditional

FTX115|FTX.004.115|CHECK-NUM|Check Num|Conditional|The check or electronic funds
transfer number.|N/A|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X(15)|11|202|216
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

FTX116|FTX.004.116|PAYER-ID|Payer ID|Mandatory|This is the identifier that corresponds w
the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking th
action of either making a payment or taking a recoupment, as opposed to the payee who i
object of the transaction. The payer is the entity that is either making a payment or recoup
a payment from another entity or individual. The payee is the individual or entity that is ei
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)|12|217|246|1. Value must be 30 characters or less
2. If PAYER-ID-TYPE = '01' then PAYER-ID = SUBMITTING-STATE (FTX00001)
3. Mandatory

FTX117|FTX.004.117|PAYER-ID-TYPE|Payer ID Type|Mandatory|This is a qualifier that indica
what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid
CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted a
submitting state code.|PAYER-ID-TYPE|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X
13|247|248|1. Value must be 2 characters
2. Value must be in PAYER-ID-TYPE list (VVL)
3. Mandatory

FTX118|FTX.004.118|PAYER-ID-TYPE-OTHER-TEXT|Payer ID Type Other Text|Conditional|Th
a description of what the payer ID represents when the payer ID was reported with a paye
type of "Other".|N/A|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X(100)|14|249|348
Value must be 100 characters or less
2. PAYER-ID-TYPE must = '95'
3. Conditional

FTX119|FTX.004.119|PAYEE-ID|Payee ID|Mandatory|This is the identifier that corresonds w
the payee's role in relation to the Medicaid/CHIP system.The payee is the individual or enti
that is either receiving a payment or having a previous payment recouped. The payee is th
object of the transaction, as opposed to the payer who is the subject taking the action of e
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)|15|349|378|1. Value must be 30 characters or less
2. If PAYEE-ID-TYPE = '01' then PAYEE-ID = SUBMITTING-STATE (FTX00001)
3. If PAYEE-ID-TYPE = '02' then PAYEE-ID = STATE-PLAN-ID-NUM (MCR00002)
4. If PAYEE-ID-TYPE = '04' or '05' then PAYEE-ID = SUBMITTING-STATE-PROV-ID (PRV0002)
6. If PAYEE-ID-TYPE = '06' then PAYEE-ID = PROV-IDENTIFIER where PROV-IDENTIFIER-TYPE
(PRV00005)
7. If PAYEE-ID-TYPE = '07' then PAYEE-ID = INSURANCE-CARRIER-ID-NUM (TPL00006)
8. If PAYER-ID-TYPE = '08' then PAYEE-ID = MSIS-IDENTIFICATION-NUM (ELG00002)
9. Mandatory

FTX120|FTX.004.120|PAYEE-ID-TYPE |Payee ID Type|Mandatory|This is a qualifier that indic
what type of ID the payee ID is. For example, if the payee ID represents a provider ID, ther
payee ID type will indicate that the payee ID should be interpreted as a provider ID.|PAYEE
TYPE |FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X(2)|16|379|380|1. Value must be
characters
2. Value must be in PAYEE-ID-TYPE list (VVL)
3. Mandatory

FTX121|FTX.004.121|PAYEE-ID-TYPE-OTHER-TEXT|Payee ID Type Other Text|Conditional|Th
a description of what the PAYEE-ID-TYPE represents when the PAYEE-ID-TYPE was reported
a payee ID type of "Other".|N/A|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X(100)|
381|480|1. Value must be 100 characters or less
2. PAYEE-ID-TYPE must = '95'
3. Conditional

FTX122|FTX.004.122|PAYEE-TAX-ID|Payee Tax ID|Mandatory|This is the identifier that
corresonds 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 recou
The payee is the object of the transaction, as opposed to the payer who is the subject taki
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)|18|481|510|1. Value must be 12
characters or less
2. Mandatory

FTX123|FTX.004.123|PAYEE-TAX-ID-TYPE|Payee Tax ID Type|Mandatory|This is a qualifier t
indicates what type of tax ID the payee tax ID is. For example, if the payee tax ID represer
SSN, then the payee tax ID type will indicate that the payee tax ID should be interpreted a
SSN.|PAYEE-TAX-ID-TYPE|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X(2)|19|511|5
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 PAYE
TAX-ID-TYPE was reported with a payee tax ID type of "Other".|N/A|FTX00004|GROUP-
INSURANCE-PREMIUM-PAYMENT|X(100)|20|513|612|1. Value must be 100 characters or les
2. PAYEE-TAX-ID-TYPE must = '95'
3. Conditional

FTX125|FTX.004.125|INSURANCE-CARRIER-ID-NUM|Insurance Carrier ID Num|Mandatory|
The state-assigned identification number of the Third Party Liability (TPL) Entity.|N/A|FTX0
GROUP-INSURANCE-PREMIUM-PAYMENT|X(12)|21|613|624|1. Value must be 12 characters
less
2. Value must not contain a pipe or asterisk symbols
3. Mandatory

FTX126|FTX.004.126|INSURANCE-PLAN-ID|Insurance Plan ID|Conditional|The ID number iss
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)|22|625|644|1. Value must not contain a pipe
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 iden
MSIS Identification Numbers are a unique “key” value used to maintain referential integrity
data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for informatio
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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-blog/entry/4757
N/A|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X(20)|23|645|664|1. Value must be
characters or less
2. Conditional
3. If value is not populated, then SSN must be populated.

FTX128|FTX.004.128|SSN|SSN|Conditional|The eligible individual's social security number. 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, t MSIS Identification Number field should be populated |N/A|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X(9)|24|665|673|1. Value must be 9-digit number
2. For any individual, the value must be the same over all segment effective and end date
3. (SSN State) if associated SSN Indicator (ELG.001.012) value is coded as "1", then value 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 va must not equal MSIS Identification Number (ELG.002.019)

FTX129|FTX.004.129|MEMBER-ID|Member ID|Conditional|Member identification number as appears on the card issued by the TPL insurance carrier.|N/A|FTX00004|GROUP-INSURANC PREMIUM-PAYMENT|X(20)|25|674|693|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 he insurance policy.|N/A|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X(16)|26|694|709 Value must not contain a pipe symbol
2. Value must be 16 characters or less
3. Conditional

FTX131|FTX.004.131|POLICY-OWNER-CODE|Policy Owner Code|Conditional|This code ident the relationship of the policy holder to the Medicaid/CHIP beneficiary.|POLICY-OWNER-COD FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X(2)|27|710|711|1. Value must be 2 characters
2. Value must be in VVL
3. Conditional

FTX132|FTX.004.132|PREMIUM-PERIOD-START-DATE|Premium Period Start Date|Mandatory 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 th insurance plan that the payment is intended to cover (whether or not the beneficiary actua receives services during that month).|N/A|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMEI 9(8)|28|712|719|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 or Sept 31st)
3. Value must be before or the same as the associated PREMIUM-PERIOD-END-DATE

4. Value of the CC component must be in ['19', '20']
5. Mandatory

FTX133|FTX.004.133|PREMIUM-PERIOD-END-DATE|Premium Period End Date|Mandatory|Th
date representing the end of the period covered by the premium payment or recoupment;
example, the last day of the calendar month of beneficiary coverage in the insurance plan
the payment is intended to cover (whether or not the beneficiary actually receives service
during that month).|N/A|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|9(8)|29|720|72
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
or Sept 31st)
3. Value must be after or the same as the associated PREMIUM-PERIOD-START-DATE

4. Value of the CC component must be in ['19', '20']
5. 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-PAYM
X(2)|30|728|729|1. Value must be 2 characters
2. Value must be in CATEGORY-OF-FEDERAL-REIMBURSEMENT list (VVL)
3. Value must be populated if POLICY-OWNER-CODE = '01'
4. Conditional

FTX135|FTX.004.135|MBESCBES-CATEGORY-OF-SERVICE|MBES or CBES Category of Servic
Conditional|A code indicating the category of service for the paid claim. The category of se
is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM
21, 64.9 WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS) that states use to report
expenditures and request federal financial participation.|MBESCBES-CATEGORY-OF-SERVIC
(XIX), MBESCBES-CATEGORY-OF-SERVICE (XXI)|FTX00004|GROUP-INSURANCE-PREMIUM-
PAYMENT|X(5)|31|730|734|1. Value must be in XIX-MBESCBES-CATEGORY-OF-SERVICE or X
MBESCBES-CATEGORY-OF-SERVICE lists (VVLs)
2. Value must be 5 characters or less
3. Value must be populated if POLICY-OWNER-CODE = '01'
4. Conditional

FTX136|FTX.004.136|MBESCBES-FORM|MBES or CBES Form|Conditional|The MBES or CBES
to which the expenditured will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, 64.9
WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS). This should be determined by th
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.|MBESCBE
FORM|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X(50)|32|735|784|1. Value must
characters or less
2. Value must be in MBES or CBES Form list (VVL)
3. Value must be populated if POLICY-OWNER-CODE = '01'
4. Conditional

FTX137|FTX.004.137|MBESCBES-FORM-GROUP|MBES or CBES Form Group|Conditional|Indi
group of MBES/CBES forms that this payment applies to.|MBESCBES-FORM-GROUP|FTX000
GROUP-INSURANCE-PREMIUM-PAYMENT|X(1)|33|785|785|1. Value must be one character
2. Value must be in MBESCBES-FORM-GROUP list (VVL)
3. Value must be populated if POLICY-OWNER-CODE = '01'
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 wa
ID number assigned during the state submission and CMS approval process. Waiver IDs sh
actually only be the "core" part of the waiver IDs, without including suffixes for renewals o
amendments.|N/A|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X(20)|34|786|805|1.
Value must be associated with a populated WAIVER-TYPE
2. Value must be 20 characters or less
3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associated Cl
Waiver Type value must be 01 or in [21-30]
4. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation follow
by a period (.), the associated Claim Waiver Type value must be in [02-20, 32, 33]
5. Value must match Eligible Waiver ID (ELG.012.172) for the enrollee for the same time p
6. Conditional

FTX139|FTX.004.139|WAIVER-TYPE|Waiver Type|Conditional|A code for specifying waiver t
under which the eligible individual is covered during the month and receiving services/und
which transaction is submitted.|WAIVER-TYPE|FTX00004|GROUP-INSURANCE-PREMIUM-
PAYMENT|X(2)|35|806|807|1. Value must have a corresponding value in WAIVER-ID

2. Value must be in WAIVER-TYPE list (VVL)
3. Value must be 2 characters
4. Value must match ELIGIBLE-WAIVER-TYPE (ELG.012.173) for the enrollee for the same ti
period
5. Conditional

FTX140|FTX.004.140|FUNDING-CODE|Funding Code|Conditional|A code to indicate the sou
non-federal share funds.
|FUNDING-CODE|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X(2)|36|808|809|1. Val
must be in FUNDING-CODE list (VVL)
2. Value must be 2 character
3. If FTX0004, then conditionally mandatory if the POLICY-OWNER-CODE = '01'
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 fina its expenditure to the provider. In the event of two sources, states are to report the portio which represents the largest proportion not funded by the Federal government.|FUNDING-SOURCE-NONFEDERAL-SHARE|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X(2)|37|8 811|1. Value must be in FUNDING-SOURCE-NONFEDERAL-SHARE list (VVL)
2. Value must be 2 characters
3. Value must be populated if POLICY-OWNER-CODE = '01'
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)|38| 813|1. Value must be in SOURCE-LOCATION list (VVL)
2. Value must be 2 characters
3. Mandatory

FTX143|FTX.004.143|SPA-NUMBER|SPA Number|Conditional|State plan amendment (SPA) I 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 th 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 optional entry for specific SPA types|N/A|FTX00004|GROUP-INSURANCE-PREMIU PAYMENT|X(15)|39|814|828|1. Value must be 15 characters or less
2. Conditional

FTX144|FTX.004.144|EXPENDITURE-AUTHORITY-TYPE|Expenditure Authority Type|Condition This is the federal statute or regulation under which the expenditure is authorized/justified federal statute or regulation is usually referenced in either the Medicaid or CHIP State Plan waiver documentation. For waivers, do not reference the federal statute or regulation bein waived by the waiver. For waivers, referring to the waiver authority is sufficient. If the fed statute or regulation is not available in the list of valid values, choose the value for "Other" report the authority in the Expenditure Authority Type Text.|EXPENDITURE-AUTHORITY-TYP FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X(2)|40|829|830|1. Value must be 2 characters
2. Value must be in EXPENDITURE-AUTHORITY-TYPE list (VVL)
3. Value must be populated if POLICY-OWNER-CODE = '01'
4. Conditional

FTX145|FTX.004.145|EXPENDITURE-AUTHORITY-TYPE-OTHER-TEXT|Expenditure Authority T
Other Text|Conditional|This field is only to be used if EXPENDITURE-AUTHORITY-TYPE "Othe
valid value is selected. Enter a specific text description of the "Other" expenditure authori
type.|N/A|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X(100)|41|831|930|1. Value m
be 100 characters or less
2. EXPENDITURE-AUTHORITY-TYPE must = '95'
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|GROU
INSURANCE-PREMIUM-PAYMENT|X(500)|42|931|1430|1. Value must be 500 characters or le
2. Conditional

FTX147|FTX.004.147|STATE-NOTATION |State Notation |Optional|A free text field for the
submitting state to enter whatever information it chooses.|N/A|FTX00004|GROUP-INSURAN
PREMIUM-PAYMENT|X(500)|43|1431|1930|1. Value must be 500 characters or less
2. Value must not contain a pipe or asterisk symbols
3. Optional

FTX149|FTX.005.149|RECORD-ID|Record ID|Mandatory|The Record ID represents the type
segment being reported. The Record ID communicates how the contents of a given row of
should be interpreted depending on which segment type the Record ID represents. Each t
of segment collects different data elements so each segment type has a distinct layout. Th
first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th
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 exactly 8 characters
2. Value must be in RECORD-ID list (VVL)
3. Value must equal "FTX00005"
4. Mandatory

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 receiv
STATE|FTX00005|COST-SHARING-OFFSET|X(2)|2|9|10|1. Value must be in State Code list (V
2. Value must be 2 characters
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 recor within the submission file.|N/A|FTX00005|COST-SHARING-OFFSET|9(11)|3|11|21|1. Value m be unique within record segment over all records associated with a given Record ID
2. Value must be 11 digits or less
3. Mandatory

FTX152|FTX.005.152|ICN-ORIG|ICN Orig|Conditional|A unique item control number assigne 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. If UNIQUE-TRANSACTION-ID is populated, ICN-ORIG must not be populated
4. Conditional

FTX153|FTX.005.153|ICN-ADJ|ICN Adj|Conditional|A unique claim/transaction number assig by the state’s payment system that identifies the adjustment claim/transaction for an orig item control number.|N/A|FTX00005|COST-SHARING-OFFSET|X(50)|5|72|121|1. Value must 50 characters or less
2. Value must not contain a pipe or asterisk symbols
3. If UNIQUE-TRANSACTION-ID is populated, ICN-ADJ must not be populated
4. Conditional

FTX154|FTX.005.154|UNIQUE-TRANSACTION-ID|Unique Transaction ID|Conditional|For transactions that are not assigned an ICN-ORIG or ICN-ADJ in the MMIS, this unique transac ID distinguishes this transaction from all other transactions in T-MSIS.|N/A|FTX00005|COST SHARING-OFFSET|X(50)|6|122|171|1. Value must be 50 characters or less
2. If ICN-ORIG or ICN-ADJ are populated, UNIQUE-TRANSACTION-ID must not be populated
3. Conditional

FTX155|FTX.005.155|ADJUSTMENT-IND|Adjustment Ind|Conditional|Indicates the type of adjustment record.|ADJUSTMENT-IND|FTX00005|COST-SHARING-OFFSET|X(1)|7|172|172|1. Value must be 1 character
2. Value must be in ADJUSTMENT-IND list (VVL)
3. If UNIQUE-TRANSACTION-ID is populated, ADJUSTMENT-IND must not be populated
4. Conditional

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)|8|173|180|1. Value must be 8 characters in the for “CCYYMMDD”
2. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April or Sept 31st)
3. Value of the CC component must be in ['19', '20']
4. Mandatory

FTX157|FTX.005.157|PAYMENT-OR-RECOUPMENT-AMOUNT|Payment Or Recoupment Amou
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|9|181|193|1. Value must be between -99999999999.99
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 Eff Date|Conditional|The date a check is issu
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)|10|194|201|1. Value must be 8 digits in the form
"CCYYMMDD"
2. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April
or Sept 31st)
3. Must have an associated Check Number
4. Conditional

FTX159|FTX.005.159|CHECK-NUM|Check Num|Conditional|The check or electronic funds transfer number.|N/A|FTX00005|COST-SHARING-OFFSET|X(15)|11|202|216|1. Value must b
characters or less
2. 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 w
the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking th
action of either making a payment or taking a recoupment, as opposed to the payee who i
object of the transaction. The payer is the entity that is either making a payment or recoup
a payment from another entity or individual. The payee is the individual or entity that is ei
receiving a payment or having a previous payment recouped.

For beneficiary Cost Sharing Offset, the payee is always the state and the payee is always
beneficiary.|N/A|FTX00005|COST-SHARING-OFFSET|X(30)|12|217|246|1. Value must be 30
characters or less
2. Value must equal SUBMITTING-STATE (FTX00001)
5. Mandatory

FTX161|FTX.005.161|PAYER-ID-TYPE|Payer ID Type|Mandatory|This is a qualifier that indica
what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid
CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted a
submitting state code.|PAYER-ID-TYPE|FTX00005|COST-SHARING-OFFSET|X(2)|13|247|248|
Value must be 2 characters
2. Value must be in PAYER-ID-TYPE list (VVL)
3. Mandatory

FTX162|FTX.005.162|PAYER-ID-TYPE-OTHER-TEXT|Payer ID Type Other Text|Conditional|Th
a description of what the payer ID represents when the payer ID was reported with a paye
type of "Other".|N/A|FTX00005|COST-SHARING-OFFSET|X(100)|14|249|348|1. Value must b
100 characters or less
2. PAYER-ID-TYPE must = '95'
3. Conditional

FTX163|FTX.005.163|PAYEE-ID|Payee ID|Mandatory|This is the identifier that corresonds w
the payee's role in relation to the Medicaid/CHIP system.The payee is the individual or enti
that is either receiving a payment or having a previous payment recouped. The payee is th
object of the transaction, as opposed to the payer who is the subject taking the action of e
making a payment or taking a recoupment.

For beneficiary Cost Sharing Offset, the beneficiary is always the payee. |N/A|FTX00005|CO
SHARING-OFFSET|X(30)|15|349|378|1. Value must be 30 characters or less
2. Value must equal MSIS-IDENTIFICATION-NUM (ELG00002)
3. Mandatory

FTX164|FTX.005.164|PAYEE-ID-TYPE |Payee ID Type|Mandatory|This is a qualifier that indic
what type of ID the payee ID is. For example, if the payee ID represents a provider ID, ther
payee ID type will indicate that the payee ID should be interpreted as a provider ID.|PAYEE
TYPE |FTX00005|COST-SHARING-OFFSET|X(2)|16|379|380|1. Value must be 2 characters
2. Value must be in PAYEE-ID-TYPE list (VVL)
3. Mandatory

FTX165|FTX.005.165|PAYEE-ID-TYPE-OTHER-TEXT|Payee ID Type Other Text|Conditional|Th
a description of what the PAYEE-ID-TYPE represents when the PAYEE-ID-TYPE was reported
a payee ID type of "Other".|N/A|FTX00005|COST-SHARING-OFFSET|X(100)|17|381|480|1. Va
must be 100 characters or less
2. PAYEE-ID-TYPE must = '95'
3. Conditional

FTX166|FTX.005.166|PAYEE-MCR-PLAN-TYPE|Payee MCR Plan Type |Conditional|This descri
the type of managed care plan or care coordination model of the payee, when applicable.
valid value code set is comprised of the standard managed care plan type list from the MC
and ELG files and a complementary list of care coordination models.|MANAGED-CARE-PLAN
TYPE|FTX00005|COST-SHARING-OFFSET|X(2)|18|481|482|1. Value must be 2 characters
2. Value must be in MANAGED-CARE-PLAN-TYPE list (VVL)
3. If PAYEE-ID-TYPE is '02' or ‘03’ then PAYEE-MCR-PLAN-TYPE must be populated
4. If PAYEE-ID-TYPE is not '02' or ‘03’ then PAYEE-MCR-PLAN-TYPE must not be populated
5. Conditional

FTX167|FTX.005.167|PAYEE-MCR-PLAN-TYPE-OTHER-TEXT|Payee MCR Plan Type Other Tex
Conditional|This is a description of what type of managed care plan or care coordination m
the payee ID was reported with a payee MCR plan or other care coordination model type o
"Other".|N/A|FTX00005|COST-SHARING-OFFSET|X(100)|19|483|582|1. Value must be 100
characters or less
2. PAYEE-MCR-PLAN-TYPE must = '95'
3. Conditional

FTX168|FTX.005.168|PAYEE-TAX-ID|Payee Tax ID|Mandatory|This is the identifier that
corresonds 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 recou
The payee is the object of the transaction, as opposed to the payer who is the subject taki
the action of either making a payment or taking a recoupment.|N/A|FTX00005|COST-SHAR
OFFSET|X(30)|20|583|612|1. Value must be 12 characters or less
2. Mandatory
3. Value must meet requirements of SSN if PAYEE-ID-TYPE = '01'

FTX169|FTX.005.169|PAYEE-TAX-ID-TYPE|Payee Tax ID Type|Mandatory|This is a qualifier t
indicates what type of tax ID the payee tax ID is. For example, if the payee tax ID represen
SSN, then the payee tax ID type will indicate that the payee tax ID should be interpreted a
SSN.|PAYEE-TAX-ID-TYPE|FTX00005|COST-SHARING-OFFSET|X(2)|21|613|614|1. Value must
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 PAYE
TAX-ID-TYPE was reported with a payee tax ID type of "Other".|N/A|FTX00005|COST-SHARI
OFFSET|X(100)|22|615|714|1. Value must be 100 characters or less
2. PAYEE-TAX-ID-TYPE must = '95'
3. Conditional

FTX171|FTX.005.171|CONTRACT-ID|Contract ID|Conditional| Managed care plan contract ID
FTX00005|COST-SHARING-OFFSET|X(100)|23|715|814|1. Value must be 100 characters or
2. Value must be populated if OFFSET-TRANS-TYPE = '1'
3. Conditional

FTX172|FTX.005.172|INSURANCE-PLAN-ID|Insurance Plan ID|Conditional|The ID number iss
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|C
SHARING-OFFSET|X(20)|24|815|834|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 s
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 da
distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for informatio
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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-blog/entry/4757
N/A|FTX00005|COST-SHARING-OFFSET|X(20)|25|835|854|1. Value must be 20 characters o

2. Mandatory

FTX174|FTX.005.174|COVERAGE-PERIOD-START-DATE|Coverage Period Start Date|Mandato
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 calen
month of beneficiary enrollment in the managed care plan to which the off-setting amount
applied. If returning money to the beneficiary, this is the date representing the beginning o
period for which the beneficiary had previously made an offsetting payment that is now be
returned to them.|N/A|FTX00005|COST-SHARING-OFFSET|9(8)|26|855|862|1. Value must be
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
or Sept 31st)
3. Value must be before or the same as the associated COVERAGE-PERIOD-END-DATE

4. Value of the CC component must be in ['19', '20']
5. Mandatory

FTX175|FTX.005.175|COVERAGE-PERIOD-END-DATE|Coverage Period End Date|Mandatory|
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 beneficiary enrollment in the managed care plan to which the off-setting amount is applied returning money to the beneficiary, this is the date representing the end of the period for the beneficiary had previously made an offsetting payment that is now being returned to them.|N/A|FTX00005|COST-SHARING-OFFSET|9(8)|27|863|870|1. Value must be 8 characte the form “CCYYMMDD”
2. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April or Sept 31st)
3. Value must be after or the same as the associated COVERAGE-PERIOD-START-DATE

4. Value of the CC component must be in ['19', '20']
5. 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)|28|871 872|1. Value must be 2 characters
2. Value must be in CATEGORY-OF-FEDERAL-REIMBURSEMENT list (VVL)
3. Mandatory

FTX177|FTX.005.177|MBESCBES-CATEGORY-OF-SERVICE|MBES or CBES Category of Servic Mandatory|A code indicating the category of service for the paid claim. The category of se is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM 21, 64.9 WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS) that states use to report expenditures and request federal financial participation.|MBESCBES-CATEGORY-OF-SERVIC (XIX), MBESCBES-CATEGORY-OF-SERVICE (XXI)|FTX00005|COST-SHARING-OFFSET|X(5)|29| 877|1. Value must be in XIX-MBESCBES-CATEGORY-OF-SERVICE or XXI-MBESCBES-CATEGO OF-SERVICE lists (VVLs)
2. Value must be 5 characters or less
3. Mandatory

FTX178|FTX.005.178|MBESCBES-FORM|MBES or CBES Form|Mandatory|The MBES or CBES to which the expenditured will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, 64.9 WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS). This should be determined by th 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.|MBESCBE FORM|FTX00005|COST-SHARING-OFFSET|X(50)|30|878|927|1. Value must be 50 characters less
2. Value must be in MBES or CBES Form list (VVL)
3. Mandatory

FTX179|FTX.005.179|MBESCBES-FORM-GROUP|MBES or CBES Form Group|Mandatory|Indic
group of MBES/CBES forms that this payment applies to.|MBESCBES-FORM-GROUP|FTX000
COST-SHARING-OFFSET|X(1)|31|928|928|1. Value must be one 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 wa
ID number assigned during the state submission and CMS approval process. Waiver IDs sh
actually only be the "core" part of the waiver IDs, without including suffixes for renewals o
amendments.|N/A|FTX00005|COST-SHARING-OFFSET|X(20)|32|929|948|1. Value must be
associated with a populated WAIVER-TYPE
2. Value must be 20 characters or less
3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associated Cl
Waiver Type value must be 01 or in [21-30]
4. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation follow
by a period (.), the associated Claim Waiver Type value must be in [02-20, 32, 33]
5. Conditional

FTX181|FTX.005.181|WAIVER-TYPE|Waiver Type|Conditional|A code for specifying waiver t
under which the eligible individual is covered during the month and receiving services/und
which transaction is submitted.|WAIVER-TYPE|FTX00005|COST-SHARING-OFFSET|X(2)|33|9
950|1. Value must have a corresponding value in WAIVER-ID

2. Value must be in WAIVER-TYPE list (VVL)
3. Value must be 2 characters
4. Conditional

FTX182|FTX.005.182|FUNDING-CODE|Funding Code|Mandatory|A code to indicate the sour
non-federal share funds.
|FUNDING-CODE|FTX00005|COST-SHARING-OFFSET|X(2)|34|951|952|1. Value must be in
FUNDING-CODE list (VVL)
2. Value must be 2 character
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 fina
its expenditure to the provider. In the event of two sources, states are to report the portio
which represents the largest proportion not funded by the Federal government.|FUNDING-
SOURCE-NONFEDERAL-SHARE|FTX00005|COST-SHARING-OFFSET|X(2)|35|953|954|1. Value
must be in FUNDING-SOURCE-NONFEDERAL-SHARE list (VVL)
2. Value must be 2 characters
3. Mandatory

FTX184|FTX.005.184|OFFSET-TRANS-TYPE|Offset Trans Type|Conditional|This indicates the
of payment that the beneficiary cost-sharing is/was offsetting.|OFFSET-TRANS-TYPE|FTX00
COST-SHARING-OFFSET|X(1)|36|955|955|1. Value must be one character
2. Value must be in OFFSET-TRANS-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)|37|956|957|1. Valu
must be in SOURCE-LOCATION list (VVL)
2. Value must be 2 characters
3. Mandatory

FTX186|FTX.005.186|SPA-NUMBER|SPA Number|Conditional|State plan amendment (SPA) I
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 th
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 optional entry for specific SPA types|N/A|FTX00005|COST-SHARING-OFFSET|X(15
958|972|1. Value must be 15 characters or less
2. Conditional

FTX187|FTX.005.187|EXPENDITURE-AUTHORITY-TYPE|Expenditure Authority Type|Mandato
This is the federal statute or regulation under which the expenditure is authorized/justified
federal statute or regulation is usually referenced in either the Medicaid or CHIP State Plan
waiver documentation. For waivers, do not reference the federal statute or regulation bein
waived by the waiver. For waivers, referring to the waiver authority is sufficient. If the fed
statute or regulation is not available in the list of valid values, choose the value for "Other"
report the authority in the Expenditure Authority Type Text.|EXPENDITURE-AUTHORITY-TYP
FTX00005|COST-SHARING-OFFSET|X(2)|39|973|974|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 T
Other Text|Conditional|This field is only to be used if EXPENDITURE-AUTHORITY-TYPE "Othe
valid value is selected. Enter a specific text description of the "Other" expenditure authori
type.|N/A|FTX00005|COST-SHARING-OFFSET|X(100)|40|975|1074|1. Value must be 100
characters or less
2. EXPENDITURE-AUTHORITY-TYPE must = '95'
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)|41|1075|1574|1. Value must be 500 characters or less
2. Conditional

FTX190|FTX.005.190|STATE-NOTATION |State Notation |Optional|A free text field for the submitting state to enter whatever information it chooses.|N/A|FTX00005|COST-SHARING-OFFSET|X(500)|42|1575|2074|1. Value must be 500 characters or less
2. Value must not contain a pipe or asterisk symbols
3. Optional

FTX192|FTX.006.192|RECORD-ID|Record ID|Mandatory|The Record ID represents the type o segment being reported. The Record ID communicates how the contents of a given row of should be interpreted depending on which segment type the Record ID represents. Each t of segment collects different data elements so each segment type has a distinct layout. Th first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).|RECORD-ID FTX00006|VALUE-BASED-PAYMENT|X(8)|1|1|8|1. Value must be exactly 8 characters
2. Value must be in RECORD-ID list (VVL)
3. Value must equal "FTX00006"
4. Mandatory

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 receiv STATE|FTX00006|VALUE-BASED-PAYMENT|X(2)|2|9|10|1. Value must be in State Code list (
2. Value must be 2 characters
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 recor within the submission file.|N/A|FTX00006|VALUE-BASED-PAYMENT|9(11)|3|11|21|1. Value m be unique within record segment over all records associated with a given Record ID
2. Value must be 11 digits or less
3. Mandatory

FTX195|FTX.006.195|ICN-ORIG|ICN Orig|Conditional|A unique item control number assigne 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. If UNIQUE-TRANSACTION-ID is populated, ICN-ORIG must not be populated
4. Conditional

FTX196|FTX.006.196|ICN-ADJ|ICN Adj|Conditional|A unique claim/transaction number assig
by the state’s payment system that identifies the adjustment claim/transaction for an orig
item control number.|N/A|FTX00006|VALUE-BASED-PAYMENT|X(50)|5|72|121|1. Value must
50 characters or less
2. Value must not contain a pipe or asterisk symbols
3. If UNIQUE-TRANSACTION-ID is populated, ICN-ADJ must not be populated
4. Conditional

FTX197|FTX.006.197|UNIQUE-TRANSACTION-ID|Unique Transaction ID|Conditional|For
transactions that are not assigned an ICN-ORIG or ICN-ADJ in the MMIS, this unique transac
ID distinguishes this transaction from all other transactions in T-MSIS.|N/A|FTX00006|VALU
BASED-PAYMENT|X(50)|6|122|171|1. Value must be 50 characters or less
2. If ICN-ORIG or ICN-ADJ are populated, UNIQUE-TRANSACTION-ID must not be populated
3. Conditional

FTX198|FTX.006.198|ADJUSTMENT-IND|Adjustment Ind|Conditional|Indicates the type of
adjustment record.|ADJUSTMENT-IND|FTX00006|VALUE-BASED-PAYMENT|X(1)|7|172|172|1
Value must be 1 character
2. Value must be in ADJUSTMENT-IND list (VVL)
3. If UNIQUE-TRANSACTION-ID is populated, ADJUSTMENT-IND must not be populated
4. Conditional

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)|8|173|180|1. Value must be 8 characters in the for
“CCYYMMDD”
2. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April
or Sept 31st)
3. Value of the CC component must be in ['19', '20']
4. Mandatory

FTX200|FTX.006.200|PAYMENT-OR-RECOUPMENT-AMOUNT|Payment Or Recoupment Amou
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|9|181|193|1. Value must be between -99999999999.9
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 Eff Date|Conditional|The date a check is issu
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)|10|194|201|1. Value must be 8 digits in the form
"CCYYMMDD"
2. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April
or Sept 31st)
3. Must have an associated Check Number
4. Conditional

FTX202|FTX.006.202|CHECK-NUM|Check Num|Conditional|The check or electronic funds
transfer number.|N/A|FTX00006|VALUE-BASED-PAYMENT|X(15)|11|202|216|1. Value must b
characters or less
2. 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 w
the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking th
action of either making a payment or taking a recoupment, as opposed to the payee who i
object of the transaction. The payer is the entity that is either making a payment or recoup
a payment from another entity or individual. The payee is the individual or entity that is ei
receiving a payment or having a previous payment recouped.|N/A|FTX00006|VALUE-BASED
PAYMENT|X(30)|12|217|246|1. Value must be 30 characters or less
2. If PAYER-ID-TYPE = '01' then PAYER-ID = SUBMITTING-STATE (FTX00001)
3. If PAYER-ID-TYPE = '02' then PAYER-ID = STATE-PLAN-ID-NUM (MCR00002)
4. If PAYER-ID-TYPE = '04' then PAYER-ID = SUBMITTING-STATE-PROV-ID (PRV00002)
5. Mandatory

FTX204|FTX.006.204|PAYER-ID-TYPE|Payer ID Type|Mandatory|This is a qualifier that indica
what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid
CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted a
submitting state code.|PAYER-ID-TYPE|FTX00006|VALUE-BASED-PAYMENT|X(2)|13|247|248
Value must be 2 characters
2. Value must be in PAYER-ID-TYPE list (VVL)
3. Mandatory

FTX205|FTX.006.205|PAYER-ID-TYPE-OTHER-TEXT|Payer ID Type Other Text|Conditional|Th
a description of what the payer ID represents when the payer ID was reported with a paye
type of "Other".|N/A|FTX00006|VALUE-BASED-PAYMENT|X(100)|14|249|348|1. Value must
100 characters or less
2. PAYER-ID-TYPE must = '95'
3. Conditional

FTX206|FTX.006.206|PAYEE-ID|Payee ID|Mandatory|This is the identifier that corresonds w
the payee's role in relation to the Medicaid/CHIP system.The payee is the individual or enti
that is either receiving a payment or having a previous payment recouped. The payee is th
object of the transaction, as opposed to the payer who is the subject taking the action of e
making a payment or taking a recoupment.|N/A|FTX00006|VALUE-BASED-PAYMENT|X(30)|1
349|378|1. Value must be 30 characters or less
2. If PAYEE-ID-TYPE = '01' then PAYEE-ID = SUBMITTING-STATE (FTX00001)
3. If PAYEE-ID-TYPE = '02' then PAYEE-ID = STATE-PLAN-ID-NUM (MCR00002)
4. If PAYEE-ID-TYPE = '04' or '05' then PAYEE-ID = SUBMITTING-STATE-PROV-ID (PRV0002)
6. If PAYEE-ID-TYPE = '06' then PAYEE-ID = PROV-IDENTIFIER where PROV-IDENTIFIER-TYPE
(PRV00005)
7. If PAYEE-ID-TYPE = '07' then PAYEE-ID = INSURANCE-CARRIER-ID-NUM (TPL00006)
8. If PAYER-ID-TYPE = '08' then PAYEE-ID = MSIS-IDENTIFICATION-NUM (ELG00002)
9. Mandatory

FTX207|FTX.006.207|PAYEE-ID-TYPE |Payee ID Type|Mandatory|This is a qualifier that indic
what type of ID the payee ID is. For example, if the payee ID represents a provider ID, then
payee ID type will indicate that the payee ID should be interpreted as a provider ID.|PAYEE
TYPE |FTX00006|VALUE-BASED-PAYMENT|X(2)|16|379|380|1. Value must be 2 characters
2. Value must be in PAYEE-ID-TYPE list (VVL)
3. Mandatory

FTX208|FTX.006.208|PAYEE-ID-TYPE-OTHER-TEXT|Payee ID Type Other Text|Conditional|Th
a description of what the PAYEE-ID-TYPE represents when the PAYEE-ID-TYPE was reported
a payee ID type of "Other".|N/A|FTX00006|VALUE-BASED-PAYMENT|X(100)|17|381|480|1. V
must be 100 characters or less
2. PAYEE-ID-TYPE must = '95'
3. Conditional

FTX209|FTX.006.209|PAYEE-MCR-PLAN-TYPE|Payee MCR Plan Type |Conditional|This descri
the type of managed care plan or care coordination model of the payee, when applicable. T
valid value code set is comprised of the standard managed care plan type list from the MC
and ELG files and a complementary list of care coordination models.|MANAGED-CARE-PLAN
TYPE|FTX00006|VALUE-BASED-PAYMENT|X(2)|18|481|482|1. Value must be 2 characters
2. Value must be in MANAGED-CARE-PLAN-TYPE list (VVL)
3. If PAYEE-ID-TYPE is '02' or ‘03’ then PAYEE-MCR-PLAN-TYPE must be populated
4. If PAYEE-ID-TYPE is not '02' or ‘03’ then PAYEE-MCR-PLAN-TYPE must not be populated
5. Conditional

FTX210|FTX.006.210|PAYEE-MCR-PLAN-TYPE-OTHER-TEXT|Payee MCR Plan Type Other Tex
Conditional|This is a description of what type of managed care plan or care coordination m
the payee ID was reported with a payee MCR plan or other care coordination model type o
"Other".|N/A|FTX00006|VALUE-BASED-PAYMENT|X(100)|19|483|582|1. Value must be 100
characters or less
2. PAYEE-MCR-PLAN-TYPE must = '95'
3. Conditional

FTX211|FTX.006.211|PAYEE-TAX-ID|Payee Tax ID|Mandatory|This is the identifier that
corresonds 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 recou
The payee is the object of the transaction, as opposed to the payer who is the subject taki
the action of either making a payment or taking a recoupment.|N/A|FTX00006|VALUE-BASE
PAYMENT|X(30)|20|583|612|1. Value must be 12 characters or less
2. Mandatory
3. Value must meet requirements of SSN if PAYEE-ID-TYPE = '01'

FTX212|FTX.006.212|PAYEE-TAX-ID-TYPE|Payee Tax ID Type|Mandatory|This is a qualifier t
indicates what type of tax ID the payee tax ID is. For example, if the payee tax ID represer
SSN, then the payee tax ID type will indicate that the payee tax ID should be interpreted a
SSN.|PAYEE-TAX-ID-TYPE|FTX00006|VALUE-BASED-PAYMENT|X(2)|21|613|614|1. Value mus
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 PAYE
TAX-ID-TYPE was reported with a payee tax ID type of "Other".|N/A|FTX00006|VALUE-BASE
PAYMENT|X(100)|22|615|714|1. Value must be 100 characters or less
2. PAYEE-TAX-ID-TYPE must = '95'
3. Conditional

FTX214|FTX.006.214|CONTRACT-ID|Contract ID|Conditional| Managed care plan contract ID
FTX00006|VALUE-BASED-PAYMENT|X(100)|23|715|814|1. Value must be 100 characters or
2. Value must be populated if either PAYEE-ID-TYPE = '02' or PAYER-ID-TYPE = '02'
3. Conditional

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 iden MSIS Identification Numbers are a unique “key” value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for informatio reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
N/A|FTX00006|VALUE-BASED-PAYMENT|X(20)|24|815|834|1. Value must be 20 characters o less
2. Conditional

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(8 835|842|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 or Sept 31st)
3. Value must be before or the same as the associated PERFORMANCE-PERIOD-END-DATE

4. Value of the CC component must be in ['19', '20']
5. 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)|26|8 850|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 or Sept 31st)
3. Value must be after or the same as the associated PERFORMANCE-PERIOD-START-DATE

4. Value of the CC component must be in ['19', '20']
5. 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)|27|85 852|1. Value must be 2 characters
2. Value must be in CATEGORY-OF-FEDERAL-REIMBURSEMENT list (VVL)
3. Mandatory

FTX219|FTX.006.219|MBESCBES-CATEGORY-OF-SERVICE|MBES or CBES Category of Servic
Mandatory|A code indicating the category of service for the paid claim. The category of se
is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM
21, 64.9 WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS) that states use to report
expenditures and request federal financial participation.|MBESCBES-CATEGORY-OF-SERVIC
(XIX), MBESCBES-CATEGORY-OF-SERVICE (XXI)|FTX00006|VALUE-BASED-PAYMENT|X(5)|28
857|1. Value must be in XIX-MBESCBES-CATEGORY-OF-SERVICE or XXI-MBESCBES-CATEGO
OF-SERVICE lists (VVLs)
2. Value must be 5 characters or less
3. Mandatory

FTX220|FTX.006.220|MBESCBES-FORM|MBES or CBES Form|Mandatory|The MBES or CBES
to which the expenditured will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, 64.9
WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS). This should be determined by th
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.|MBESCBE
FORM|FTX00006|VALUE-BASED-PAYMENT|X(50)|29|858|907|1. Value must be 50 character
less
2. Value must be in MBES or CBES Form list (VVL)
3. Mandatory

FTX221|FTX.006.221|MBESCBES-FORM-GROUP|MBES or CBES Form Group|Mandatory|Indic
group of MBES/CBES forms that this payment applies to.|MBESCBES-FORM-GROUP|FTX000
VALUE-BASED-PAYMENT|X(1)|30|908|908|1. Value must be one 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 wa
ID number assigned during the state submission and CMS approval process. Waiver IDs sh
actually only be the "core" part of the waiver IDs, without including suffixes for renewals o
amendments.|N/A|FTX00006|VALUE-BASED-PAYMENT|X(20)|31|909|928|1. Value must be
associated with a populated WAIVER-TYPE
2. Value must be 20 characters or less
3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associated Cl
Waiver Type value must be 01 or in [21-30]
4. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation follow
by a period (.), the associated Claim Waiver Type value must be in [02-20, 32, 33]
5. Conditional

FTX223|FTX.006.223|WAIVER-TYPE|Waiver Type|Conditional|A code for specifying waiver t
under which the eligible individual is covered during the month and receiving services/und
which transaction is submitted.|WAIVER-TYPE|FTX00006|VALUE-BASED-PAYMENT|X(2)|32|9
930|1. Value must have a corresponding value in WAIVER-ID

2. Value must be in WAIVER-TYPE list (VVL)
3. Value must be 2 characters
4. Conditional

FTX224|FTX.006.224|FUNDING-CODE|Funding Code|Mandatory|A code to indicate the sour
non-federal share funds.
|FUNDING-CODE|FTX00006|VALUE-BASED-PAYMENT|X(2)|33|931|932|1. Value must be in
FUNDING-CODE list (VVL)
2. Value must be 2 character
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 fina
its expenditure to the provider. In the event of two sources, states are to report the portio
which represents the largest proportion not funded by the Federal government.|FUNDING-
SOURCE-NONFEDERAL-SHARE|FTX00006|VALUE-BASED-PAYMENT|X(2)|34|933|934|1. Valu
must be in FUNDING-SOURCE-NONFEDERAL-SHARE list (VVL)
2. Value must be 2 characters
3. Mandatory

FTX226|FTX.006.226|SDP-IND|State Directed Payment Indicator|Mandatory|Indicates whet
the financial transaction from an MC plan plan to a provider or other entity is a type of Sta
Directed Payment.|SDP-IND|FTX00006|VALUE-BASED-PAYMENT|X(1)|35|935|935|1. Value n
be 1 character
2. Value must be in SPD-IND 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)|36|936|937|1. Valu
must be in SOURCE-LOCATION list (VVL)
2. Value must be 2 characters
3. Mandatory

FTX228|FTX.006.228|SPA-NUMBER|SPA Number|Conditional|State plan amendment (SPA) I
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 th
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 optional entry for specific SPA types|N/A|FTX00006|VALUE-BASED-PAYMENT|X(1
37|938|952|1. Value must be 15 characters or less
2. Conditional

FTX229|FTX.006.229|VALUE-BASED-PAYMENT-MODEL-TYPE|Value Based Payment Model Ty
Conditional|This is the type of value-based payment model to which the financial transacti
applies. These values come from the “Alternative Payment Model (APM) Framework Final W
Paper”. Produced by the Healthcare Learning
and Action Network. https://hcp-lan.org/workproducts/apm-whitepaper.pdf |VALUE-BASED-
PAYMENT-MODEL-TYPE|FTX00006|VALUE-BASED-PAYMENT|X(2)|38|953|954|1. Value must
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
applicable payment category in the managed care plan's contract with the state Medicaid/
agency or their fiscal intermediary.|N/A|FTX00006|VALUE-BASED-PAYMENT|X(50)|39|955|1
1. Value must be 50 characters or less
2. Conditional

FTX231|FTX.006.231|EXPENDITURE-AUTHORITY-TYPE|Expenditure Authority Type|Mandato
This is the federal statute or regulation under which the expenditure is authorized/justified
federal statute or regulation is usually referenced in either the Medicaid or CHIP State Plan
waiver documentation. For waivers, do not reference the federal statute or regulation bein
waived by the waiver. For waivers, referring to the waiver authority is sufficient. If the fed
statute or regulation is not available in the list of valid values, choose the value for "Other"
report the authority in the Expenditure Authority Type Text.|EXPENDITURE-AUTHORITY-TYP
FTX00006|VALUE-BASED-PAYMENT|X(2)|40|1005|1006|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 T
Other Text|Conditional|This field is only to be used if EXPENDITURE-AUTHORITY-TYPE "Othe
valid value is selected. Enter a specific text description of the "Other" expenditure authori
type.|N/A|FTX00006|VALUE-BASED-PAYMENT|X(100)|41|1007|1106|1. Value must be 100
characters or less
2. EXPENDITURE-AUTHORITY-TYPE must = '95'
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)|42|1107|1606|1. Value must be 500 characters or less
2. Conditional

FTX234|FTX.006.234|STATE-NOTATION |State Notation |Optional|A free text field for the
submitting state to enter whatever information it chooses.|N/A|FTX00006|VALUE-BASED-
PAYMENT|X(500)|43|1607|2106|1. Value must be 500 characters or less
2. Value must not contain a pipe or asterisk symbols
3. Optional

FTX236|FTX.007.236|RECORD-ID|Record ID|Mandatory|The Record ID represents the type
segment being reported. The Record ID communicates how the contents of a given row of
should be interpreted depending on which segment type the Record ID represents. Each t
of segment collects different data elements so each segment type has a distinct layout. Th
first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th
segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).|RECORD-ID
FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|X(8)|1|1|8|1. Value must
exactly 8 characters
2. Value must be in RECORD-ID list (VVL)
3. Value must equal "FTX00007"
4. Mandatory

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 receiv
STATE|FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|X(2)|2|9|10|1. Val
must be in State Code list (VVL)
2. Value must be 2 characters
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 recor within the submission file.|N/A|FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|9(11)|3|11|21|1. Value must be unique within record segment over all records assoc with a given Record ID
2. Value must be 11 digits or less
3. Mandatory

FTX239|FTX.007.239|ICN-ORIG|ICN Orig|Conditional|A unique item control number assigne 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 m be 50 characters or less
2. Value must not contain a pipe or asterisk symbols
3. If UNIQUE-TRANSACTION-ID is populated, ICN-ORIG must not be populated
4. Conditional

FTX240|FTX.007.240|ICN-ADJ|ICN Adj|Conditional|A unique claim/transaction number assig by the state’s payment system that identifies the adjustment claim/transaction for an orig 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 UNIQUE-TRANSACTION-ID is populated, ICN-ADJ must not be populated
4. Conditional

FTX241|FTX.007.241|UNIQUE-TRANSACTION-ID|Unique Transaction ID|Conditional|For transactions that are not assigned an ICN-ORIG or ICN-ADJ in the MMIS, this unique transac ID distinguishes this transaction from all other transactions in T-MSIS.|N/A|FTX00007|STATE DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|X(50)|6|122|171|1. Value must be 50 characters or less
2. If ICN-ORIG or ICN-ADJ are populated, UNIQUE-TRANSACTION-ID must not be populated
3. Conditional

FTX242|FTX.007.242|ADJUSTMENT-IND|Adjustment Ind|Conditional|Indicates the type of adjustment record.|ADJUSTMENT-IND|FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|X(1)|7|172|172|1. Value must be 1 character
2. Value must be in ADJUSTMENT-IND list (VVL)
3. If UNIQUE-TRANSACTION-ID is populated, ADJUSTMENT-IND must not be populated
4. Conditional

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)|8|173|180|1. Value 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 or Sept 31st)
3. Value of the CC component must be in ['19', '20']
4. Mandatory

FTX244|FTX.007.244|PAYMENT-OR-RECOUPMENT-AMOUNT|Payment Or Recoupment Amou
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|FTX0000
STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|S9(11)V99|9|181|193|1. Value mus
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 Eff Date|Conditional|The date a check is issu
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)|10|194|201|1. Value
must be 8 digits in the form "CCYYMMDD"
2. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April
or Sept 31st)
3. Must have an associated Check Number
4. Conditional

FTX246|FTX.007.246|CHECK-NUM|Check Num|Conditional|The check or electronic funds transfer number.|N/A|FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|X(
11|202|216|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

FTX247|FTX.007.247|PAYER-ID|Payer ID|Mandatory|This is the identifier that corresponds w
the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking th
action of either making a payment or taking a recoupment, as opposed to the payee who i
object of the transaction. The payer is the entity that is either making a payment or recoup
a payment from another entity or individual. The payee is the individual or entity that is ei
receiving a payment or having a previous payment recouped.|N/A|FTX00007|STATE-DIREC
PAYMENT-SEPARATE-PAYMENT-TERM|X(30)|12|217|246|1. Value must be 30 characters or
2. If PAYER-ID-TYPE = '01' then PAYER-ID = SUBMITTING-STATE (FTX00001)
3. If PAYER-ID-TYPE = '02' then PAYER-ID = STATE-PLAN-ID-NUM (MCR00002)
4. If PAYER-ID-TYPE = '04' then PAYER-ID = SUBMITTING-STATE-PROV-ID (PRV00002)
5. Mandatory

FTX248|FTX.007.248|PAYER-ID-TYPE|Payer ID Type|Mandatory|This is a qualifier that indica
what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid
CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted a
submitting state code.|PAYER-ID-TYPE|FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-
PAYMENT-TERM|X(2)|13|247|248|1. Value must be 2 characters
2. Value must be in PAYER-ID-TYPE list (VVL)
3. Mandatory

FTX249|FTX.007.249|PAYER-ID-TYPE-OTHER-TEXT|Payer ID Type Other Text|Conditional|Th
a description of what the payer ID represents when the payer ID was reported with a paye
type of "Other".|N/A|FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|X(1
14|249|348|1. Value must be 100 characters or less
2. PAYER-ID-TYPE must = '95'
3. Conditional

FTX250|FTX.007.250|PAYEE-ID|Payee ID|Mandatory|This is the identifier that corresonds w
the payee's role in relation to the Medicaid/CHIP system.The payee is the individual or enti
that is either receiving a payment or having a previous payment recouped. The payee is th
object of the transaction, as opposed to the payer who is the subject taking the action of e
making a payment or taking a recoupment.|N/A|FTX00007|STATE-DIRECTED-PAYMENT-
SEPARATE-PAYMENT-TERM|X(30)|15|349|378|1. Value must be 30 characters or less
2. If PAYEE-ID-TYPE = '01' then PAYEE-ID = SUBMITTING-STATE (FTX00001)
3. If PAYEE-ID-TYPE = '02' then PAYEE-ID = STATE-PLAN-ID-NUM (MCR00002)
4. If PAYEE-ID-TYPE = '04' or '05' then PAYEE-ID = SUBMITTING-STATE-PROV-ID (PRV0002)
6. If PAYEE-ID-TYPE = '06' then PAYEE-ID = PROV-IDENTIFIER where PROV-IDENTIFIER-TYPE
(PRV00005)
7. If PAYEE-ID-TYPE = '07' then PAYEE-ID = INSURANCE-CARRIER-ID-NUM (TPL00006)
8. If PAYER-ID-TYPE = '08' then PAYEE-ID = MSIS-IDENTIFICATION-NUM (ELG00002)
9. Mandatory

FTX251|FTX.007.251|PAYEE-ID-TYPE |Payee ID Type|Mandatory|This is a qualifier that indic
what type of ID the payee ID is. For example, if the payee ID represents a provider ID, ther
payee ID type will indicate that the payee ID should be interpreted as a provider ID.|PAYEE
TYPE |FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|X(2)|16|379|380|1
Value must be 2 characters
2. Value must be in PAYEE-ID-TYPE list (VVL)
3. Mandatory

FTX252|FTX.007.252|PAYEE-ID-TYPE-OTHER-TEXT|Payee ID Type Other Text|Conditional|Th
a description of what the PAYEE-ID-TYPE represents when the PAYEE-ID-TYPE was reported
a payee ID type of "Other".|N/A|FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT
TERM|X(100)|17|381|480|1. Value must be 100 characters or less
2. PAYEE-ID-TYPE must = '95'
3. Conditional

FTX253|FTX.007.253|PAYEE-MCR-PLAN-TYPE|Payee MCR Plan Type |Conditional|This descri
the type of managed care plan or care coordination model of the payee, when applicable.
valid value code set is comprised of the standard managed care plan type list from the MC
and ELG files and a complementary list of care coordination models.|MANAGED-CARE-PLAN
TYPE|FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|X(2)|18|481|482|1.
Value must be 2 characters
2. Value must be in MANAGED-CARE-PLAN-TYPE list (VVL)
3. If PAYEE-ID-TYPE is '02' or ‘03’ then PAYEE-MCR-PLAN-TYPE must be populated
4. If PAYEE-ID-TYPE is not '02' or ‘03’ then PAYEE-MCR-PLAN-TYPE must not be populated
5. Conditional

FTX254|FTX.007.254|PAYEE-MCR-PLAN-TYPE-OTHER-TEXT|Payee MCR Plan Type Other Tex
Conditional|This is a description of what type of managed care plan or care coordination m
the payee ID was reported with a payee MCR plan or other care coordination model type o
"Other".|N/A|FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|X(100)|19|4
582|1. Value must be 100 characters or less
2. PAYEE-MCR-PLAN-TYPE must = '95'
3. Conditional

FTX255|FTX.007.255|PAYEE-TAX-ID|Payee Tax ID|Mandatory|This is the identifier that
corresonds 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 recou
The payee is the object of the transaction, as opposed to the payer who is the subject taki
the action of either making a payment or taking a recoupment.|N/A|FTX00007|STATE-
DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|X(30)|20|583|612|1. Value must be 12
characters or less
2. Mandatory
3. Value must meet requirements of SSN if PAYEE-ID-TYPE = '01'

FTX256|FTX.007.256|PAYEE-TAX-ID-TYPE|Payee Tax ID Type|Mandatory|This is a qualifier t
indicates what type of tax ID the payee tax ID is. For example, if the payee tax ID represen
SSN, then the payee tax ID type will indicate that the payee tax ID should be interpreted a
SSN.|PAYEE-TAX-ID-TYPE|FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM
X(2)|21|613|614|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 PAYE
TAX-ID-TYPE was reported with a payee tax ID type of "Other".|N/A|FTX00007|STATE-DIREC
PAYMENT-SEPARATE-PAYMENT-TERM|X(100)|22|615|714|1. Value must be 100 characters
less
2. PAYEE-TAX-ID-TYPE must = '95'
3. Conditional

FTX258|FTX.007.258|CONTRACT-ID|Contract ID|Mandatory| Managed care plan contract ID
FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|X(100)|23|715|814|1. Va
must be 100 characters or less
2. Mandatory

FTX259|FTX.007.259|PAYMENT-PERIOD-BEGIN-DATE|Payment Period Begin Date|Mandator
date representing the beginning of the time period that the payment is expected to be use
the provider. |N/A|FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|9(8)|2
815|822|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
or Sept 31st)
3. Value must be before or the same as the associated PAYMENT-PERIOD-END-DATE

4. Value of the CC component must be in ['19', '20']
5. Mandatory

FTX260|FTX.007.260|PAYMENT-PERIOD-END-DATE|Payment Period End Date|Mandatory|Th
date representing the end of the time period that the payment is expected to be used by t
provider.|N/A|FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|9(8)|25|82
830|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
or Sept 31st)
3. Value must be after or the same as the associated PAYMENT-PERIOD-START-DATE

4. Value of the CC component must be in ['19', '20']
5. Mandatory

FTX261|FTX.007.261|PAYMENT-PERIOD-TYPE|Payment Period Type|Conditional|A qualifier t
identifies what the payment period begin and end dates represent. For example, the paym
period begin an dend dates may correspond to a range of service dates from claims or
encounters or they may represent a period of beneficiary eligibility or enrollment.|PAYMEN
PERIOD-TYPE|FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|X(2)|26|83
832|1. Value must be 2 characters
2. Value must be in PAYMENT-PERIOD-TYPE list
3. Conditional

FTX262|FTX.007.262|PAYMENT-PERIOD-TYPE-OTHER-TEXT|Payment Period Type Other Tex
Conditional|This is a description of the type of financial transaction when the PAYMENT-PE
TYPE is "Other".|N/A|FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|X(1
27|833|932|1. Value must be 100 characters or less
2. PAYMENT-PERIOD-TYPE must = '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-SEPARA
PAYMENT-TERM|X(2)|28|933|934|1. Value must be 2 characters
2. Value must be in CATEGORY-OF-FEDERAL-REIMBURSEMENT list (VVL)
3. Mandatory

FTX264|FTX.007.264|MBESCBES-CATEGORY-OF-SERVICE|MBES or CBES Category of Servic
Mandatory|A code indicating the category of service for the paid claim. The category of se
is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM
21, 64.9 WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS) that states use to report
expenditures and request federal financial participation.|MBESCBES-CATEGORY-OF-SERVIC
(XIX), MBESCBES-CATEGORY-OF-SERVICE (XXI)|FTX00007|STATE-DIRECTED-PAYMENT-
SEPARATE-PAYMENT-TERM|X(5)|29|935|939|1. Value must be in XIX-MBESCBES-CATEGORY
SERVICE or XXI-MBESCBES-CATEGORY-OF-SERVICE lists (VVLs)
2. Value must be 5 characters or less
3. Mandatory

FTX265|FTX.007.265|MBESCBES-FORM|MBES or CBES Form|Mandatory|The MBES or CBES
to which the expenditured will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, 64.9
WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS). This should be determined by th
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.|MBESCBE
FORM|FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|X(50)|30|940|989|
Value must be 50 characters or less
2. Value must be in MBES or CBES Form list (VVL)
3. Mandatory

FTX266|FTX.007.266|MBESCBES-FORM-GROUP|MBES or CBES Form Group|Mandatory|Indic
group of MBES/CBES forms that this payment applies to.|MBESCBES-FORM-GROUP|FTX000
STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|X(1)|31|990|990|1. Value must be c
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 wa ID number assigned during the state submission and CMS approval process. Waiver IDs sh actually only be the "core" part of the waiver IDs, without including suffixes for renewals o amendments.|N/A|FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|X(20) 991|1010|1. Value must be associated with a populated WAIVER-TYPE
2. Value must be 20 characters or less
3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associated Cl Waiver Type value must be 01 or in [21-30]
4. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation follow by a period (.), the associated Claim Waiver Type value must be in [02-20, 32, 33]
5. Conditional

FTX268|FTX.007.268|WAIVER-TYPE|Waiver Type|Conditional|A code for specifying waiver t under which the eligible individual is covered during the month and receiving services/und which transaction is submitted.|WAIVER-TYPE|FTX00007|STATE-DIRECTED-PAYMENT-SEPAR PAYMENT-TERM|X(2)|33|1011|1012|1. Value must have a corresponding value in WAIVER-I

2. Value must be in WAIVER-TYPE list (VVL)
3. Value must be 2 characters
4. Conditional

FTX269|FTX.007.269|FUNDING-CODE|Funding Code|Mandatory|A code to indicate the sour non-federal share funds.
|FUNDING-CODE|FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|X(2)|34 1013|1014|1. Value must be in FUNDING-CODE list (VVL)
2. Value must be 2 character
3. Mandatory

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 fina its expenditure to the provider. In the event of two sources, states are to report the portio which represents the largest proportion not funded by the Federal government.|FUNDING-SOURCE-NONFEDERAL-SHARE|FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|X(2)|35|1015|1016|1. Value must be in FUNDING-SOURCE-NONFEDERAL-SHARE list (
2. Value must be 2 characters
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)|36|1017|1018|1. Value must be in SOURCE-LOCATION list (VVL)

2. Value must be 2 characters
3. Mandatory

FTX272|FTX.007.272|SPA-NUMBER|SPA Number|Conditional|State plan amendment (SPA) I
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 th
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 optional entry for specific SPA types|N/A|FTX00007|STATE-DIRECTED-PAYMENT-
SEPARATE-PAYMENT-TERM|X(15)|37|1019|1033|1. Value must be 15 characters or less
2. Conditional

FTX273|FTX.007.273|PAYMENT-CAT-XREF|Payment Cat Xref|Conditional|Cross-reference to
applicable payment category in the managed care plan's contract with the state Medicaid/
agency or their fiscal intermediary.|N/A|FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-
PAYMENT-TERM|X(50)|38|1034|1083|1. Value must be 50 characters or less
2. Conditional

FTX274|FTX.007.274|EXPENDITURE-AUTHORITY-TYPE|Expenditure Authority Type|Mandato
This is the federal statute or regulation under which the expenditure is authorized/justified
federal statute or regulation is usually referenced in either the Medicaid or CHIP State Plan
waiver documentation. For waivers, do not reference the federal statute or regulation bein
waived by the waiver. For waivers, referring to the waiver authority is sufficient. If the fed
statute or regulation is not available in the list of valid values, choose the value for "Other"
report the authority in the Expenditure Authority Type Text.|EXPENDITURE-AUTHORITY-TYP
FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|X(2)|39|1084|1085|1. Va
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 T
Other Text|Conditional|This field is only to be used if EXPENDITURE-AUTHORITY-TYPE "Othe
valid value is selected. Enter a specific text description of the "Other" expenditure authori
type.|N/A|FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|X(100)|40|108
1185|1. Value must be 100 characters or less
2. EXPENDITURE-AUTHORITY-TYPE must = '95'
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)|41|1186|1685|1. Value must be 50
characters or less
2. Conditional

FTX277|FTX.007.277|STATE-NOTATION |State Notation |Optional|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)|42|1686|2185|1. Value must be 500 characte less
2. Value must not contain a pipe or asterisk symbols
3. Optional

FTX279|FTX.008.279|RECORD-ID|Record ID|Mandatory|The Record ID represents the type segment being reported. The Record ID communicates how the contents of a given row of should be interpreted depending on which segment type the Record ID represents. Each t of segment collects different data elements so each segment type has a distinct layout. Th first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th 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 exactly 8 characters
2. Value must be in RECORD-ID list (VVL)
3. Value must equal "FTX00008"
4. Mandatory

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 receiv STATE|FTX00008|COST-SETTLEMENT-PAYMENT|X(2)|2|9|10|1. Value must be in State Code (VVL)
2. Value must be 2 characters
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 recor within the submission file.|N/A|FTX00008|COST-SETTLEMENT-PAYMENT|9(11)|3|11|21|1. Va must be unique within record segment over all records associated with a given Record ID
2. Value must be 11 digits or less
3. Mandatory

FTX282|FTX.008.282|ICN-ORIG|ICN Orig|Conditional|A unique item control number assigne 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 l
2. Value must not contain a pipe or asterisk symbols
3. If UNIQUE-TRANSACTION-ID is populated, ICN-ORIG must not be populated
4. Conditional

FTX283|FTX.008.283|ICN-ADJ|ICN Adj|Conditional|A unique claim/transaction number assig
by the state’s payment system that identifies the adjustment claim/transaction for an orig
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 UNIQUE-TRANSACTION-ID is populated, ICN-ADJ must not be populated
4. Conditional

FTX284|FTX.008.284|UNIQUE-TRANSACTION-ID|Unique Transaction ID|Conditional|For
transactions that are not assigned an ICN-ORIG or ICN-ADJ in the MMIS, this unique transac
ID distinguishes this transaction from all other transactions in T-MSIS.|N/A|FTX00008|COST
SETTLEMENT-PAYMENT|X(50)|6|122|171|1. Value must be 50 characters or less
2. If ICN-ORIG or ICN-ADJ are populated, UNIQUE-TRANSACTION-ID must not be populated
3. Conditional

FTX285|FTX.008.285|ADJUSTMENT-IND|Adjustment Ind|Conditional|Indicates the type of
adjustment record.|ADJUSTMENT-IND|FTX00008|COST-SETTLEMENT-PAYMENT|X(1)|7|172|1
1. Value must be 1 character
2. Value must be in ADJUSTMENT-IND list (VVL)
3. If UNIQUE-TRANSACTION-ID is populated, ADJUSTMENT-IND must not be populated
4. Conditional

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)|8|173|180|1. Value must be 8 characters in t
form “CCYYMMDD”
2. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April
or Sept 31st)
3. Value of the CC component must be in ['19', '20']
4. Mandatory

FTX287|FTX.008.287|PAYMENT-OR-RECOUPMENT-AMOUNT|Payment Or Recoupment Amou
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|FTX0000
COST-SETTLEMENT-PAYMENT|S9(11)V99|9|181|193|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 Eff Date|Conditional|The date a check is issu
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)|10|194|201|1. Value must be 8 digits in the fo
"CCYYMMDD"
2. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April
or Sept 31st)
3. Must have an associated Check Number
4. Conditional

FTX289|FTX.008.289|CHECK-NUM|Check Num|Conditional|The check or electronic funds
transfer number.|N/A|FTX00008|COST-SETTLEMENT-PAYMENT|X(15)|11|202|216|1. Value m
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

FTX290|FTX.008.290|PAYER-ID|Payer ID|Mandatory|This is the identifier that corresponds w
the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking th
action of either making a payment or taking a recoupment, as opposed to the payee who i
object of the transaction. The payer is the entity that is either making a payment or recoup
a payment from another entity or individual. The payee is the individual or entity that is ei
receiving a payment or having a previous payment recouped.|N/A|FTX00008|COST-
SETTLEMENT-PAYMENT|X(30)|12|217|246|1. Value must be 30 characters or less
2. If PAYER-ID-TYPE = '01' then PAYER-ID = SUBMITTING-STATE (FTX00001)
3. If PAYER-ID-TYPE = '02' then PAYER-ID = STATE-PLAN-ID-NUM (MCR00002)
4. If PAYER-ID-TYPE = '04' then PAYER-ID = SUBMITTING-STATE-PROV-ID (PRV00002)
5. Mandatory

FTX291|FTX.008.291|PAYER-ID-TYPE|Payer ID Type|Mandatory|This is a qualifier that indica
what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid
CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted a
submitting state code.|PAYER-ID-TYPE|FTX00008|COST-SETTLEMENT-PAYMENT|X(2)|13|247
248|1. Value must be 2 characters
2. Value must be in PAYER-ID-TYPE list (VVL)
3. Mandatory

FTX292|FTX.008.292|PAYER-ID-TYPE-OTHER-TEXT|Payer ID Type Other Text|Conditional|Th
a description of what the payer ID represents when the payer ID was reported with a paye
type of "Other".|N/A|FTX00008|COST-SETTLEMENT-PAYMENT|X(100)|14|249|348|1. Value m
be 100 characters or less
2. PAYER-ID-TYPE must = '95'
3. Conditional

FTX293|FTX.008.293|PAYEE-ID|Payee ID|Mandatory|This is the identifier that corresonds w
the payee's role in relation to the Medicaid/CHIP system.The payee is the individual or enti
that is either receiving a payment or having a previous payment recouped. The payee is th
object of the transaction, as opposed to the payer who is the subject taking the action of e
making a payment or taking a recoupment.|N/A|FTX00008|COST-SETTLEMENT-PAYMENT|X
15|349|378|1. Value must be 30 characters or less
2. If PAYEE-ID-TYPE = '01' then PAYEE-ID = SUBMITTING-STATE (FTX00001)
3. If PAYEE-ID-TYPE = '02' then PAYEE-ID = STATE-PLAN-ID-NUM (MCR00002)
4. If PAYEE-ID-TYPE = '04' or '05' then PAYEE-ID = SUBMITTING-STATE-PROV-ID (PRV0002)
6. If PAYEE-ID-TYPE = '06' then PAYEE-ID = PROV-IDENTIFIER where PROV-IDENTIFIER-TYPE
(PRV00005)
7. If PAYEE-ID-TYPE = '07' then PAYEE-ID = INSURANCE-CARRIER-ID-NUM (TPL00006)
8. If PAYER-ID-TYPE = '08' then PAYEE-ID = MSIS-IDENTIFICATION-NUM (ELG00002)
9. Mandatory

FTX294|FTX.008.294|PAYEE-ID-TYPE |Payee ID Type|Mandatory|This is a qualifier that indic
what type of ID the payee ID is. For example, if the payee ID represents a provider ID, then
payee ID type will indicate that the payee ID should be interpreted as a provider ID.|PAYEE
TYPE |FTX00008|COST-SETTLEMENT-PAYMENT|X(2)|16|379|380|1. Value must be 2 charact
2. Value must be in PAYEE-ID-TYPE list (VVL)
3. Mandatory

FTX295|FTX.008.295|PAYEE-ID-TYPE-OTHER-TEXT|Payee ID Type Other Text|Conditional|Th
a description of what the PAYEE-ID-TYPE represents when the PAYEE-ID-TYPE was reported
a payee ID type of "Other".|N/A|FTX00008|COST-SETTLEMENT-PAYMENT|X(100)|17|381|48
Value must be 100 characters or less
2. PAYEE-ID-TYPE must = '95'
3. Conditional

FTX296|FTX.008.296|PAYEE-MCR-PLAN-TYPE|Payee MCR Plan Type |Conditional|This descri
the type of managed care plan or care coordination model of the payee, when applicable.
valid value code set is comprised of the standard managed care plan type list from the MC
and ELG files and a complementary list of care coordination models.|MANAGED-CARE-PLAN
TYPE|FTX00008|COST-SETTLEMENT-PAYMENT|X(2)|18|481|482|1. Value must be 2 charact
2. Value must be in MANAGED-CARE-PLAN-TYPE list (VVL)
3. If PAYEE-ID-TYPE is '02' or ‘03’ then PAYEE-MCR-PLAN-TYPE must be populated
4. If PAYEE-ID-TYPE is not '02' or ‘03’ then PAYEE-MCR-PLAN-TYPE must not be populated
5. Conditional

FTX297|FTX.008.297|PAYEE-MCR-PLAN-TYPE-OTHER-TEXT|Payee MCR Plan Type Other Tex
Conditional|This is a description of what type of managed care plan or care coordination m
the payee ID was reported with a payee MCR plan or other care coordination model type o
"Other".|N/A|FTX00008|COST-SETTLEMENT-PAYMENT|X(100)|19|483|582|1. Value must be
characters or less
2. PAYEE-MCR-PLAN-TYPE must = '95'
3. Conditional

FTX298|FTX.008.298|PAYEE-TAX-ID|Payee Tax ID|Mandatory|This is the identifier that
corresonds 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 recou
The payee is the object of the transaction, as opposed to the payer who is the subject taki
the action of either making a payment or taking a recoupment.|N/A|FTX00008|COST-
SETTLEMENT-PAYMENT|X(30)|20|583|612|1. Value must be 12 characters or less
2. Mandatory
3. Value must meet requirements of SSN if PAYEE-ID-TYPE = '01'

FTX299|FTX.008.299|PAYEE-TAX-ID-TYPE|Payee Tax ID Type|Mandatory|This is a qualifier t
indicates what type of tax ID the payee tax ID is. For example, if the payee tax ID represer
SSN, then the payee tax ID type will indicate that the payee tax ID should be interpreted a
SSN.|PAYEE-TAX-ID-TYPE|FTX00008|COST-SETTLEMENT-PAYMENT|X(2)|21|613|614|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 PAYE
TAX-ID-TYPE was reported with a payee tax ID type of "Other".|N/A|FTX00008|COST-
SETTLEMENT-PAYMENT|X(100)|22|615|714|1. Value must be 100 characters or less
2. PAYEE-TAX-ID-TYPE must = '95'
3. Conditional

FTX301|FTX.008.301|COST-SETTLEMENT-PERIOD-START-DATE|Cost Settlement Period Star
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)|23|715|722|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
or Sept 31st)
3. Value must be before or the same as the associated COST-SETTLEMENT-PERIOD-END-D

4. Value of the CC component must be in ['19', '20']
5. Mandatory

FTX302|FTX.008.302|COST-SETTLEMENT-PERIOD-END-DATE|Cost Settlement Period End Da
Mandatory|The date representing the end of the cost-settlement period. For example, if th
cost-settlement is for the first calendar quarter of the year, then the cost settlement end d
would be March 31 of that year. |N/A|FTX00008|COST-SETTLEMENT-PAYMENT|9(8)|24|723|
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
or Sept 31st)
3. Value must be after or the same as the associated COST-SETTLEMENT-PERIOD-START-D

4. Value of the CC component must be in ['19', '20']
5. 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)|2
731|732|1. Value must be 2 characters
2. Value must be in CATEGORY-OF-FEDERAL-REIMBURSEMENT list (VVL)
3. Mandatory

FTX304|FTX.008.304|MBESCBES-CATEGORY-OF-SERVICE|MBES or CBES Category of Servic
Mandatory|A code indicating the category of service for the paid claim. The category of se
is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM
21, 64.9 WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS) that states use to report
expenditures and request federal financial participation.|MBESCBES-CATEGORY-OF-SERVIC
(XIX), MBESCBES-CATEGORY-OF-SERVICE (XXI)|FTX00008|COST-SETTLEMENT-PAYMENT|X(
26|733|737|1. Value must be in XIX-MBESCBES-CATEGORY-OF-SERVICE or XXI-MBESCBES-
CATEGORY-OF-SERVICE lists (VVLs)
2. Value must be 5 characters or less
3. Mandatory

FTX305|FTX.008.305|MBESCBES-FORM|MBES or CBES Form|Mandatory|The MBES or CBES
to which the expenditured will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, 64.9
WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS). This should be determined by th
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.|MBESCBE
FORM|FTX00008|COST-SETTLEMENT-PAYMENT|X(50)|27|738|787|1. Value must be 50
characters or less
2. Value must be in MBES or CBES Form list (VVL)
3. Mandatory

FTX306|FTX.008.306|MBESCBES-FORM-GROUP|MBES or CBES Form Group|Mandatory|Indic
group of MBES/CBES forms that this payment applies to.|MBESCBES-FORM-GROUP|FTX000
COST-SETTLEMENT-PAYMENT|X(1)|28|788|788|1. Value must be one 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 wa
ID number assigned during the state submission and CMS approval process. Waiver IDs sh
actually only be the "core" part of the waiver IDs, without including suffixes for renewals o
amendments.|N/A|FTX00008|COST-SETTLEMENT-PAYMENT|X(20)|29|789|808|1. Value mus
associated with a populated WAIVER-TYPE
2. Value must be 20 characters or less
3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associated Cl
Waiver Type value must be 01 or in [21-30]
4. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation follow
by a period (.), the associated Claim Waiver Type value must be in [02-20, 32, 33]
5. Conditional

FTX308|FTX.008.308|WAIVER-TYPE|Waiver Type|Conditional|A code for specifying waiver t
under which the eligible individual is covered during the month and receiving services/und
which transaction is submitted.|WAIVER-TYPE|FTX00008|COST-SETTLEMENT-PAYMENT|X(2
809|810|1. Value must have a corresponding value in WAIVER-ID

2. Value must be in WAIVER-TYPE list (VVL)
3. Value must be 2 characters
4. Conditional

FTX309|FTX.008.309|FUNDING-CODE|Funding Code|Mandatory|A code to indicate the sour
non-federal share funds.
|FUNDING-CODE|FTX00008|COST-SETTLEMENT-PAYMENT|X(2)|31|811|812|1. Value must b
FUNDING-CODE list (VVL)
2. Value must be 2 character
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 fina
its expenditure to the provider. In the event of two sources, states are to report the portio
which represents the largest proportion not funded by the Federal government.|FUNDING-
SOURCE-NONFEDERAL-SHARE|FTX00008|COST-SETTLEMENT-PAYMENT|X(2)|32|813|814|1.
Value must be in FUNDING-SOURCE-NONFEDERAL-SHARE list (VVL)
2. Value must be 2 characters
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)|33|815|816|1
Value must be in SOURCE-LOCATION list (VVL)
2. Value must be 2 characters
3. Mandatory

FTX312|FTX.008.312|SPA-NUMBER|SPA Number|Conditional|State plan amendment (SPA) I
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 th
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 optional entry for specific SPA types|N/A|FTX00008|COST-SETTLEMENT-PAYMEN
X(15)|34|817|831|1. Value must be 15 characters or less
2. Conditional

FTX313|FTX.008.313|EXPENDITURE-AUTHORITY-TYPE|Expenditure Authority Type|Mandato
This is the federal statute or regulation under which the expenditure is authorized/justified
federal statute or regulation is usually referenced in either the Medicaid or CHIP State Plan
waiver documentation. For waivers, do not reference the federal statute or regulation bein
waived by the waiver. For waivers, referring to the waiver authority is sufficient. If the fed
statute or regulation is not available in the list of valid values, choose the value for "Other"
report the authority in the Expenditure Authority Type Text.|EXPENDITURE-AUTHORITY-TYP
FTX00008|COST-SETTLEMENT-PAYMENT|X(2)|35|832|833|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 T
Other Text|Conditional|This field is only to be used if EXPENDITURE-AUTHORITY-TYPE "Othe
valid value is selected. Enter a specific text description of the "Other" expenditure authori
type.|N/A|FTX00008|COST-SETTLEMENT-PAYMENT|X(100)|36|834|933|1. Value must be 10
characters or less
2. EXPENDITURE-AUTHORITY-TYPE must = '95'
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)|37|934|1433|1. Value must be 500 characters or less
2. Conditional

FTX316|FTX.008.316|STATE-NOTATION |State Notation |Optional|A free text field for the submitting state to enter whatever information it chooses.|N/A|FTX00008|COST-SETTLEME PAYMENT|X(500)|38|1434|1933|1. Value must be 500 characters or less
2. Value must not contain a pipe or asterisk symbols
3. Optional

FTX318|FTX.009.318|RECORD-ID|Record ID|Mandatory|The Record ID represents the type segment being reported. The Record ID communicates how the contents of a given row of should be interpreted depending on which segment type the Record ID represents. Each t of segment collects different data elements so each segment type has a distinct layout. Th first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).|RECORD-ID FTX00009| FQHC-WRAP-PAYMENT|X(8)|1|1|8|1. Value must be exactly 8 characters
2. Value must be in RECORD-ID list (VVL)
3. Value must equal "FTX00009"
4. Mandatory

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 receiv STATE|FTX00009| FQHC-WRAP-PAYMENT|X(2)|2|9|10|1. Value must be in State Code list (V
2. Value must be 2 characters
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 recor within the submission file.|N/A|FTX00009| FQHC-WRAP-PAYMENT|9(11)|3|11|21|1. Value m be unique within record segment over all records associated with a given Record ID
2. Value must be 11 digits or less
3. Mandatory

FTX321|FTX.009.321|ICN-ORIG|ICN Orig|Conditional|A unique item control number assigne 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. If UNIQUE-TRANSACTION-ID is populated, ICN-ORIG must not be populated
4. Conditional

FTX322|FTX.009.322|ICN-ADJ|ICN Adj|Conditional|A unique claim/transaction number assig
by the state’s payment system that identifies the adjustment claim/transaction for an orig
item control number.|N/A|FTX00009| FQHC-WRAP-PAYMENT|X(50)|5|72|121|1. Value must
50 characters or less
2. Value must not contain a pipe or asterisk symbols
3. If UNIQUE-TRANSACTION-ID is populated, ICN-ADJ must not be populated
4. Conditional

FTX323|FTX.009.323|UNIQUE-TRANSACTION-ID|Unique Transaction ID|Conditional|For
transactions that are not assigned an ICN-ORIG or ICN-ADJ in the MMIS, this unique transac
ID distinguishes this transaction from all other transactions in T-MSIS.|N/A|FTX00009| FQH
WRAP-PAYMENT|X(50)|6|122|171|1. Value must be 50 characters or less
2. If ICN-ORIG or ICN-ADJ are populated, UNIQUE-TRANSACTION-ID must not be populated
3. Conditional

FTX324|FTX.009.324|ADJUSTMENT-IND|Adjustment Ind|Conditional|Indicates the type of
adjustment record.|ADJUSTMENT-IND|FTX00009| FQHC-WRAP-PAYMENT|X(1)|7|172|172|1.
must be 1 character
2. Value must be in ADJUSTMENT-IND list (VVL)
3. If UNIQUE-TRANSACTION-ID is populated, ADJUSTMENT-IND must not be populated
4. Conditional

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)|8|173|180|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
or Sept 31st)
3. Value of the CC component must be in ['19', '20']
4. Mandatory

FTX326|FTX.009.326|PAYMENT-OR-RECOUPMENT-AMOUNT|Payment Or Recoupment Amou
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|FTX0000
FQHC-WRAP-PAYMENT|S9(11)V99|9|181|193|1. Value must be between -99999999999.99
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 Eff Date|Conditional|The date a check is issu
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)|10|194|201|1. Value must be 8 digits in the form
"CCYYMMDD"
2. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April
or Sept 31st)
3. Must have an associated Check Number
4. Conditional

FTX328|FTX.009.328|CHECK-NUM|Check Num|Conditional|The check or electronic funds
transfer number.|N/A|FTX00009| FQHC-WRAP-PAYMENT|X(15)|11|202|216|1. Value must be
characters or less
2. 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 w
the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking th
action of either making a payment or taking a recoupment, as opposed to the payee who i
object of the transaction. The payer is the entity that is either making a payment or recoup
a payment from another entity or individual. The payee is the individual or entity that is ei
receiving a payment or having a previous payment recouped.|N/A|FTX00009| FQHC-WRAP-
PAYMENT|X(30)|12|217|246|1. Value must be 30 characters or less
2. If PAYER-ID-TYPE = '01' then PAYER-ID = SUBMITTING-STATE (FTX00001)
3. If PAYER-ID-TYPE = '02' then PAYER-ID = STATE-PLAN-ID-NUM (MCR00002)
4. If PAYER-ID-TYPE = '04' then PAYER-ID = SUBMITTING-STATE-PROV-ID (PRV00002)
5. Mandatory

FTX330|FTX.009.330|PAYER-ID-TYPE|Payer ID Type|Mandatory|This is a qualifier that indica
what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid
CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted a
submitting state code.|PAYER-ID-TYPE|FTX00009| FQHC-WRAP-PAYMENT|X(2)|13|247|248|
Value must be 2 characters
2. Value must be in PAYER-ID-TYPE list (VVL)
3. Mandatory

FTX331|FTX.009.331|PAYER-ID-TYPE-OTHER-TEXT|Payer ID Type Other Text|Conditional|Th
a description of what the payer ID represents when the payer ID was reported with a paye
type of "Other".|N/A|FTX00009| FQHC-WRAP-PAYMENT|X(100)|14|249|348|1. Value must be
characters or less
2. PAYER-ID-TYPE must = '95'
3. Conditional

FTX332|FTX.009.332|PAYEE-ID|Payee ID|Mandatory|This is the identifier that corresonds w
the payee's role in relation to the Medicaid/CHIP system.The payee is the individual or enti
that is either receiving a payment or having a previous payment recouped. The payee is th
object of the transaction, as opposed to the payer who is the subject taking the action of e
making a payment or taking a recoupment.|N/A|FTX00009| FQHC-WRAP-PAYMENT|X(30)|15
349|378|1. Value must be 30 characters or less
2. If PAYEE-ID-TYPE = '01' then PAYEE-ID = SUBMITTING-STATE (FTX00001)
3. If PAYEE-ID-TYPE = '02' then PAYEE-ID = STATE-PLAN-ID-NUM (MCR00002)
4. If PAYEE-ID-TYPE = '04' or '05' then PAYEE-ID = SUBMITTING-STATE-PROV-ID (PRV0002)
6. If PAYEE-ID-TYPE = '06' then PAYEE-ID = PROV-IDENTIFIER where PROV-IDENTIFIER-TYPE
(PRV00005)
7. If PAYEE-ID-TYPE = '07' then PAYEE-ID = INSURANCE-CARRIER-ID-NUM (TPL00006)
8. If PAYER-ID-TYPE = '08' then PAYEE-ID = MSIS-IDENTIFICATION-NUM (ELG00002)
9. Mandatory

FTX333|FTX.009.333|PAYEE-ID-TYPE |Payee ID Type|Mandatory|This is a qualifier that indic
what type of ID the payee ID is. For example, if the payee ID represents a provider ID, then
payee ID type will indicate that the payee ID should be interpreted as a provider ID.|PAYEE
TYPE |FTX00009| FQHC-WRAP-PAYMENT|X(2)|16|379|380|1. Value must be 2 characters
2. Value must be in PAYEE-ID-TYPE list (VVL)
3. Mandatory

FTX334|FTX.009.334|PAYEE-ID-TYPE-OTHER-TEXT|Payee ID Type Other Text|Conditional|Th
a description of what the PAYEE-ID-TYPE represents when the PAYEE-ID-TYPE was reported
a payee ID type of "Other".|N/A|FTX00009| FQHC-WRAP-PAYMENT|X(100)|17|381|480|1. Va
must be 100 characters or less
2. PAYEE-ID-TYPE must = '95'
3. Conditional

FTX335|FTX.009.335|PAYEE-MCR-PLAN-TYPE|Payee MCR Plan Type |Conditional|This descri
the type of managed care plan or care coordination model of the payee, when applicable. T
valid value code set is comprised of the standard managed care plan type list from the MC
and ELG files and a complementary list of care coordination models.|MANAGED-CARE-PLAN
TYPE|FTX00009| FQHC-WRAP-PAYMENT|X(2)|18|481|482|1. Value must be 2 characters
2. Value must be in MANAGED-CARE-PLAN-TYPE list (VVL)
3. If PAYEE-ID-TYPE is '02' or ‘03’ then PAYEE-MCR-PLAN-TYPE must be populated
4. If PAYEE-ID-TYPE is not '02' or ‘03’ then PAYEE-MCR-PLAN-TYPE must not be populated
5. Conditional

FTX336|FTX.009.336|PAYEE-MCR-PLAN-TYPE-OTHER-TEXT|Payee MCR Plan Type Other Tex
Conditional|This is a description of what type of managed care plan or care coordination m
the payee ID was reported with a payee MCR plan or other care coordination model type o
"Other".|N/A|FTX00009| FQHC-WRAP-PAYMENT|X(100)|19|483|582|1. Value must be 100
characters or less
2. PAYEE-MCR-PLAN-TYPE must = '95'
3. Conditional

FTX337|FTX.009.337|PAYEE-TAX-ID|Payee Tax ID|Mandatory|This is the identifier that
corresonds 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 recou
The payee is the object of the transaction, as opposed to the payer who is the subject taki
the action of either making a payment or taking a recoupment.|N/A|FTX00009| FQHC-WRA
PAYMENT|X(30)|20|583|612|1. Value must be 12 characters or less
2. Mandatory
3. Value must meet requirements of SSN if PAYEE-ID-TYPE = '01'

FTX338|FTX.009.338|PAYEE-TAX-ID-TYPE|Payee Tax ID Type|Mandatory|This is a qualifier t
indicates what type of tax ID the payee tax ID is. For example, if the payee tax ID represer
SSN, then the payee tax ID type will indicate that the payee tax ID should be interpreted a
SSN.|PAYEE-TAX-ID-TYPE|FTX00009| FQHC-WRAP-PAYMENT|X(2)|21|613|614|1. Value must
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 PAYE
TAX-ID-TYPE was reported with a payee tax ID type of "Other".|N/A|FTX00009| FQHC-WRAP
PAYMENT|X(100)|22|615|714|1. Value must be 100 characters or less
2. PAYEE-TAX-ID-TYPE must = '95'
3. Conditional

FTX340|FTX.009.340|WRAP-PERIOD-START-DATE|Wrap Period Start Date|Mandatory|The da
representing the beginning of the FQHC wrap payment or recoupment period. For example
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|
23|715|722|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
or Sept 31st)
3. Value must be before or the same as the associated WRAP-PERIOD-END-DATE

4. Value of the CC component must be in ['19', '20']
5. 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 dat would be March 31 of that year.|N/A|FTX00009| FQHC-WRAP-PAYMENT|9(8)|24|723|730|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 or Sept 31st)
3. Value must be after or the same as the associated WRAP-PERIOD-START-DATE

4. Value of the CC component must be in ['19', '20']
5. 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)|25|731
1. Value must be 2 characters
2. Value must be in CATEGORY-OF-FEDERAL-REIMBURSEMENT list (VVL)
3. Mandatory

FTX343|FTX.009.343|MBESCBES-CATEGORY-OF-SERVICE|MBES or CBES Category of Servic Mandatory|A code indicating the category of service for the paid claim. The category of se is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM 21, 64.9 WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS) that states use to report expenditures and request federal financial participation.|MBESCBES-CATEGORY-OF-SERVIC (XIX), MBESCBES-CATEGORY-OF-SERVICE (XXI)|FTX00009| FQHC-WRAP-PAYMENT|X(5)|26|7 737|1. Value must be in XIX-MBESCBES-CATEGORY-OF-SERVICE or XXI-MBESCBES-CATEGO OF-SERVICE lists (VVLs)
2. Value must be 5 characters or less
3. Mandatory

FTX344|FTX.009.344|MBESCBES-FORM|MBES or CBES Form|Mandatory|The MBES or CBES to which the expenditured will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, 64.9 WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS). This should be determined by th 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.|MBESCBE FORM|FTX00009| FQHC-WRAP-PAYMENT|X(50)|27|738|787|1. Value must be 50 characters less
2. Value must be in MBES or CBES Form list (VVL)
3. Mandatory

FTX345|FTX.009.345|MBESCBES-FORM-GROUP|MBES or CBES Form Group|Mandatory|Indic
group of MBES/CBES forms that this payment applies to.|MBESCBES-FORM-GROUP|FTX000
FQHC-WRAP-PAYMENT|X(1)|28|788|788|1. Value must be one 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 wa
ID number assigned during the state submission and CMS approval process. Waiver IDs sh
actually only be the "core" part of the waiver IDs, without including suffixes for renewals o
amendments.|N/A|FTX00009| FQHC-WRAP-PAYMENT|X(20)|29|789|808|1. Value must be
associated with a populated WAIVER-TYPE
2. Value must be 20 characters or less
3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associated Cl
Waiver Type value must be 01 or in [21-30]
4. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation follow
by a period (.), the associated Claim Waiver Type value must be in [02-20, 32, 33]
5. Conditional

FTX347|FTX.009.347|WAIVER-TYPE|Waiver Type|Conditional|A code for specifying waiver t
under which the eligible individual is covered during the month and receiving services/und
which transaction is submitted.|WAIVER-TYPE|FTX00009| FQHC-WRAP-PAYMENT|X(2)|30|80
810|1. Value must have a corresponding value in WAIVER-ID

2. Value must be in WAIVER-TYPE list (VVL)
3. Value must be 2 characters
4. Conditional

FTX348|FTX.009.348|FUNDING-CODE|Funding Code|Mandatory|A code to indicate the sour
non-federal share funds.
|FUNDING-CODE|FTX00009| FQHC-WRAP-PAYMENT|X(2)|31|811|812|1. Value must be in
FUNDING-CODE list (VVL)
2. Value must be 2 character
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 fina
its expenditure to the provider. In the event of two sources, states are to report the portio
which represents the largest proportion not funded by the Federal government.|FUNDING-
SOURCE-NONFEDERAL-SHARE|FTX00009| FQHC-WRAP-PAYMENT|X(2)|32|813|814|1. Value
be in FUNDING-SOURCE-NONFEDERAL-SHARE list (VVL)
2. Value must be 2 characters
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)|33|815|816|1. Value
must be in SOURCE-LOCATION list (VVL)
2. Value must be 2 characters
3. Mandatory

FTX351|FTX.009.351|SPA-NUMBER|SPA Number|Conditional|State plan amendment (SPA) I
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 th
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 optional entry for specific SPA types|N/A|FTX00009| FQHC-WRAP-PAYMENT|X(15
817|831|1. Value must be 15 characters or less
2. Conditional

FTX352|FTX.009.352|EXPENDITURE-AUTHORITY-TYPE|Expenditure Authority Type|Mandato
This is the federal statute or regulation under which the expenditure is authorized/justified
federal statute or regulation is usually referenced in either the Medicaid or CHIP State Plan
waiver documentation. For waivers, do not reference the federal statute or regulation bein
waived by the waiver. For waivers, referring to the waiver authority is sufficient. If the fed
statute or regulation is not available in the list of valid values, choose the value for "Other"
report the authority in the Expenditure Authority Type Text.|EXPENDITURE-AUTHORITY-TYP
FTX00009| FQHC-WRAP-PAYMENT|X(2)|35|832|833|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 T
Other Text|Conditional|This field is only to be used if EXPENDITURE-AUTHORITY-TYPE "Othe
valid value is selected. Enter a specific text description of the "Other" expenditure authori
type.|N/A|FTX00009| FQHC-WRAP-PAYMENT|X(100)|36|834|933|1. Value must be 100
characters or less
2. EXPENDITURE-AUTHORITY-TYPE must = '95'
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)|37|934|1433|1. Value must be 500 characters or less
2. Conditional

FTX355|FTX.009.355|STATE-NOTATION |State Notation |Optional|A free text field for the submitting state to enter whatever information it chooses.|N/A|FTX00009| FQHC-WRAP-PAYMENT|X(500)|38|1434|1933|1. Value must be 500 characters or less
2. Value must not contain a pipe or asterisk symbols
3. Optional

FTX357|FTX.095.357|RECORD-ID|Record ID|Mandatory|The Record ID represents the type segment being reported. The Record ID communicates how the contents of a given row of should be interpreted depending on which segment type the Record ID represents. Each t of segment collects different data elements so each segment type has a distinct layout. Th first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).|RECORD-ID FTX00095 |MISCELLANEOUS-PAYMENT|X(8)|1|1|8|1. Value must be exactly 8 characters
2. Value must be in RECORD-ID list (VVL)
3. Value must equal "FTX00095"
4. Mandatory

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 receive STATE|FTX00095 |MISCELLANEOUS-PAYMENT|X(2)|2|9|10|1. Value must be in State Code li (VVL)
2. Value must be 2 characters
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 recor within the submission file.|N/A|FTX00095 |MISCELLANEOUS-PAYMENT|9(11)|3|11|21|1. Valu must be unique within record segment over all records associated with a given Record ID
2. Value must be 11 digits or less
3. Mandatory

FTX360|FTX.095.360|ICN-ORIG|ICN Orig|Conditional|A unique item control number assigne 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 les
2. Value must not contain a pipe or asterisk symbols
3. If UNIQUE-TRANSACTION-ID is populated, ICN-ORIG must not be populated
4. Conditional

FTX361|FTX.095.361|ICN-ADJ|ICN Adj|Conditional|A unique claim/transaction number assig
by the state’s payment system that identifies the adjustment claim/transaction for an orig
item control number.|N/A|FTX00095 |MISCELLANEOUS-PAYMENT|X(50)|5|72|121|1. Value n
be 50 characters or less
2. Value must not contain a pipe or asterisk symbols
3. If UNIQUE-TRANSACTION-ID is populated, ICN-ADJ must not be populated
4. Conditional

FTX362|FTX.095.362|UNIQUE-TRANSACTION-ID|Unique Transaction ID|Conditional|For
transactions that are not assigned an ICN-ORIG or ICN-ADJ in the MMIS, this unique transac
ID distinguishes this transaction from all other transactions in T-MSIS.|N/A|FTX00095 |
MISCELLANEOUS-PAYMENT|X(50)|6|122|171|1. Value must be 50 characters or less
2. If ICN-ORIG or ICN-ADJ are populated, UNIQUE-TRANSACTION-ID must not be populated
3. Conditional

FTX363|FTX.095.363|ADJUSTMENT-IND|Adjustment Ind|Conditional|Indicates the type of
adjustment record.|ADJUSTMENT-IND|FTX00095 |MISCELLANEOUS-PAYMENT|X(1)|7|172|17
Value must be 1 character
2. Value must be in ADJUSTMENT-IND list (VVL)
3. If UNIQUE-TRANSACTION-ID is populated, ADJUSTMENT-IND must not be populated
4. Conditional

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)|8|173|180|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
or Sept 31st)
3. Value of the CC component must be in ['19', '20']
4. Mandatory

FTX365|FTX.095.365|PAYMENT-OR-RECOUPMENT-AMOUNT|Payment Or Recoupment Amou
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|FTX0009
MISCELLANEOUS-PAYMENT|S9(11)V99|9|181|193|1. Value must be between -9999999999
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 Eff Date|Conditional|The date a check is issu
the payee. In the case of electronic funds transfer, it is the date the transfer is made.|N/A|
FTX00095 |MISCELLANEOUS-PAYMENT|9(8)|10|194|201|1. Value must be 8 digits in the for
"CCYYMMDD"
2. The date must be a valid calendar date (i.e. Feb 29th only on the leap year, never April
or Sept 31st)
3. Must have an associated Check Number
4. Conditional

FTX367|FTX.095.367|CHECK-NUM|Check Num|Conditional|The check or electronic funds
transfer number.|N/A|FTX00095 |MISCELLANEOUS-PAYMENT|X(15)|11|202|216|1. Value mu
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

FTX368|FTX.095.368|PAYER-ID|Payer ID|Mandatory|This is the identifier that corresponds w
the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking th
action of either making a payment or taking a recoupment, as opposed to the payee who i
object of the transaction. The payer is the entity that is either making a payment or recoup
a payment from another entity or individual. The payee is the individual or entity that is ei
receiving a payment or having a previous payment recouped.|N/A|FTX00095 |MISCELLANE
PAYMENT|X(30)|12|217|246|1. Value must be 30 characters or less
2. If PAYER-ID-TYPE = '01' then PAYER-ID = SUBMITTING-STATE (FTX00001)
3. If PAYER-ID-TYPE = '02' then PAYER-ID = STATE-PLAN-ID-NUM (MCR00002)
4. If PAYER-ID-TYPE = '04' then PAYER-ID = SUBMITTING-STATE-PROV-ID (PRV00002)
5. Mandatory

FTX369|FTX.095.369|PAYER-ID-TYPE|Payer ID Type|Mandatory|This is a qualifier that indica
what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid
CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted a
submitting state code.|PAYER-ID-TYPE|FTX00095 |MISCELLANEOUS-PAYMENT|X(2)|13|247|
1. Value must be 2 characters
2. Value must be in PAYER-ID-TYPE list (VVL)
3. Mandatory

FTX370|FTX.095.370|PAYER-ID-TYPE-OTHER-TEXT|Payer ID Type Other Text|Conditional|Th
a description of what the payer ID represents when the payer ID was reported with a paye
type of "Other".|N/A|FTX00095 |MISCELLANEOUS-PAYMENT|X(100)|14|249|348|1. Value mu
100 characters or less
2. PAYER-ID-TYPE must = '95'
3. Conditional

FTX371|FTX.095.371|PAYER-MCR-PLAN-TYPE|Payer MCR Plan Type|Conditional|This describ
the type of managed care plan or care coordination model of the payer, when applicable. T
valid value list is comprised of the standard managed care plan type list from the MCR and
files and a complementary list of care coordination models.|MANAGED-CARE-PLAN-TYPE|
FTX00095 |MISCELLANEOUS-PAYMENT|X(2)|15|349|350|1. Value must be 2 characters
2. Value must be in MANAGED-CARE-PLAN-TYPE list (VVL)
3. If PAYER-ID-TYPE is '02' then PAYER-MCR-PLAN-TYPE must be populated
4. If PAYER-ID-TYPE is not '02' then PAYER-MCR-PLAN-TYPE 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 m
the payer ID was reported with a PAYER-MCR-PLAN-OR-OTHER-TYPE of "Other".|N/A|FTX00
MISCELLANEOUS-PAYMENT|X(100)|16|351|450|1. Value must be 100 characters or less
2. PAYER-MCR-PLAN-TYPE must = '95'
3. Conditional

FTX373|FTX.095.373|PAYEE-ID|Payee ID|Mandatory|This is the identifier that corresonds w
the payee's role in relation to the Medicaid/CHIP system.The payee is the individual or enti
that is either receiving a payment or having a previous payment recouped. The payee is th
object of the transaction, as opposed to the payer who is the subject taking the action of e
making a payment or taking a recoupment.|N/A|FTX00095 |MISCELLANEOUS-PAYMENT|X(3
17|451|480|1. Value must be 30 characters or less
2. If PAYEE-ID-TYPE = '01' then PAYEE-ID = SUBMITTING-STATE (FTX00001)
3. If PAYEE-ID-TYPE = '02' then PAYEE-ID = STATE-PLAN-ID-NUM (MCR00002)
4. If PAYEE-ID-TYPE = '04' or '05' then PAYEE-ID = SUBMITTING-STATE-PROV-ID (PRV0002)
6. If PAYEE-ID-TYPE = '06' then PAYEE-ID = PROV-IDENTIFIER where PROV-IDENTIFIER-TYPE
(PRV00005)
7. If PAYEE-ID-TYPE = '07' then PAYEE-ID = INSURANCE-CARRIER-ID-NUM (TPL00006)
8. If PAYER-ID-TYPE = '08' then PAYEE-ID = MSIS-IDENTIFICATION-NUM (ELG00002)
9. Mandatory

FTX374|FTX.095.374|PAYEE-ID-TYPE |Payee ID Type|Mandatory|This is a qualifier that indic
what type of ID the payee ID is. For example, if the payee ID represents a provider ID, ther
payee ID type will indicate that the payee ID should be interpreted as a provider ID.|PAYEE
TYPE |FTX00095 |MISCELLANEOUS-PAYMENT|X(2)|18|481|482|1. Value must be 2 characte
2. Value must be in PAYEE-ID-TYPE list (VVL)
3. Mandatory

FTX375|FTX.095.375|PAYEE-ID-TYPE-OTHER-TEXT|Payee ID Type Other Text|Conditional|Th
a description of what the PAYEE-ID-TYPE represents when the PAYEE-ID-TYPE was reported
a payee ID type of "Other".|N/A|FTX00095 |MISCELLANEOUS-PAYMENT|X(100)|19|483|582|
Value must be 100 characters or less
2. PAYEE-ID-TYPE must = '95'
3. Conditional

FTX376|FTX.095.376|PAYEE-MCR-PLAN-TYPE|Payee MCR Plan Type |Conditional|This descri
the type of managed care plan or care coordination model of the payee, when applicable.
valid value code set is comprised of the standard managed care plan type list from the MC
and ELG files and a complementary list of care coordination models.|MANAGED-CARE-PLAN
TYPE|FTX00095 |MISCELLANEOUS-PAYMENT|X(2)|20|583|584|1. Value must be 2 character
2. Value must be in MANAGED-CARE-PLAN-TYPE list (VVL)
3. If PAYEE-ID-TYPE is '02' or ‘03’ then PAYEE-MCR-PLAN-TYPE must be populated
4. If PAYEE-ID-TYPE is not '02' or ‘03’ then PAYEE-MCR-PLAN-TYPE must not be populated
5. Conditional

FTX377|FTX.095.377|PAYEE-MCR-PLAN-TYPE-OTHER-TEXT|Payee MCR Plan Type Other Tex
Conditional|This is a description of what type of managed care plan or care coordination m
the payee ID was reported with a payee MCR plan or other care coordination model type o
"Other".|N/A|FTX00095 |MISCELLANEOUS-PAYMENT|X(100)|21|585|684|1. Value must be 1
characters or less
2. PAYEE-MCR-PLAN-TYPE must = '95'
3. Conditional

FTX378|FTX.095.378|PAYEE-TAX-ID|Payee Tax ID|Mandatory|This is the identifier that
corresonds 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 recou
The payee is the object of the transaction, as opposed to the payer who is the subject taki
the action of either making a payment or taking a recoupment.|N/A|FTX00095 |
MISCELLANEOUS-PAYMENT|X(30)|22|685|714|1. Value must be 12 characters or less
2. Mandatory
3. Value must meet requirements of SSN if PAYEE-ID-TYPE = '01'

FTX379|FTX.095.379|PAYEE-TAX-ID-TYPE|Payee Tax ID Type|Mandatory|This is a qualifier t
indicates what type of tax ID the payee tax ID is. For example, if the payee tax ID represer
SSN, then the payee tax ID type will indicate that the payee tax ID should be interpreted a
SSN.|PAYEE-TAX-ID-TYPE|FTX00095 |MISCELLANEOUS-PAYMENT|X(2)|23|715|716|1. Value
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 PAYE
TAX-ID-TYPE was reported with a payee tax ID type of "Other".|N/A|FTX00095 |
MISCELLANEOUS-PAYMENT|X(100)|24|717|816|1. Value must be 100 characters or less
2. PAYEE-TAX-ID-TYPE must = '95'
3. Conditional

FTX381|FTX.095.381|CONTRACT-ID|Contract ID|Conditional| Managed care plan contract ID
FTX00095 |MISCELLANEOUS-PAYMENT|X(100)|25|817|916|1. Value must be 100 characters
less
2. Conditional

FTX382|FTX.095.382|INSURANCE-CARRIER-ID-NUM|Insurance Carrier ID Num|Conditional|
The state-assigned identification number of the Third Party Liability (TPL) Entity.|N/A|FTX0
|MISCELLANEOUS-PAYMENT|X(12)|26|917|928|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 iden
MSIS Identification Numbers are a unique “key” value used to maintain referential integrity
data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for informatio
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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-blog/entry/4757
N/A|FTX00095 |MISCELLANEOUS-PAYMENT|X(20)|27|929|948|1. Value must be 20 characte
less
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 individua
SSN
4. Conditional

FTX384|FTX.095.384|PAYMENT-PERIOD-BEGIN-DATE|Payment Period Begin Date|Mandator
date representing the beginning of the time period that the payment is expected to be use
the provider. |N/A|FTX00095 |MISCELLANEOUS-PAYMENT|9(8)|28|949|956|1. Value must be
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
or Sept 31st)
3. Value must be before or the same as the associated PAYMENT-PERIOD-END-DATE

4. Value of the CC component must be in ['19', '20']
5. Mandatory

FTX385|FTX.095.385|PAYMENT-PERIOD-END-DATE|Payment Period End Date|Mandatory|Th
date representing the end of the time period that the payment is expected to be used by t
provider.|N/A|FTX00095 |MISCELLANEOUS-PAYMENT|9(8)|29|957|964|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
or Sept 31st)
3. Value must be after or the same as the associated PAYMENT-PERIOD-START-DATE

4. Value of the CC component must be in ['19', '20']
5. Mandatory

FTX386|FTX.095.386|PAYMENT-PERIOD-TYPE|Payment Period Type|Conditional|A qualifier t
identifies what the payment period begin and end dates represent. For example, the paym
period begin an dend dates may correspond to a range of service dates from claims or
encounters or they may represent a period of beneficiary eligibility or enrollment.|PAYMEN
PERIOD-TYPE|FTX00095 |MISCELLANEOUS-PAYMENT|X(2)|30|965|966|1. Value must be 2
characters
2. Value must be in PAYMENT-PERIOD-TYPE list
3. Conditional

FTX387|FTX.095.387|PAYMENT-PERIOD-TYPE-OTHER-TEXT|Payment Period Type Other Tex
Conditional|This is a description of the type of financial transaction when the PAYMENT-PE
TYPE is "Other".|N/A|FTX00095 |MISCELLANEOUS-PAYMENT|X(100)|31|967|1066|1. Value m
be 100 characters or less
2. PAYMENT-PERIOD-TYPE must = '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 a
other financial transaction segment type (e.g., FTX00002, FTX00003, FTX00004, etc.). |
TRANSACTION-TYPE|FTX00095 |MISCELLANEOUS-PAYMENT|X(2)|32|1067|1068|1. Value mu
2 characters
2. Value must be in TRANSACTION-TYPE list
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 TRANSACTIO
TYPE is "Other".|N/A|FTX00095 |MISCELLANEOUS-PAYMENT|X(100)|33|1069|1168|1. Value
be 100 characters or less
2. PAYEE-ID-TYPE must = '95'
2. 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)|34
1169|1170|1. Value must be 2 characters
2. Value must be in CATEGORY-OF-FEDERAL-REIMBURSEMENT list (VVL)
3. Mandatory

FTX391|FTX.095.391|MBESCBES-CATEGORY-OF-SERVICE|MBES or CBES Category of Servic
Mandatory|A code indicating the category of service for the paid claim. The category of se
is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM
21, 64.9 WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS) that states use to report
expenditures and request federal financial participation.|MBESCBES-CATEGORY-OF-SERVIC
(XIX), MBESCBES-CATEGORY-OF-SERVICE (XXI)|FTX00095 |MISCELLANEOUS-PAYMENT|X(5)
1171|1175|1. Value must be in XIX-MBESCBES-CATEGORY-OF-SERVICE or XXI-MBESCBES-
CATEGORY-OF-SERVICE lists (VVLs)
2. Value must be 5 characters or less
3. Mandatory

FTX392|FTX.095.392|MBESCBES-FORM|MBES or CBES Form|Mandatory|The MBES or CBES
to which the expenditured will be mapped (e.g., CMS-64 Base, CMS-64.21U, CMS-21, 64.9
WAIVER OTHER ARP 9815 URBAN INDIAN HEALTH ORGS). This should be determined by th
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.|MBESCBE
FORM|FTX00095 |MISCELLANEOUS-PAYMENT|X(50)|36|1176|1225|1. Value must be 50
characters or less
2. Value must be in MBES or CBES Form list (VVL)
3. Mandatory

FTX393|FTX.095.393|MBESCBES-FORM-GROUP|MBES or CBES Form Group|Mandatory|Indic
group of MBES/CBES forms that this payment applies to.|MBESCBES-FORM-GROUP|FTX000
MISCELLANEOUS-PAYMENT|X(1)|37|1226|1226|1. Value must be one 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 wa
ID number assigned during the state submission and CMS approval process. Waiver IDs sh
actually only be the "core" part of the waiver IDs, without including suffixes for renewals o
amendments.|N/A|FTX00095 |MISCELLANEOUS-PAYMENT|X(20)|38|1227|1246|1. Value mu
associated with a populated WAIVER-TYPE
2. Value must be 20 characters or less
3. (1115 demonstration waivers) If value begins with "11-W-" or "21-W-", the associated Cl
Waiver Type value must be 01 or in [21-30]
4. (1915(b) or 1915(c) waivers) If value begins with the two-letter state abbreviation follow
by a period (.), the associated Claim Waiver Type value must be in [02-20, 32, 33]
5. Conditional

FTX395|FTX.095.395|WAIVER-TYPE|Waiver Type|Conditional|A code for specifying waiver t
under which the eligible individual is covered during the month and receiving services/und
which transaction is submitted.|WAIVER-TYPE|FTX00095 |MISCELLANEOUS-PAYMENT|X(2)|
1247|1248|1. Value must have a corresponding value in WAIVER-ID

2. Value must be in WAIVER-TYPE list (VVL)
3. Value must be 2 characters
4. Conditional

FTX396|FTX.095.396|FUNDING-CODE|Funding Code|Mandatory|A code to indicate the sour
non-federal share funds.
|FUNDING-CODE|FTX00095 |MISCELLANEOUS-PAYMENT|X(2)|40|1249|1250|1. Value must b
FUNDING-CODE list (VVL)
2. Value must be 2 character
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 fina
its expenditure to the provider. In the event of two sources, states are to report the portio
which represents the largest proportion not funded by the Federal government.|FUNDING-
SOURCE-NONFEDERAL-SHARE|FTX00095 |MISCELLANEOUS-PAYMENT|X(2)|41|1251|1252|1
Value must be in FUNDING-SOURCE-NONFEDERAL-SHARE list (VVL)
2. Value must be 2 characters
3. Mandatory

FTX398|FTX.095.398|SDP-IND|State Directed Payment Indicator|Mandatory|Indicates whet
the financial transaction from an MC plan plan to a provider or other entity is a type of Sta
Directed Payment.|SDP-IND|FTX00095 |MISCELLANEOUS-PAYMENT|X(1)|42|1253|1253|1. V
must be 1 character
2. Value must be in SPD-IND 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)|43|1254|1255|
Value must be in SOURCE-LOCATION list (VVL)
2. Value must be 2 characters
3. Mandatory

FTX400|FTX.095.400|SPA-NUMBER|SPA Number|Conditional|State plan amendment (SPA) I
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 th
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 optional entry for specific SPA types|N/A|FTX00095 |MISCELLANEOUS-PAYMENT|
X(15)|44|1256|1270|1. Value must be 15 characters or less
2. Conditional

FTX401|FTX.095.401|PAYMENT-CAT-XREF|Payment Cat Xref|Conditional|Cross-reference to
applicable payment category in the managed care plan's contract with the state Medicaid/
agency or their fiscal intermediary.|N/A|FTX00095 |MISCELLANEOUS-PAYMENT|X(50)|45|12
1320|1. Value must be 50 characters or less
2. Conditional

FTX402|FTX.095.402|EXPENDITURE-AUTHORITY-TYPE|Expenditure Authority Type|Mandato
This is the federal statute or regulation under which the expenditure is authorized/justified
federal statute or regulation is usually referenced in either the Medicaid or CHIP State Plan
waiver documentation. For waivers, do not reference the federal statute or regulation bein
waived by the waiver. For waivers, referring to the waiver authority is sufficient. If the fed
statute or regulation is not available in the list of valid values, choose the value for "Other"
report the authority in the Expenditure Authority Type Text.|EXPENDITURE-AUTHORITY-TYP
FTX00095 |MISCELLANEOUS-PAYMENT|X(2)|46|1321|1322|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 T
Other Text|Conditional|This field is only to be used if EXPENDITURE-AUTHORITY-TYPE "Othe
valid value is selected. Enter a specific text description of the "Other" expenditure authori
type.|N/A|FTX00095 |MISCELLANEOUS-PAYMENT|X(100)|47|1323|1422|1. Value must be 10
characters or less
2. EXPENDITURE-AUTHORITY-TYPE must = '95'
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)|48|1423|1922|1. Value must be 500 characters or less
2. Conditional

FTX405|FTX.095.405|STATE-NOTATION |State Notation |Optional|A free text field for the submitting state to enter whatever information it chooses.|N/A|FTX00095 |MISCELLANEOUS PAYMENT|X(500)|49|1923|2422|1. Value must be 500 characters or less
2. Value must not contain a pipe or asterisk symbols
3. Optional

MCR113|MCR.001.113|FILE-SUBMISSION-METHOD|File Submission Method|Mandatory|The submission method (e.g., TFFR, RHFR, IT, or CSO) used by the state to build and submit the This should correspond with the state's declared file submission method for the same file t and time period.|FILE-SUBMISSION-METHOD|MCR00001|FILE-SUBMISSION-METHOD|X(2)|1379|1. Value must be in File Submission Method List (VVL)
2. Value must be 2 characters
3. Mandatory

MCR114|MCR.010.114|RECORD-ID|Record ID|Mandatory|The Record ID represents the type segment being reported. The Record ID communicates how the contents of a given row of should be interpreted depending on which segment type the Record ID represents. Each t of segment collects different data elements so each segment type has a distinct layout. Th first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).|N/A|MCR0 MANAGED-CARE-ID|X(8)|1|1|8|1. Mandatory
2. Value must be 8 characters
3. Value must be in Record ID List (VVL)

MCR115|MCR.010.115|SUBMITTING-STATE|Submitting State|Mandatory|A code that unique identifies the U.S. State or Territory from which T-MSIS system data resources were receiv STATE|MCR00010|MANAGED-CARE-ID|X(2)|2|9|10|1. Value must be in State Code List (VVL
2. Value must be 2 characters
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 recor within the submission file.|N/A|MCR00010|MANAGED-CARE-ID|9(11)|3|11|21|1. Value must unique within record segment over all records associated with a given Record ID (CE)
2. Value must be 11 digits or less
3. Mandatory

MCR117|MCR.010.117|STATE-PLAN-ID-NUM|State Plan ID Number|Mandatory|The ID numb 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-ID-TYPE|Managed Care Plan ID Type|Mandato
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
retired or issued.|MANAGED-CARE-PLAN-ID-TYPE|MCR00010|MANAGED-CARE-ID|X(2)|5|34|
Value must be in Managed Care Plan ID Type List (VVL)
2. Value must be 2 characters
3. Mandatory

MCR119|MCR.010.119|MANAGED-CARE-PLAN-ID|Managed Care Plan ID|Mandatory|A data
element to capture the various IDs used to identify a managed care plan. The specific type
identifier is defined in the corresponding value in the Managed Care Plan Identifier Type da
element.|N/A|MCR00010|MANAGED-CARE-ID|X(30)|6|36|65|1. Value must be 2 characters
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-CA
ID|9(8)|7|66|73|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
or Sept 31st)
3. Value must be before or the same as the associated Segment End Date value
4. Mandatory
5. Value of the CC component must be in ['18', '19', '20']

MCR121|MCR.010.121|MANAGED-CARE-ID-END-DATE|Managed Care ID End Date|Mandato
The date when organization's accreditation ends.|N/A|MCR00010|MANAGED-CARE-ID|9(8)|8
81|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
or Sept 31st)
3. Value must be greater than or equal to associated Segment Effective Date value
4. Mandatory
5. Value of the CC component must be in ['18', '19', '20', '99']

MCR122|MCR.010.122|STATE-NOTATION|State Notation|Optional|A free text field for the
submitting state to enter whatever information it chooses.|N/A|MCR00010|MANAGED-CARE
X(500)|9|82|581|1. Value must be 500 characters or less
2. Value must not contain a pipe or asterisk symbols
3. Optional

PRV139|PRV.001.139|FILE-SUBMISSION-METHOD|File Submission Method|Mandatory|The fi
submission method (e.g., TFFR, RHFR, IT, or CSO) used by the state to build and submit th
This should correspond with the state's declared file submission method for the same file t
and time period.|FILE-SUBMISSION-METHOD|PRV00001|FILE-SUBMISSION-METHOD|X(2)|13
79|1. Value must be in File Submission Method List (VVL)
2. Value must be 2 characters
3. Mandatory

PRV140|PRV.002.140|ATYPICAL-PROV-IND|Ayptical Provider Indicator|Mandatory|An indicat
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
character
2. Value must be in Atypical Provider Indicator code list (VVL)
3. Mandatory

TPL095|TPL.001.095|FILE-SUBMISSION-METHOD|File Submission Method|Mandatory|The fil
submission method (e.g., TFFR, RHFR, IT, or CSO) used by the state to build and submit th
This should correspond with the state's declared file submission method for the same file t
and time period.|FILE-SUBMISSION-METHOD|TPL00001|FILE-SUBMISSION-METHOD|X(2)|14
80|1. Value must be in File Submission Method List (VVL)
2. Value must be 2 characters
3. Mandatory

TPL019|TPL.002.019|MSIS-IDENTIFICATION-NUM|MSIS Identification Number|Mandatory|A s
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 da
distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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-blog/entry/4757
|N/A|TPL00002|TPL-MEDICAID-ELIGIBLE-PERSON-MAIN|X(20)|4|22|41|1. Mandatory
2. Value must be 20 characters or less

TPL032|TPL.003.032|MSIS-IDENTIFICATION-NUM|MSIS Identification Number|Mandatory|A s
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 da
distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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-blog/entry/4757
|N/A|TPL00003|TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO|X(2
22|41|1. Mandatory
2. Value must be 20 characters or less

TPL066|TPL.005.066|MSIS-IDENTIFICATION-NUM|MSIS Identification Number|Mandatory|A s
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 da
distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, 'CMS Guidance: Reporting Shared MSIS Identification Numbers' for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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-blog/entry/4757
|N/A|TPL00005|TPL-MEDICAID-ELIGIBLE-OTHER-THIRD-PARTY-COVERAGE-INFORMATION|X(2
22|41|1. Mandatory
2. Value must be 20 characters or less

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
the version number specified on the Cover Sheet of the data dictionary.|DATA-DICTIONARY
VERSION|CIP00001|FILE-HEADER-RECORD-IP|X(10)|2|9|18|1. Value must be 10 characters
less
2. Value must be in Data Dictionary Version List (VVL)
3. Value must not include the pipe ("|") symbol
4. 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 one subject area (i.e., Eligible, Third-party liability, Provider, Managed Care Plan Informatic Inpatient, Long-Term Care, Other, Pharmacy Claim, and Financial Transactions).|N/A|CIP00 FILE-HEADER-RECORD-IP|X(8)|6|32|39|1. Value must equal "CLAIM-IP"
2. Mandatory

CIP020|CIP.002.020|ICN-ADJ|Adjustment ICN|Conditional|A unique claim number assigned b 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 equals "0", then value must not be populated
4. Conditional
5. If associated Adjustment Indicator value equals "4", then value must be populated

CIP022|CIP.002.022|MSIS-IDENTIFICATION-NUM|MSIS Identification Number|Mandatory|A st 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 da distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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|CIP00002|CLAIM-HEADER-RECORD-IP|X(20)|7|134|15 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 E Date (ELG.021.254)

CIP023|CIP.002.023|CROSSOVER-INDICATOR|Crossover Indicator|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. Value mus
1 character
2. Value must be in Crossover Indicator List (VVL)
3. If Crossover Indicator value equals "1", then associated Dual Eligible Code (ELG.005.085
value must be in [01,02,04,08,09,10] for the same time period (by date of service)
4. Mandatory

CIP026|CIP.002.026|ADJUSTMENT-IND|Adjustment Indicator|Mandatory|Indicates the type o
adjustment record.|ADJUSTMENT-IND|CIP00002|CLAIM-HEADER-RECORD-IP|X(1)|11|158|15
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"

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 hospital stay referenced by this claim. The principal procedure and related info should be recorded in Procedure Code1, Procedure Code Date-1, and Procedure Code Flag 1. The prin 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 2 through Procedure Code 6 (and related dat elements) to record secondary, tertiary, etc. procedures.|PROCEDURE-CODE|CIP00002|CLA HEADER-RECORD-IP|X(8)|17|191|198|1. Value must be 8 characters or less
2. When populated, there must be a corresponding Procedure Code Flag
3. If associated Procedure Code Flag value indicates an ICD-9-CM encoding "02", then valu must be a valid ICD-9-CM procedure code
4. If associated Procedure Code Flag value indicates an ICD-10-CM encoding "07", then val must be a valid ICD-10-CM procedure code
5. If associated Procedure Code Flag value indicates an "Other" encoding "10-87", then Sta must provide T-MSIS system with State-specific procedure code list, and value must be a v State-specific procedure code
6. Value must be in Procedure Code List (VVL)
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 hospital stay referenced by this claim. The principal procedure and related info should be recorded in Procedure Code 1, Procedure Code 1, and Procedure Code Flag 1. The principa 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 aris during other treatments. Use Procedure Code 2 through Procedure Code 6 (and related da elements) to record secondary, tertiary, etc. procedures.|PROCEDURE-CODE|CIP00002|CLA HEADER-RECORD-IP|X(8)|20|209|216|1. Value must be 8 characters or less
2. When populated, there must be a corresponding Procedure Code Flag
3. If associated Procedure Code Flag value indicates an ICD-9-CM encoding "02", then valu must be a valid ICD-9-CM procedure code
4. If associated Procedure Code Flag value indicates an ICD-10-CM encoding "07", then val must be a valid ICD-10-CM procedure code
5. If associated Procedure Code Flag value indicates an "Other" encoding "10-87", then Sta must provide T-MSIS system with State-specific procedure code list, and value must be a v State-specific procedure code
6. Value must be in Procedure Code List (VVL)
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 hospital stay referenced by this claim. The principal procedure and related info should be recorded in Procedure Code 1, Procedure Code Date 1, and Procedure 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 complicatio that arise during other treatments. Use Procedure Code 2 through Procedure Code 6 (and related data elements) to record secondary, tertiary, etc. procedures.|PROCEDURE-CODE| CIP00002|CLAIM-HEADER-RECORD-IP|X(8)|23|227|234|1. Value must be 8 characters or les
2. When populated, there must be a corresponding Procedure Code Flag
3. If associated Procedure Code Flag value indicates an ICD-9-CM encoding "02", then valu must be a valid ICD-9-CM procedure code
4. If associated Procedure Code Flag value indicates an ICD-10-CM encoding "07", then val must be a valid ICD-10-CM procedure code
5. If associated Procedure Code Flag value indicates an "Other" encoding "10-87", then Sta must provide T-MSIS system with State-specific procedure code list, and value must be a v State-specific procedure code
6. Value must be in Procedure Code List (VVL)
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 hospital stay referenced by this claim. The principal procedure and related info should be recorded in Procedure Code 1, Procedure Code Date 1, and Procedure 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 complicatio that arise during other treatments. Use Procedure Code 2 through Procedure Code 6 (and related data elements) to record secondary, tertiary, etc. procedures.|PROCEDURE-CODE| CIP00002|CLAIM-HEADER-RECORD-IP|X(8)|26|245|252|1. Value must be 8 characters or les
2. When populated, there must be a corresponding Procedure Code Flag
3. If associated Procedure Code Flag value indicates an ICD-9-CM encoding "02", then valu must be a valid ICD-9-CM procedure code
4. If associated Procedure Code Flag value indicates an ICD-10-CM encoding "07", then val must be a valid ICD-10-CM procedure code
5. If associated Procedure Code Flag value indicates an "Other" encoding "10-87", then Sta must provide T-MSIS system with State-specific procedure code list, and value must be a v State-specific procedure code
6. Value must be in Procedure Code List (VVL)
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 hospital stay referenced by this claim. The principal procedure and related info should be recorded in Procedure Code 1, Procedure Code Date 1, and Procedure 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 complicatio that arise during other treatments. Use Procedure Code 2 through Procedure Code 6 (and related data elements) to record secondary, tertiary, etc. procedures.|PROCEDURE-CODE| CIP00002|CLAIM-HEADER-RECORD-IP|X(8)|29|263|270|1. Value must be 8 characters or les
2. When populated, there must be a corresponding Procedure Code Flag
3. If associated Procedure Code Flag value indicates an ICD-9-CM encoding "02", then valu must be a valid ICD-9-CM procedure code
4. If associated Procedure Code Flag value indicates an ICD-10-CM encoding "07", then val must be a valid ICD-10-CM procedure code
5. If associated Procedure Code Flag value indicates an "Other" encoding "10-87", then Sta must provide T-MSIS system with State-specific procedure code list, and value must be a v State-specific procedure code
6. Value must be in Procedure Code List (VVL)
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 hospital stay referenced by this claim. The principal procedure and related info should be recorded in Procedure Code 1, Procedure Code Date 1, and Procedure 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 complicatio that arise during other treatments. Use Procedure Code 2 through Procedure Code 6 (and related data elements) to record secondary, tertiary, etc. procedures.|PROCEDURE-CODE| CIP00002|CLAIM-HEADER-RECORD-IP|X(8)|32|281|288|1. Value must be 8 characters or les
2. When populated, there must be a corresponding Procedure Code Flag
3. If associated Procedure Code Flag value indicates an ICD-9-CM encoding "02", then valu must be a valid ICD-9-CM procedure code
4. If associated Procedure Code Flag value indicates an ICD-10-CM encoding "07", then val must be a valid ICD-10-CM procedure code
5. If associated Procedure Code Flag value indicates an "Other" encoding "10-87", then Sta must provide T-MSIS system with State-specific procedure code list, and value must be a v State-specific procedure code
6. Value must be in Procedure Code List (VVL)
7. Conditional

CIP100|CIP.002.100|TYPE-OF-CLAIM|Type of Claim|Mandatory|A code to indicate what type payment is covered in this claim. For sub-capitated encounters from a sub-capitated entity 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)|41|335|335|1. Value must be 1 character
2. Value must be in Type of Claim List (VVL)
3. Mandatory

CIP104|CIP.002.104|SOURCE-LOCATION|Source Location|Mandatory|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 netwo 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 t 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)|45|3 347|1. Value must be 2 characters
2. Value must be in Source Location List (VVL)
3. Mandatory

CIP114|CIP.002.114|TOT-MEDICAID-PAID-AMT|Total Medicaid Paid Amount|Conditional|The amount paid by Medicaid/CHIP or the managed care plan on this claim or adjustment at th 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 netwo provider, report the total amount that the sub-capitated entity paid the provider for the se 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, re a null value in this field.|N/A|CIP00002|CLAIM-HEADER-RECORD-IP|S9(11)V99|54|417|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 reporte must equal Total Medicaid Paid Amount
5. When Payment Level Indicator equals "2", value must equal the sum of line level Medica 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)

CIP126|CIP.002.126|FUNDING-CODE|Funding Code|Conditional|A code to indicate the sourc
non-federal share funds.|FUNDING-CODE|CIP00002|CLAIM-HEADER-RECORD-IP|X(2)|62|487
488|1. Value must be 1 character
2. Value must be in Funding Code List (VVL)
3. If Type of Claim is in [3,C,W], then value must be populated
4. Conditional

CIP127|CIP.002.127|FUNDING-SOURCE-NONFEDERAL-SHARE|Funding Source Non-Federal
Share|Conditional|A code to indicate the type of non-federal share used by the state to fina
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)|63|489|490|1. Va
must be 2 characters
2. Value must be in Funding Source Non-Federal Share List (VVL)
3. If Type of Claim is in [3,C,W], then value must be populated
4. 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 combin
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)|71|527|533|1. Value m
be a positive integer
2. Value must be between 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 d
5. Value must be 7 digits or less
6. Value is required if the associated Type of Service (CIP.002.257) 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) in [100-219]

CIP137|CIP.002.137|CLAIM-LINE-COUNT|Claim Line Count|Mandatory|The total number of li
on the claim.|N/A|CIP00002|CLAIM-HEADER-RECORD-IP|9(4)|72|534|537|1. Value must be 4
characters or less
2. Value must be a positive integer
3. Value must be between 0000:9999 (inclusive)
4. Value must not include commas or other non-numeric characters
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
6. 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 He
Home care model to provide services for the beneficiary on the claim. Health home provid
provide service for patients with chronic illnesses. States that do not specify an eligible
individual's health home provider number, if applicable, should not report claims that indic
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)|111|818|818|1. Value
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"
4. 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, ful
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 suffi
for renewals or amendments.|N/A|CIP00002|CLAIM-HEADER-RECORD-IP|X(20)|113|821|840
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 Wai
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 inclu
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 follow
by a period (.), the associated Claim Waiver Type value must be in [02-20,32,33]
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 managed care plan. This data element should represent the entity billing for the service. For encounter records, if associ Type of Claim value equals 3, C, or W, then value must be the state identifier of the provid entity (billing or reporting) to the managed care plan.|N/A|CIP00002|CLAIM-HEADER-RECOI IP|X(30)|114|841|870|1. Value must be 30 characters or less
2. Conditional
3. When Type of Claim not in [3,C,W] then value may match (PRV.002.019) Submitting Sta Provider ID or
4. When Type of Claim not in [3,C,W] then value may match (PRV.005.081) Provider Identi where the Provider Identifier Type (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|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 b admitting provider except for Long Term Care.|N/A|CIP00002|CLAIM-HEADER-RECORD-IP|X 115|871|880|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)

CIP184|CIP.002.184|ADMITTING-PROV-NPI-NUM|Admitting Provider NPI Number|Conditiona National Provider ID (NPI) of the doctor responsible for admitting a patient to a hospital or inpatient health facility.|N/A|CIP00002|CLAIM-HEADER-RECORD-IP|X(10)|119|897|906|1. Va 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

CIP190|CIP.002.190|REFERRING-PROV-NPI-NUM|Referring Provider NPI Number|Conditional National Provider ID (NPI) of the provider who recommended the servicing provider to the patient.|N/A|CIP00002|CLAIM-HEADER-RECORD-IP|X(10)|125|983|992|1. Value must be 10
2. Value must have an associated Provider Identifier Type equal to "2"
3. Value must exist in the NPPES NPI data file
4. Conditional

CIP203|CIP.002.203|SPLIT-CLAIM-IND|Split Claim Indicator|Conditional|An indicator that der
that claims in excess of a pre-determined number of claim lines (threshold determined by
individual state) will be split during processing.|SPLIT-CLAIM-IND|CIP00002|CLAIM-HEADER-
RECORD-IP|X(1)|133|1065|1065|1. Value must be 1 character
2. Value must be in Split Claim Indicator List (VVL)
3. Conditional

CIP221|CIP.002.221|HEALTH-HOME-PROVIDER-NPI|Health Home Provider NPI Number|
Conditional|The National Provider ID (NPI) of the health home provider.|N/A|CIP00002|CLAI
HEADER-RECORD-IP|X(10)|149|1237|1246|1. Value must be 10 digits
2. Value must have an associated Provider Identifier, where Provider Identifier Type
(PRV.005.077) equals "2"
3. Value must exist in the NPPES NPI data file
4. Conditional

CIP298|CIP.002.298|BILLING-PROV-ADDR-LN-1|Billing Provider Address Line 1|Mandatory|B
provider address line 1 from X12 837I loop 2010AA.|N/A|CIP00002|CLAIM-HEADER-RECORD
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|B
provider address line 2 from X12 837I loop 2010AA.|N/A|CIP00002|CLAIM-HEADER-RECORD
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 ad
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 pro
address state code from X12 837I loop 2010AA.|STATE|CIP00002|CLAIM-HEADER-RECORD-
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 (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 Addr 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 tha 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 Addr 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 tha 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 tha 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
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 Co
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-
(Example: 91320) or 9 digits (0-9) (Example: 913200011)
2. Value must be in ZIP Code List (VVL)
3. Conditional

CIP234|CIP.003.234|MSIS-IDENTIFICATION-NUM|MSIS Identification Number|Mandatory|A st
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 da
distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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|CIP00003|CLAIM-LINE-RECORD-IP|X(20)|4|22|41|1. Va
must be 20 characters or less
2. Mandatory

CIP236|CIP.003.236|ICN-ADJ|Adjustment ICN|Conditional|A unique claim number assigned b
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 equals "0", then value must not be populated
4. Conditional
5. If associated Adjustment Indicator value equals "4", then value must be populated

CIP254|CIP.003.254|MEDICAID-PAID-AMT|Medicaid Paid Amount|Conditional|The amount pa
by Medicaid/CHIP agency or the managed care plan on this claim or adjustment at the clai
detail level. 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 provi
at the claim line detail level. Report a null value in this field if the provider is a sub-capitate
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, re
a null value in this field.|N/A|CIP00003|CLAIM-LINE-RECORD-IP|S9(11)V99|20|231|243|1. Va
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 should not be populated or should be equal to zero, when associated Claim Line S
is in [542,585,654]

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|CIP00003|CLAIM-LINE-
RECORD-IP|X(3)|23|259|261|1. Value must be 3 characters
2. Mandatory
3. Value must be in Type of Service List (VVL)
4. If Sex (ELG.002.023) equals "M", then value must not equal "086"
5. Value must be in [001,058,060,084,086,090,091,092,093,123,132,135,136,137]

CIP261|CIP.003.261|SERVICING-PROV-NPI-NUM|Servicing Provider NPI Number|Conditional|
NPI of the health care professional who delivers or completes a particular medical service
non-surgical procedure. The Servicing Provider NPI Number is required when rendering pro
is different than the attending provider and state or federal regulatory requirements call fo
"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-LI
RECORD-IP|X(10)|25|292|301|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

CIP265|CIP.003.265|OPERATING-PROV-NPI-NUM|Operating Provider NPI Number|Conditiona
National Provider ID (NPI) of the provider who performed the surgical procedures on the beneficiary.|N/A|CIP00003|CLAIM-LINE-RECORD-IP|X(10)|28|306|315|1. Value must be 10 d
2. Value must have an associated Provider Identifier Type equal to "2"
3. Conditional
4. Value must exist in the NPPES NPI data file

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.|
SERVICE-IND|CIP00003|CLAIM-LINE-RECORD-IP|X(1)|39|404|404|1. Value must be 1 charac
2. Value must be in the IHS Service Indicator List (VVL)
3. Mandatory

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 se
is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM
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 Medi
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 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 service value is.|MBESCBES-FORM|CIP00003|CLAIM-LINE-RECORD-IP|X(50)|42|482|531|1. V
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 Medica
Paid Amount greater than $0

CIP319|CIP.003.319|REFERRING-PROV-NPI-NUM|Referring Provider NPI Number|Conditional
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

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 fo Title XIX-funded Medicaid, the CMS-64.21 form is for Title XXI-funded Medicaid-expansion C (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 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 Medica
Paid Amount greater than $0

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 should be interpreted depending on which segment type the Record ID represents. Each ty of segment collects different data elements so each segment type has a distinct layout. Th first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).|RECORD-I
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 receiv
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)

CIP326|CIP.004.326|ICN-ADJ|Adjustment ICN|Conditional|A unique claim number assigned
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
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
adjustment record.|ADJUSTMENT-IND|CIP00004|CLAIM-DX-IP|X(1)|6|122|122|1. Value must
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)

CIP330|CIP.004.330|DIAGNOSIS-SEQUENCE-NUMBER|Diagnosis Sequence Number|Mandat
The order in which the diagnosis occurred on the provider's claim for a given type of diagn
code (e.g., an 837I claim can have up to 12 external cause of injury diagnosis codes and u
24 other diagnosis codes).|N/A|CIP00004|CLAIM-DX-IP|9(2)|9|132|133|1. Value must be in [
24]
2. Mandatory

CLT006|CLT.001.006|FILE-NAME|File Name|Mandatory|A code to identify the subject area t
which the records in its file relate. Each T-MSIS submission file should only contain records
one subject area (i.e., Eligible, Third-party liability, Provider, Managed Care Plan Informatio
Inpatient, Long-Term Care, Other, Pharmacy Claim, and Financial Transactions).|N/A|CLT00
FILE-HEADER-RECORD-LT|X(8)|6|32|39|1. Value must equal "CLAIM-LT"
2. Mandatory

CLT020|CLT.002.020|ICN-ADJ|Adjustment ICN|Conditional|A unique claim number assigned
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 equals "0", then value must not be populated
4. Conditional
5. If associated Adjustment Indicator value equals "4", then value must be populated

CLT022|CLT.002.022|MSIS-IDENTIFICATION-NUM|MSIS Identification Number|Mandatory|A s
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 da
distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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|CLT00002|CLAIM-HEADER-RECORD-LT|X(20)|7|134|1
Mandatory
2. Value must be 20 characters or less.
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|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. Value mu
be 1 character
2. Value must be in Crossover Indicator List (VVL)
3. If Crossover Indicator value equals "1", then associated Dual Eligible Code (ELG.005.085
value must be in [01,02,04,08,09,10] for the same time period (by date of service)
4. Mandatory

CLT025|CLT.002.025|ADJUSTMENT-IND|Adjustment Indicator|Mandatory|Indicates the type
adjustment record.|ADJUSTMENT-IND|CLT00002|CLAIM-HEADER-RECORD-LT|X(1)|10|156|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)

CLT052|CLT.002.052|TYPE-OF-CLAIM|Type of Claim|Mandatory|A code to indicate what typ
payment is covered in this claim. For sub-capitated encounters from a sub-capitated entity
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)|20|212|212|1. Value must be 1 character
2. Value must be in Type of Claim List (VVL)
3. Mandatory

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 the claim header level, which is the sum of the amounts paid by Medicaid or the managed plan at the detail level for the claim.

For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated netwo provider, report the total amount that the sub-capitated entity paid the provider for the se 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, re a null value in this field.|N/A|CLT00002|CLAIM-HEADER-RECORD-LT|S9(11)V99|33|294|306| 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 reporte must equal Total Medicaid Paid Amount
5. When Payment Level Indicator equals "2", value must equal the sum of line level Medica 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)

CLT076|CLT.002.076|FUNDING-CODE|Funding Code|Conditional|A code to indicate the sou non-federal share funds.|FUNDING-CODE|CLT00002|CLAIM-HEADER-RECORD-LT|X(2)|41|36 365|1. Value must be 1 character
2. Value must be in Funding Code List (VVL)
3. If Type of Claim is in [3,C,W], then value must be populated
4. 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/ CLT00002|CLAIM-HEADER-RECORD-LT|S9(5)|50|404|408|1. Value must be a positive intege
2. Value must be between 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 in [044,048,050], this field must be populated

CLT087|CLT.002.087|CLAIM-LINE-COUNT|Claim Line Count|Mandatory|The total number of on the claim.|N/A|CLT00002|CLAIM-HEADER-RECORD-LT|9(4)|51|409|412|1. Value must be characters or less
2. Value must be a positive integer
3. Value must be between 0000:9999 (inclusive)
4. Value must not include commas or other non-numeric characters
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
6. 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 He Home care model to provide services for the beneficiary on the claim. Health home provid provide service for patients with chronic illnesses. States that do not specify an eligible individual's health home provider number, if applicable, should not report claims that indic 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)|89|684|684|1. Value 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"
4. 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, ful 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 suffi for renewals or amendments.|N/A|CLT00002|CLAIM-HEADER-RECORD-LT|X(20)|91|687|706 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 Wai 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 inclu 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 follow by a period (.), the associated Claim Waiver Type value must be in [02-20,32,33]
6. Conditional

CLT131|CLT.002.131|BILLING-PROV-NPI-NUM|Billing Provider NPI Number|Conditional|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 b admitting provider except for Long Term Care.|N/A|CLT00002|CLAIM-HEADER-RECORD-LT|X(10)|93|737|746|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)

CLT136|CLT.002.136|REFERRING-PROV-NPI-NUM|Referring Provider NPI Number|Conditiona National Provider ID (NPI) of the provider who recommended the servicing provider to the patient.|N/A|CLT00002|CLAIM-HEADER-RECORD-LT|X(10)|98|793|802|1. Value must be 10
2. Value must have an associated Provider Identifier Type equal to "2"
3. Value must exist in the NPPES NPI data file
4. Conditional

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 determ by the individual state) will be split during processing.|SPLIT-CLAIM-IND|CLT00002|CLAIM-HEADER-RECORD-LT|X(1)|106|875|875|1. Value must be 1 character
2. Value must be in Split Claim Indicator List (VVL)
3. Conditional

CLT167|CLT.002.167|HEALTH-HOME-PROVIDER-NPI|Health Home Provider NPI Number|Conditional|The National Provider ID (NPI) of the health home provider.|N/A|CLT00002|CLA HEADER-RECORD-LT|X(12)|121|1034|1045|1. Value must be 12 digits
2. Value must have an associated Provider Identifier, where Provider Identifier Type (PRV.005.077) equals "2"
3. Value must exist in the NPPES NPI data file
4. Conditional

CLT174|CLT.002.174|ADMITTING-PROV-NPI-NUM|Admitting Provider NPI Number|Conditiona The National Provider ID (NPI) of the doctor responsible for admitting a patient to a hospita other inpatient health facility.|N/A|CLT00002|CLAIM-HEADER-RECORD-LT|X(10)|123|1058|1
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

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 Add
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 tha
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 Add
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 tha
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 tha
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
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 C
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
(Example: 91320) or 9 digits (0-9) (Example: 913200011)
2. Value must be in ZIP Code List (VVL)
3. Conditional

CLT187|CLT.003.187|MSIS-IDENTIFICATION-NUM|MSIS Identification Number|Mandatory|A s
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 da
distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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|CLT00003|CLAIM-LINE-RECORD-LT|X(20)|4|22|41|1. V
must be 20 characters or less
2. Mandatory

CLT189|CLT.003.189|ICN-ADJ|Adjustment ICN|Conditional|A unique claim number assigned
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 equals "0", then value must not be populated
4. Conditional
5. If associated Adjustment Indicator value equals "4", then value must be populated

CLT208|CLT.003.208|MEDICAID-PAID-AMT|Medicaid Paid Amount|Conditional|The amount p
by Medicaid/CHIP agency or the managed care plan on this claim or adjustment at the clai
detail level. 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 provi
at the claim line detail level. Report a null value in this field if the provider is a sub-capitate
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, re
a null value in this field.|N/A|CLT00003|CLAIM-LINE-RECORD-LT|S9(11)V99|22|257|269|1. V
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 should not be populated or should be equal to zero, when associated Claim Line S
is in [542,585,654]

CLT213|CLT.003.213|SERVICING-PROV-NPI-NUM|Servicing Provider NPI Number|Conditiona
NPI of the health care professional who delivers or completes a particular medical service
non-surgical procedure. The Servicing Provider NPI Number is required when rendering pro
is different than the attending provider and state or federal regulatory requirements call fo
"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-L
RECORD-LT|X(10)|27|318|327|1. Value must be 10 digits
2. Value must have an associated Provider Identifier Type equal to "2"
3. Conditional
4. If Type of Claim (CLT.002.052) not in [3,C,W], then value must match Provider Identifier
(PRV.005.081)
5. Value must exist in the NPPES NPI data file

CLT219|CLT.003.219|CATEGORY-FOR-FEDERAL-REIMBURSEMENT|Category for Federal
Reimbursement|Conditional|A code to indicate the Federal funding source for the payment
CATEGORY-FOR-FEDERAL-REIMBURSEMENT|CLT00003|CLAIM-LINE-RECORD-LT|X(2)|31|335
336|1. Value must be 2 characters
2. Value must be in Category for Federal Reimbursement List (VVL)
3. (Federal Funding under Title XXI) if value equals "02", then the eligible's CHIP Code
(ELG.003.054) must be in [2,3]
4. (Federal Funding under Title XIX) if value equals "01" then the eligible's CHIP Code
(ELG.003.054) must be "1"
5. Conditional
6. If Type of Claim is in [1,A,U] and the Total Medicaid Paid Amount is populated on the
corresponding claim header, then value must be reported

CLT233|CLT.003.233|ADJUDICATION-DATE|Adjudication Date|Mandatory|The date on which
payment status of the claim was finally adjudicated by the state. For Encounter Records (T
of Claim = 3, C, W), use date the encounter was processed by the state.|N/A|CLT00003|CL
LINE-RECORD-LT|9(8)|36|378|385|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

CLT243|CLT.003.243|IHS-SERVICE-IND|IHS Service Indicator|Mandatory|To indicate Service
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.|
SERVICE-IND|CLT00003|CLAIM-LINE-RECORD-LT|X(1)|39|407|407|1. Value must be 1 chara
2. Value must be in the IHS Service Indicator List (VVL)
3. Mandatory

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 se
is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM
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 Medi
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 for
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
service value is.|MBESCBES-FORM|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 Medica
Paid Amount greater than $0

CLT265|CLT.003.265|REFERRING-PROV-NPI-NUM|Referring Provider NPI Number|Conditiona
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 digit
2. Conditional
3. Value must have an associated Provider Identifier Type equal to "2"
4. Value must exist in the NPPES NPI File

CLT282|CLT.003.282|MBESCBES-FORM-GROUP|MBESCBES Form Group|Conditional|Indicate
group of MBES/CBES forms that this payment applies to (e.g., the CMS-64.9 Base form is fo
Title XIX-funded Medicaid, the CMS-64.21 form is for Title XXI-funded Medicaid-expansion C
(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 mus
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 Medica
Paid Amount greater than $0

CLT268|CLT.004.268|RECORD-ID|Record ID|Mandatory|The Record ID represents the type o
segment being reported. The Record ID communicates how the contents of a given row of
should be interpreted depending on which segment type the Record ID represents. Each ty
of segment collects different data elements so each segment type has a distinct layout. Th
first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th
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"

CLT272|CLT.004.272|ICN-ADJ|Adjustment ICN|Conditional|A unique claim number assigned
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
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
adjustment record.|ADJUSTMENT-IND|CLT00004|CLAIM-DX-LT|X(1)|6|122|122|1. Value mus
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)

CLT276|CLT.004.276|DIAGNOSIS-SEQUENCE-NUMBER|Diagnosis Sequence Number|Manda
The order in which the diagnosis occurred on the provider's claim for a given type of diagn
code (e.g., an 837I claim can have up to 12 external cause of injury diagnosis codes and u
24 other diagnosis codes).|N/A|CLT00004|CLAIM-DX-LT|9(2)|9|132|133|1. Value must be in
24]
2. Mandatory

COT020|COT.002.020|ICN-ADJ|Adjustment ICN|Conditional|A unique claim number assigne
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 5
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

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident
MSIS Identification Numbers are a unique "key" value used to maintain referential integrity
data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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|COT00002|CLAIM-HEADER-RECORD-OT|X(20)|7|134|1
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|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. Value m
be 1 character
2. Value must be in Crossover Indicator List (VVL)
3. If Crossover Indicator value equals "1", then associated Dual Eligible Code (ELG.005.085
value must be in [01,02,04,08,09,10] for the same time period (by date of service)
4. Mandatory

COT025|COT.002.025|ADJUSTMENT-IND|Adjustment Indicator|Mandatory|Indicates the type
adjustment record.|ADJUSTMENT-IND|COT00002|CLAIM-HEADER-RECORD-OT|X(1)|10|156|1
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"

COT037|COT.002.037|TYPE-OF-CLAIM|Type of Claim|Mandatory|A code to indicate what typ
payment is covered in this claim. For sub-capitated encounters from a sub-capitated entity
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)|16|192|192|1. Value must be 1 character
2. Value must be in Type of Claim List (VVL)
3. Mandatory

COT041|COT.002.041|SOURCE-LOCATION|Source Location|Mandatory|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 netwo
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 t
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)|20
203|204|1. Value must be 2 characters
2. Value must be in Source Location List (VVL)
3. Mandatory

COT048|COT.002.048|TOT-BILLED-AMT|Total Billed Amount|Conditional|The total amount b
for this claim at the claim header level as submitted by the provider. For encounter record
when Type of Claim value is in [3, C, W], then value must equal amount the provider billed
the managed care plan. For sub-capitated encounters from a sub-capitated entity that is n
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-capi
network provider. For sub-capitated encounters from a sub-capitated network provider, if t
sub-capitated network provider directly employs the provider that renders the service to th
enrollee, report a null value in this field.|N/A|COT00002|CLAIM-HEADER-RECORD-OT|S9(11
27|248|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. (individual line item payments) when populated and Payment Level Indicator (COT.002.0
equals "2" value must be greater than or equal to the sum of all claim line Revenue Charg
(COT.003.168)

COT050|COT.002.050|TOT-MEDICAID-PAID-AMT|Total Medicaid Paid Amount|Conditional|Th
total amount paid by Medicaid/CHIP or the managed care plan on this claim or adjustment
the claim header level, which is the sum of the amounts paid by Medicaid or the managed
plan at the detail level for the claim.

For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated netwo
provider, report the total amount that the sub-capitated entity paid the provider for the se
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, re
a null value in this field.|N/A|COT00002|CLAIM-HEADER-RECORD-OT|S9(11)V99|29|274|286
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 reporte
must equal Total Medicaid Paid Amount
5. When Payment Level Indicator equals "2", value must equal the sum of line level Medica
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)

COT057|COT.002.057|OTHER-INSURANCE-IND|Other Insurance Indicator|Conditional|The fi 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) 339|339|1. Value must be 1 character 2. Value must be in Other Insurance Indicator List (VVL) 3. Conditional
COT062|COT.002.062|FUNDING-CODE|Funding Code|Conditional|A code to indicate the sou of non-federal share funds.|FUNDING-CODE|COT00002|CLAIM-HEADER-RECORD-OT|X(2)|37 344|345|1. Value must be 1 character 2. Value must be in Funding Code List (VVL) 3. If Type of Claim is in [3,C,W], then value must be populated 4. Conditional
COT063|COT.002.063|FUNDING-SOURCE-NONFEDERAL-SHARE|Funding Source Non-Federa Share|Conditional|A code to indicate the type of non-federal share used by the state to fina 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)|38|346|347|1. V must be 2 characters 2. Value must be in Funding Source Non-Federal Share List (VVL) 3. If Type of Claim is in [3,C,W], then value must be populated 4. Conditional

COT066|COT.002.066|PLAN-ID-NUMBER|Plan ID Number|Conditional|A unique number assi
by the state which represents a distinct comprehensive managed care plan, prepaid healt
plan, primary care case management program, a program for all-inclusive care for the elde
entity, or other approved plans.

For sub-capitated encounters from a sub-capitated entity or sub-capitated network provide
report the PLAN-ID-NUMBER for the MCP (MCO, PIHP, or PAHP that has a contract with a sta
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, re
a null value in this field.|N/A|COT00002|CLAIM-HEADER-RECORD-OT|X(12)|41|351|362|1. V
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] value must have a managed care enrollm
(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] value must have a managed care main re
(MCR.002) for the plan where the Beginning DOS (COT.002.037) occurs between the mana
care contract eff/end dates (MCR.002.020/021)

COT070|COT.002.070|CLAIM-LINE-COUNT|Claim Line Count|Mandatory|The total number o
lines on the claim.|N/A|COT00002|CLAIM-HEADER-RECORD-OT|9(4)|44|366|369|1. Value m
be 4 characters or less
2. Value must be a positive integer
3. Value must be between 0000:9999 (inclusive)
4. Value must not include commas or other non-numeric characters
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
6. Mandatory

COT109|COT.002.109|HEALTH-HOME-PROV-IND|Health Home Provider Indicator|Conditiona
Indicates whether the claim is submitted by a provider or provider group enrolled in the He
Home care model to provide services for the beneficiary on the claim. Health home provid
provide service for patients with chronic illnesses. States that do not specify an eligible
individual's health home provider number, if applicable, should not report claims that indic
the claim is submitted by a provider or provider group enrolled in the health home model.|
HEALTH-HOME-PROV-IND|COT00002|CLAIM-HEADER-RECORD-OT|X(1)|82|641|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"
4. Conditional

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, ful
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 suffi
for renewals or amendments.|N/A|COT00002|CLAIM-HEADER-RECORD-OT|X(20)|84|644|66
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 Wai
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 inclu
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 follow
by a period (.), the associated Claim Waiver Type value must be in [02-20,32,33]
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 managed care plan. This data element should represent the entity billing for the service. For encounter records, if associ Type of Claim value equals 3, C, or W, then value must be the state identifier of the provid entity (billing or reporting) to the managed care plan.|N/A|COT00002|CLAIM-HEADER-RECO OT|X(30)|85|664|693|1. Value must be 30 characters or less
2. Conditional
3. When Type of Claim not in [3,C,W] then value may match (PRV.002.019) Submitting Sta Provider ID or
4. When Type of Claim not in [3,C,W] then value may match (PRV.005.081) Provider Identi where the Provider Identifier Type (PRV.005.077) equals "1"
5. Must have an enrollment where the Ending Date of Service (COT.003.167) may be betw 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 betw Provider Identifier Effective Date (PRV.005.079) and Provider Identifier End Date (PRV.005.
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|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 b admitting provider except for Long Term Care. For sub-capitation payments, report the nat provider identifier (NPI) for the sub-capitated entity if the provider has one.|N/A|COT00002 CLAIM-HEADER-RECORD-OT|X(10)|86|694|703|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)

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)|87|704|715|1. Value must be in Provider Taxonomy List (VVL)
2. Value must be 12 characters or less
3. Conditional
4. If associated Type of Service value is in [119,120,121,122], then value should not be populated

COT118|COT.002.118|REFERRING-PROV-NPI-NUM|Referring Provider NPI Number|Condition
The National Provider ID (NPI) of the provider who recommended the servicing provider to
patient.|N/A|COT00002|CLAIM-HEADER-RECORD-OT|X(10)|91|750|759|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

COT146|COT.002.146|HEALTH-HOME-PROVIDER-NPI|Health Home Provider NPI Number|
Conditional|The National Provider ID (NPI) of the health home provider.|N/A|COT00002|CLA
HEADER-RECORD-OT|X(10)|110|969|978|1. Value must be 10 digits
2. Value must have an associated Provider Identifier, where Provider Identifier Type
(PRV.005.077) equals "2"
3. Value must exist in the NPPES NPI data file
4. 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|Conditiona
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
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|COT0000
CLAIM-HEADER-RECORD-OT|X(2)|121|1209|1210|1. Value must not be more than 2 charac
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|COT000 CLAIM-HEADER-RECORD-OT|X(9)|122|1211|1219|1. Value may only be 5 digits (0-9) (Exam 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 2 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 2310 837P and 837D loop 2310C.|N/A|COT00002|CLAIM-HEADER-RECORD-OT|X(60)|124|1230|12
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 2310 837P and 837D loop 2310C.|N/A|COT00002|CLAIM-HEADER-RECORD-OT|X(60)|125|1290|13
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 a 837D loop 2310C.|N/A|COT00002|CLAIM-HEADER-RECORD-OT|X(28)|126|1350|1377|1. Valu 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
837D loop 2310C.|STATE|COT00002|CLAIM-HEADER-RECORD-OT|X(2)|127|1378|1379|1. Va
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 83
and 837D loop 2310C.|ZIP-CODE|COT00002|CLAIM-HEADER-RECORD-OT|X(9)|128|1380|13
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

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,
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 u
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
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

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique "key" value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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|COT00003|CLAIM-LINE-RECORD-OT|X(20)|4|22|41|1. Value must be 20 characters or less
2. Mandatory

COT159|COT.003.159|ICN-ADJ|Adjustment ICN|Conditional|A unique claim number assigne 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 equals "0", then value must not be populated
4. Conditional
5. If associated Adjustment Indicator value equals "4", then value must be populated

COT169|COT.003.169|PROCEDURE-CODE|Procedure Code|Conditional|A field to capture th or HCPCS code that describes a service or good rendered by the provider to an enrollee on specified date of service.|PROCEDURE-CODE|COT00003|CLAIM-LINE-RECORD-OT|X(8)|16|1 194|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
4. If associated Procedure Code Flag value indicates an CPT-4 encoding "01", then value m be a valid CPT-4 procedure code
5. If associated Procedure Code Flag value indicates an "Other" encoding "10-87", then Sta must provide T-MSIS system with State-specific procedure code list, and value must be a v State-specific procedure code
6. If associated Procedure Code Flag List (VVL) value indicates an HCPCS encoding "06", th value must be a valid HCPCS code
7. Conditional

COT172|COT.003.172|PROCEDURE-CODE-MOD-1|Procedure Code Modifier 1|Conditional|Th
procedure code modifier used with an associated procedure code. For example, some stat
use modifiers to indicate assistance in surgery or anesthesia services.|PROCEDURE-CODE-
COT00003|CLAIM-LINE-RECORD-OT|X(2)|19|205|206|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

COT178|COT.003.178|MEDICAID-PAID-AMT|Medicaid Paid Amount|Conditional|The amount
by Medicaid/CHIP agency or the managed care plan on this claim or adjustment at the clai
detail level. 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 provi
at the claim line detail level. Report a null value in this field if the provider is a sub-capitat
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, re
a null value in this field.|N/A|COT00003|CLAIM-LINE-RECORD-OT|S9(11)V99|24|259|271|1.
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 should not be populated or should be equal to zero, when associated Claim Line S
is in [542,585,654]

COT186|COT.003.186|TYPE-OF-SERVICE|Type of Service|Mandatory|A code to categorize th
services provided to a Medicaid or CHIP enrollee.|TYPE-OF-SERVICE|COT00003|CLAIM-LINE-
RECORD-OT|X(3)|29|320|322|1. Value must be 3 characters.
2. Mandatory
3. Value must be in Type of Service List (VVL)
4. Value must be in
[002,003,004,005,006,007,008,010,011,012,013,014,015,016,017,018,019,020,
021,022,023,024,025,026,027,028,029,030,031,032,035,036,037,038,039,040,041,042,04
9,050,051,052,053,054,055,056,057,058,060,061,062,063,064,065,066,
067,068,069,070,071,072,073,074,075,076,077,078,079,080,081,082,083,084,085,
086,087,088,089,115,127,136,137,144,145,147]
5. When value is not in [025,085], Sex (ELG.002.023) equals "M"

COT190|COT.003.190|SERVICING-PROV-NPI-NUM|Servicing Provider NPI Number|Conditiona
The NPI of the health care professional who delivers or completes a particular medical serv
or non-surgical procedure. The SERVICING-PROV-NPI-NUM is required when rendering prov
is different than the attending provider and state or federal regulatory requirements call fo
"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-L
RECORD-OT|X(10)|33|359|368|1. Value must be 10 digits
2. Value must have an associated Provider Identifier Type equal to "2"
3. Conditional
4. If Type of Claim (COT.002.037) not in [3,C,W], then value must match Provider Identifier
(PRV.005.081)
5. Value must exist in the NPPES NPI data file

COT203|COT.003.203|ORIGINATION-ZIP-CODE|Origination ZIP Code|Conditional|The zip cod
the origination city 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.|ZIP-CODE|COT00003
CLAIM-LINE-RECORD-OT|X(9)|46|545|553|1. Value may only be 5 digits (0-9) (Example: 913
or 9 digits (0-9) (Example: 913200011)
2. Value must be in ZIP Code List (VVL)
3. Conditional

COT208|COT.003.208|DESTINATION-ZIP-CODE|Destination ZIP Code|Conditional|The zip co
the destination city to which a patient is transported either from home or long term care fa
to a health care provider for healthcare services or vice versa. For transportation claims or
Required if state has captured this information, otherwise it is conditional.|ZIP-CODE|
COT00003|CLAIM-LINE-RECORD-OT|X(9)|51|704|712|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

COT210|COT.003.210|CATEGORY-FOR-FEDERAL-REIMBURSEMENT|Category for Federal
Reimbursement|Conditional|A code to indicate the Federal funding source for the payment
CATEGORY-FOR-FEDERAL-REIMBURSEMENT|COT00003|CLAIM-LINE-RECORD-OT|X(2)|52|71
714|1. Value must be 2 characters
2. Value must be in Category for Federal Reimbursement List (VVL)
3. (Federal Funding under Title XXI) if value equals "02", then the eligible's CHIP Code
(ELG.003.054) must be in [2,3]
4. (Federal Funding under Title XIX) if value equals "01" then the eligible's CHIP Code
(ELG.003.054) must be "1"
5. Conditional
6. If Type of Claim is in [1,A,U] and the Total Medicaid Paid Amount is populated on the
corresponding claim header, then value must be reported

COT218|COT.003.218|PROCEDURE-CODE-MOD-3|Procedure Code Modifier 3|Conditional|Th
procedure code modifier used with an associated procedure code. For example, some stat
use modifiers to indicate assistance in surgery or anesthesia services.|PROCEDURE-CODE-
COT00003|CLAIM-LINE-RECORD-OT|X(2)|56|742|743|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

COT219|COT.003.219|PROCEDURE-CODE-MOD-4|Procedure Code Modifier 4|Conditional|Th
procedure code modifier used with an associated procedure code. For example, some stat
use modifiers to indicate assistance in surgery or anesthesia services.|PROCEDURE-CODE-
COT00003|CLAIM-LINE-RECORD-OT|X(2)|57|744|745|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

COT227|COT.003.227|PROCEDURE-CODE-MOD-2|Procedure Code Modifier 2|Conditional|Th
procedure code modifier used with an associated procedure code. For example, some stat
use modifiers to indicate assistance in surgery or anesthesia services.|PROCEDURE-CODE-
COT00003|CLAIM-LINE-RECORD-OT|X(2)|55|740|741|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

COT234|COT.003.234|IHS-SERVICE-IND|IHS Service Indicator|Mandatory|To indicate Servic
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.|
SERVICE-IND|COT00003|CLAIM-LINE-RECORD-OT|X(1)|63|795|795|1. Value must be 1 chara
2. Value must be in the IHS Service Indicator List (VVL)
3. Mandatory

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 se
is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM
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 Medi
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 fo
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
service value is.|MBESCBES-FORM|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 Medica
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.
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 2420 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 2420 and 837D loop 2420D.|N/A|COT00003|CLAIM-LINE-RECORD-OT|X(60)|74|1006|1065|1. Valu 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 837 loop 2420D.|N/A|COT00003|CLAIM-LINE-RECORD-OT|X(28)|75|1066|1093|1. Value must no 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 837 loop 2420D.|STATE|COT00003|CLAIM-LINE-RECORD-OT|X(2)|76|1094|1095|1. Value must n 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

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 characters
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, 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
line/detail of their claim.|N/A|COT00003|CLAIM-LINE-RECORD-OT|X(10)|83|1190|1199|1. Va
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

COT271|COT.003.271|ORDERING-PROV-NPI-NUM|order Provider NPI Number|Conditional|Th
Medicaid provider ID of the Ordering Provider is the individual who requested the services
items being reported on this service line. Examples include, but are not limited to, provide
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

COT290|COT.003.290|MBESCBES-FORM-GROUP|MBESCBES Form Group|Conditional|Indicat
group of MBES/CBES forms that this payment applies to (e.g., the CMS-64.9 Base form is fo
Title XIX-funded Medicaid, the CMS-64.21 form is for Title XXI-funded Medicaid-expansion C
(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 mu
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 Medica
Paid Amount greater than $0

COT274|COT.004.274|RECORD-ID|Record ID|Mandatory|The Record ID represents the type
segment being reported. The Record ID communicates how the contents of a given row of
should be interpreted depending on which segment type the Record ID represents. Each ty
of segment collects different data elements so each segment type has a distinct layout. Th
first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th
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"

COT278|COT.004.278|ICN-ADJ|Adjustment ICN|Conditional|A unique claim number assigne
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 o
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
adjustment record.|ADJUSTMENT-IND|COT00004|CLAIM-DX-OT|X(1)|6|122|122|1. Value mu
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)

COT282|COT.004.282|DIAGNOSIS-SEQUENCE-NUMBER|Diagnosis Sequence Number|Manda
The order in which the diagnosis occurred on the provider's claim for a given type of diagn
code (e.g., an 837P claim can have up to 12 external cause of injury diagnosis codes and u
24 other diagnosis codes).|N/A|COT00004|CLAIM-DX-OT|9(2)|9|132|133|1. Value must be in
24]
2. Mandatory

CRX002|CRX.001.002|DATA-DICTIONARY-VERSION|Data Dictionary Version|Mandatory|A da
element to capture the version of the T-MSIS data dictionary that was used to build the file
the version number specified on the Cover Sheet of the data dictionary.|DATA-DICTIONARY
VERSION|CRX00001|FILE-HEADER-RECORD-RX|X(10)|2|9|18|1. Value must be 10 character
less
2. Value must be in Data Dictionary Version List (VVL)
3. Value must not include the pipe ("|") symbol
4. Mandatory

CRX006|CRX.001.006|FILE-NAME|File Name|Mandatory|A code to identify the subject area
which the records in its file relate. Each T-MSIS submission file should only contain records
one subject area (i.e., Eligible, Third-party liability, Provider, Managed Care Plan Informatio
Inpatient, Long-Term Care, Other, Pharmacy Claim, and Financial Transactions).|N/A|CRX0
FILE-HEADER-RECORD-RX|X(8)|6|32|39|1. Value must equal "CLAIM-RX"
2. Mandatory

CRX020|CRX.002.020|ICN-ADJ|Adjustment ICN|Conditional|A unique claim number assigned
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 5
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

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident
MSIS Identification Numbers are a unique "key" value used to maintain referential integrity
data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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|CRX00002|CLAIM-HEADER-RECORD-RX|X(20)|7|134|1
1. Value must be 20 characters or less
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|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. Value m
be 1 character
2. Value must be in Crossover Indicator List (VVL)
3. If Crossover Indicator value equals "1", then associated Dual Eligible Code (ELG.005.085
value must be in [01,02,04,08,09,10] for the same time period (by date of service)
4. Mandatory

CRX025|CRX.002.025|ADJUSTMENT-IND|Adjustment Indicator|Mandatory|Indicates the type
adjustment record.|ADJUSTMENT-IND|CRX00002|CLAIM-HEADER-RECORD-RX|X(1)|10|156|1
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"

CRX029|CRX.002.029|TYPE-OF-CLAIM|Type of Claim|Mandatory|A code to indicate what typ
payment is covered in this claim. For sub-capitated encounters from a sub-capitated entity
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. Value must be 1 character
2. Value must be in Type of Claim List (VVL)
3. Mandatory

CRX032|CRX.002.032|SOURCE-LOCATION|Source Location|Mandatory|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 netwo
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 t
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. Value must be 2 characters
2. Value must be in Source Location List (VVL)
3. Mandatory

CRX041|CRX.002.041|TOT-MEDICAID-PAID-AMT|Total Medicaid Paid Amount|Conditional|Th
total amount paid by Medicaid/CHIP or the managed care plan on this claim or adjustment
the claim header level, which is the sum of the amounts paid by Medicaid or the managed
plan at the detail level for the claim.

For sub-capitated encounters from a sub-capitated entity that is not a sub-capitated netwo
provider, report the total amount that the sub-capitated entity paid the provider for the se
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, re
a null value in this field.|N/A|CRX00002|CLAIM-HEADER-RECORD-RX|S9(11)V99|26|254|266
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 reporte
must equal Total Medicaid Paid Amount
5. When Payment Level Indicator equals "2", value must equal the sum of line level Medica
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)

CRX048|CRX.002.048|OTHER-INSURANCE-IND|Other Insurance Indicator|Conditional|The fi
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)
319|319|1. Value must be 1 character
2. Value must be in Other Insurance Indicator List (VVL)
3. Conditional

CRX053|CRX.002.053|FUNDING-CODE|Funding Code|Conditional|A code to indicate the sou
of non-federal share funds.|FUNDING-CODE|CRX00002|CLAIM-HEADER-RECORD-RX|X(2)|34
324|325|1. Value must be 1 character
2. Value must be in Funding Code List (VVL)
3. If Type of Claim is in [3,C,W], then value must be populated
4. Conditional

CRX054|CRX.002.054|FUNDING-SOURCE-NONFEDERAL-SHARE|Funding Source Non-Federa
Share|Conditional|A code to indicate the type of non-federal share used by the state to fina
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)|35|326|327|1. V
must be 2 characters
2. Value must be in Funding Source Non-Federal Share List (VVL)
3. If Type of Claim is in [3,C,W], then value must be populated
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)|40|345|348|1. Value m
be 4 characters or less
2. Value must be a positive integer
3. Value must be between 0000:9999 (inclusive)
4. Value must not include commas or other non-numeric characters
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
6. Mandatory

CRX067|CRX.002.067|HEALTH-HOME-PROV-IND|Health Home Provider Indicator|Conditiona
Indicates whether the claim is submitted by a provider or provider group enrolled in the He
Home care model to provide services for the beneficiary on the claim. Health home provid
provide service for patients with chronic illnesses. States that do not specify an eligible
individual's health home provider number, if applicable, should not report claims that indic
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)|47|439|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"
4. Conditional

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, ful 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 suffi for renewals or amendments.|N/A|CRX00002|CLAIM-HEADER-RECORD-RX|X(20)|49|442|46 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 Wai 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 inclu 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 follow by a period (.), the associated Claim Waiver Type value must be in [02-20,32,33]
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 managed care plan. This data element should represent the entity billing for the service. For encounter records, if associ Type of Claim value equals 3, C, or W, then value must be the state identifier of the provid entity (billing or reporting) to the managed care plan.|N/A|CRX00002|CLAIM-HEADER-RECO RX|X(30)|50|462|491|1. Value must be 30 characters or less
2. Conditional
3. When Type of Claim not in [3,C,W] then value may match (PRV.002.019) Submitting Sta Provider ID or
4. When Type of Claim not in [3,C,W] then value may match (PRV.005.081) Provider Identi where the Provider Identifier Type (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)

CRX071|CRX.002.071|BILLING-PROV-NPI-NUM|Billing Provider NPI Number|Conditional|The National Provider ID (NPI) of the billing provider responsible for billing for the service on th 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)|51|492|501|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)

CRX075|CRX.002.075|PRESCRIBING-PROV-NPI-NUM|Prescribing Provider NPI Number| Mandatory|The National Provider ID (NPI) of the provider who prescribed a medication to a patient.|N/A|CRX00002|CLAIM-HEADER-RECORD-RX|X(10)|55|546|555|1. Value must be 10 digits
2. Value must have an associated Provider Identifier Type equal to "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)

CRX102|CRX.002.102|DISPENSING-PRESCRIPTION-DRUG-PROV-NPI|Dispensing Prescription Drug Provider NPI Number|Mandatory|The National Provider ID (NPI) of the provider respon for dispensing the prescription drug.|N/A|CRX00002|CLAIM-HEADER-RECORD-RX|X(10)|75| 782|1. Value must be 10 digits
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], then value must match Provider Identifier (PRV.005.
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)

CRX104|CRX.002.104|HEALTH-HOME-PROVIDER-NPI|Health Home Provider NPI Number| Conditional|The National Provider ID (NPI) of the health home provider.|N/A|CRX00002|CLA HEADER-RECORD-RX|X(10)|76|783|792|1. Value must be 10 digits
2. Value must have an associated Provider Identifier, where Provider Identifier Type (PRV.005.077) equals "2"
3. Value must exist in the NPPES NPI data file
4. Conditional

CRX162|CRX.002.162|PRESCRIPTION-ORIGIN-CODE|Prescription Origin Code|Conditional|Ho
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

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident
MSIS Identification Numbers are a unique "key" value used to maintain referential integrity
data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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|CRX00003|CLAIM-LINE-RECORD-RX|X(20)|4|22|41|1.
Value must be 20 characters or less
2. Mandatory

CRX113|CRX.003.113|ICN-ADJ|Adjustment ICN|Conditional|A unique claim number assigned
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 equals "0", then value must not be populated
4. Conditional
5. If associated Adjustment Indicator value equals "4", then value must be populated

CRX125|CRX.003.125|MEDICAID-PAID-AMT|Medicaid Paid Amount|Conditional|The amount
by Medicaid/CHIP agency or the managed care plan on this claim or adjustment at the clai
detail level. 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 provi
at the claim line detail level. Report a null value in this field if the provider is a sub-capitate
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, re
a null value in this field.|N/A|CRX00003|CLAIM-LINE-RECORD-RX|S9(11)V99|18|225|237|1. V
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 should not be populated or should be equal to zero, when associated Claim Line S
is in [542,585,654]

CRX132|CRX.003.132|PRESCRIPTION-QUANTITY-ACTUAL|Prescription Quantity Actual|
Mandatory|The quantity of a drug that is dispensed for a prescription as reported by Natio
Drug Code on the claim line. For use with CLAIMOT and CLAIMRX claims. For CLAIMIP and
CLAIMLT claims/encounter records, use the Revenue Center Quantity Actual field.|N/A|
CRX00003|CLAIM-LINE-RECORD-RX|S9(9)V(9)|24|308|325|1. Value may include up to 9 dig
to the left of the decimal point, and 9 digits to the right e.g. 123456789.123456789
2. Mandatory

CRX133|CRX.003.133|UNIT-OF-MEASURE|Unit of Measure|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|326|327|1. Value must be 2 characters
2. Value must be in Unit of Measure List (VVL)
3. Mandatory

CRX134|CRX.003.134|TYPE-OF-SERVICE|Type of Service|Mandatory|A code to categorize th
services provided to a Medicaid or CHIP enrollee.|TYPE-OF-SERVICE|CRX00003|CLAIM-LINE-
RECORD-RX|X(3)|26|328|330|1. Value must be 3 characters
2. Mandatory
3. Value must be in Type of Service List (VVL)
4. Value must be in [011,018,033,034,036,085,089,127,131,136,137,145]

CRX149|CRX.003.149|CATEGORY-FOR-FEDERAL-REIMBURSEMENT|Category for Federal Reimbursement|Conditional|A code to indicate the Federal funding source for the payment
CATEGORY-FOR-FEDERAL-REIMBURSEMENT|CRX00003|CLAIM-LINE-RECORD-RX|X(2)|39|38
388|1. Value must be 2 characters
2. Value must be in Category for Federal Reimbursement List (VVL)
3. (Federal Funding under Title XXI) if value equals "02", then the eligible's CHIP Code (ELG.003.054) must be in [2,3]
4. (Federal Funding under Title XIX) if value equals "01" then the eligible's CHIP Code (ELG.003.054) must be "1"
5. Conditional
6. If Type of Claim is in [1,A,U] and the Total Medicaid Paid Amount is populated on the corresponding claim header, then value must be reported

CRX172|CRX.003.172|IHS-SERVICE-IND|IHS Service Indicator|Mandatory|To indicate Servic
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.|
SERVICE-IND|CRX00003|CLAIM-LINE-RECORD-RX|X(1)|49|496|496|1. Value must be 1 chara
2. Value must be in the IHS Service Indicator List (VVL)
3. Mandatory

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 se
is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM
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 Medi
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 fo
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
service value is.|MBESCBES-FORM|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 Medica
Paid Amount greater than $0

CRX183|CRX.003.183|PROCEDURE-CODE-MOD-1|Procedure Code Modifier 1|Conditional|Th
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-M
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|Th
second modifier associated with the procedure code (or if procedure code is missing, then
modifier may be associated with an NDC or Unique Device Identifier).|PROCEDURE-CODE-M
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|Th
third modifier associated with the procedure code (or if procedure code is missing, then th
modifier may be associated with an NDC or Unique Device Identifier).|PROCEDURE-CODE-M
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|Th
fourth modifier associated with the procedure code (or if procedure code is missing, then t
modifier may be associated with an NDC or Unique Device Identifier).|PROCEDURE-CODE-M
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|Th
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-M
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|Th
sixth modifier associated with the procedure code (or if procedure code is missing, then th
modifier may be associated with an NDC or Unique Device Identifier).|PROCEDURE-CODE-M
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|Th
seventh modifier associated with the procedure code (or if procedure code is missing, ther
modifier may be associated with an NDC or Unique Device Identifier).|PROCEDURE-CODE-M
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|Th
eighth modifier associated with the procedure code (or if procedure code is missing, then t
modifier may be associated with an NDC or Unique Device Identifier).|PROCEDURE-CODE-M
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|Th
ninth modifier associated with the procedure code (or if procedure code is missing, then th
modifier may be associated with an NDC or Unique Device Identifier).|PROCEDURE-CODE-M
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|
tenth modifier associated with the procedure code (or if procedure code is missing, then th
modifier may be associated with an NDC or Unique Device Identifier).|PROCEDURE-CODE-M
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

CRX209|CRX.003.209|MBESCBES-FORM-GROUP|MBESCBES Form Group|Conditional|Indicat
group of MBES/CBES forms that this payment applies to (e.g., the CMS-64.9 Base form is fo
Title XIX-funded Medicaid, the CMS-64.21 form is for Title XXI-funded Medicaid-expansion C
(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 mu
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 Medica
Paid Amount greater than $0

CRX196|CRX.004.196|RECORD-ID|Record ID|Mandatory|The Record ID represents the type
segment being reported. The Record ID communicates how the contents of a given row of
should be interpreted depending on which segment type the Record ID represents. Each ty
of segment collects different data elements so each segment type has a distinct layout. Th
first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th
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"

CRX200|CRX.004.200|ICN-ADJ|Adjustment ICN|Conditional|A unique claim number assigned
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 o
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
adjustment record.|ADJUSTMENT-IND|CRX00004|CLAIM-DX-RX|X(1)|6|122|122|1. Value mu
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)

CRX204|CRX.004.204|DIAGNOSIS-SEQUENCE-NUMBER|Diagnosis Sequence Number|Manda
The order in which the diagnosis occurred on the provider's claim for a given type of diagn
code (e.g., an NCPDP claim can have up to 5 diagnosis codes).|N/A|CRX00004|CLAIM-DX-R
9(2)|9|132|133|1. Value must be in [01-24]
2. Mandatory

ELG002|ELG.001.002|DATA-DICTIONARY-VERSION|Data Dictionary Version|Mandatory|A da
element to capture the version of the T-MSIS data dictionary that was used to build the file
the version number specified on the Cover Sheet of the data dictionary.|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
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 ed
rejects.|SUBMISSION-TRANSACTION-TYPE|ELG00001|FILE-HEADER-RECORD-ELIGIBILITY|X(1
19|19|1. Value must be 1 characters
2. Value must be in Submission Transaction Type List (VVL)
3. Mandatory

ELG006|ELG.001.006|FILE-NAME|File Name|Mandatory|A code to identify the subject area t
which the records in its file relate. Each T-MSIS submission file should only contain records
one subject area (i.e., Eligible, Third-party liability, Provider, Managed Care Plan Informatic
Inpatient, Long-Term Care, Other, Pharmacy Claim, and Financial Transactions).|N/A|ELG0
FILE-HEADER-RECORD-ELIGIBILITY|X(8)|6|32|39|1. Value must equal "ELIGIBLE"
2. 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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident
MSIS Identification Numbers are a unique "key" value used to maintain referential integrity
data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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|ELG00002|PRIMARY-DEMOGRAPHICS-ELIGIBILITY|X(2
22|41|1. Value must be 20 characters or less
2. 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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique "key" value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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|ELG00003|VARIABLE-DEMOGRAPHICS-ELIGIBILITY|X(2 22|41|1. Value must be 20 characters or less
2. Mandatory

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. Value must be 1 character
2. Value must be in Veteran Indicator List (VVL)
3. Conditional
4. Value must be populated when Immigration Status (ELG.003.042) is in [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-DEMOGRAP ELIGIBILITY|X(1)|11|107|107|1. Value must be 1 character
2. Value must be in [0,1,2]
3. Value must be in Citizenship Indicator List (VVL)
4. If value equals "0", then associated Immigration Status (ELG.003.042) value must be in [1,2,3]
5. If value is coded as "1", then associated Immigration Status (ELG.003.042) value must e "8"
6. Mandatory

ELG044|ELG.003.044|IMMIGRATION-STATUS-FIVE-YEAR-BAR-END-DATE|Immigration Status
Year Bar End Date|Conditional|The date the five-year bar for an individual ends. Section 40
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
not eligible to receive federally-funded benefits, including Medicaid and the State Children
Health Insurance Program (Separate CHIP), for five years from the date they enter the cou
with a status as a "qualified alien."|N/A|ELG00003|VARIABLE-DEMOGRAPHICS-ELIGIBILITY|9
15|111|118|1. The date must be a valid calendar date in the form "CCYYMMDD"
2. Conditional
3. If Immigration Status (ELG.003.042) equals "8" (U.S. Citizen), then value should not be
populated

ELG269|ELG.003.269|ELIGIBLE-FEDERAL-POVERTY-LEVEL-PERCENTAGE|Eligibile Federal Po
Level Percentage|Conditional|This data element provides the beneficiary's or their household
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 wa
assessed using multiple methodologies (MAGI and Non-MAGI), report the income that appl
their primary eligibility group.

A beneficiary’s income is applicable unless it is not required by the eligibility group for whi
they were determined eligible. For example, the eligibility groups for children with adoptio
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
Additionally, for individuals receiving SSI, states with section 1634 agreements with the So
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 betwe
000 and 400 inclusively
2. Conditional

ELG273|ELG.003.273|APPLICATION-SIGNATURE-DATE|Application Signature Date|Condition
The date that a beneficiary signed their Medicaid or CHIP application. If the beneficiary wa
deemed eligible via an administrative determination then a signature may not be
applicable/available. |N/A|ELG00003|VARIABLE-DEMOGRAPHICS-ELIGIBILITY|9(8)|26|170|17
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

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique "key" value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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|ELG00004|ELIGIBLE-CONTACT-INFORMATION|X(20)|4 41|1. Value must be 20 characters or less
2. Mandatory

ELG071|ELG.004.071|ELIGIBLE-ZIP-CODE|Eligible ZIP Code|Mandatory|U.S. ZIP Code compo of an address associated with a given entity (e.g. person, organization, agency, etc.)|ZIP-C ELG00004|ELIGIBLE-CONTACT-INFORMATION|X(9)|11|254|262|1. Value may only be 5 digit 9) (Example: 91320) or 9 digits (0-9) (Example: 913200011)
2. Value must be in ZIP Code List (VVL)
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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique "key" value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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|ELG00005|ELIGIBILITY-DETERMINANTS|X(20)|4|22|41 Value must be 20 characters or less
2. Mandatory

ELG089|ELG.005.089|SSDI-IND|SSDI Indicator|Conditional|A flag indicating if the individual enrolled in Social Security Disability Insurance (SSDI) administered via the Social Security Administration (SSA).|SSDI-IND|ELG00005|ELIGIBILITY-DETERMINANTS|X(1)|10|62|62|1. Va must be 1 character
2. Value must be in SSDI Indicator List (VVL)
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)|11|63|63|1. Valu must be 1 character
2. Value must be in SSI Indicator List (VVL)
3. Conditional
4. Value must equal "0" when SSI status (ELG.005.092) equals "000" or "003" or is not populated
5. Value must equal "1" when SSI status (ELG.005.092) equals "001" or "002"

ELG094|ELG.005.094|CONCEPTION-TO-BIRTH-IND|Conception To Birth Indicator|Conditiona flag to identify children eligible through the conception to birth option, which is available o through a separate State CHIP Program.|CONCEPTION-TO-BIRTH-IND|ELG00005|ELIGIBILIT DETERMINANTS|X(1)|15|76|76|1. Value must be 1 character
2. Value must be in Conception to Birth Indicator List (VVL)
3. If the value is equal to "1", then the Eligibility Group (ELG.005.087) must equal "64"
4. If the value is equal to "1", then any associated claims must indicate the Program Type equals "14" (State Plan CHIP)
5. If the value is equal to "1", then CHIP Code (ELG.003.054) must equal "3" (Individual wa Medicaid Expansion CHIP eligible, but was included in a separate title XXI CHIP Program)
6. Conditional

ELG274|ELG.005.274|ELIGIBILITY-REDETERMINTATION-DATE|Eligibility Redetermination Da Conditional|The date by which a person's Medicaid or CHIP eligibility must be redetermine 1915(i)(1)(I), 42 CFR 435.916, 435.926, any other applicable regulations, or waiver of thes regulations. This is effectively the "expiration date" of the eligibility characteristics with wh 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 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

ELG277|ELG.005.277|CONTINUOUS-ELIGIBILITY-CODE|Continuous Eligibility Code|Condition code to identify the authority used to provide continuous eligibility during the period of coverage|CONTINUOUS-ELIGIBILITY-CODE|ELG00005|ELIGIBILITY-DETERMINANTS|X(3)|24|1 160|1. Value must be 3 characters
2. Value must be in Continuous Eligibility Code List (VVL)
3. Conditional

ELG281|ELG.005.281|ELIGIBILITY-TERMINATION-REASON-OTHER-TYPE-TEXT|Eligibility Termination Reason Other Type Text|Conditional|Value must be populated with a state-spe 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 less
2. Value must not be populated when Eligibility Termination Reason equals "22" (Other)
3. Value must be populated when Eligibility Termination Reason does not equal "22" (Othe
4. Conditional

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique "key" value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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|ELG00006|HEALTH-HOME-SPA-PARTICIPATION-INFORMATION|X(20)|4|22|41|1. Value must be 20 characters or less
2. 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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique "key" value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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|ELG00007|HEALTH-HOME-SPA-PROVIDERS|X(20)|4|22
1. Value must be 20 characters or less
2. 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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique "key" value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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|ELG00008|HEALTH-HOME-CHRONIC-CONDITIONS|X(2
22|41|1. Value must be 20 characters or less
2. 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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique "key" value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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|ELG00009|LOCK-IN-INFORMATION|X(20)|4|22|41|1. V must be 20 characters or less
2. Mandatory

ELG270|ELG.009.270|LOCKED-IN-SRVCS|Locked In Services|Conditional|The type(s) of serv that are locked-in.|TYPE-OF-SERVICE|ELG00009|LOCK-IN-INFORMATION|X(3)|9|90|92|1. Val must be 3 characters
2. Conditional
3. Value must be in Type of Service List (VVL)

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique "key" value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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|ELG00010|MFP-INFORMATION|X(20)|4|22|41|1. Value must be 20 characters or less
2. 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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique "key" value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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|ELG00011|STATE-PLAN-OPTION-PARTICIPATION|X(20 22|41|1. Value must be 20 characters or less
2. 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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique "key" value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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|ELG00012|WAIVER-PARTICIPATION|X(20)|4|22|41|1. V 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, ful 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 suffi for renewals or amendments.|N/A|ELG00012|WAIVER-PARTICIPATION|X(20)|5|42|61|1. Valu 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 Wai 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 inclu 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 follow by a period (.), the associated Waiver Type value must be in [02-20,32,33]
6. Value must have a corresponding value in Waiver Type (ELG.012.173)
7. 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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique "key" value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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|ELG00013|LTSS-PARTICIPATION|X(20)|4|22|41|1. Valu must be 20 characters or less
2. 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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique "key" value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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|ELG00014|MANAGED-CARE-PARTICIPATION|X(20)|4|2
1. Value must be 20 characters or less
2. Mandatory

ELG192|ELG.014.192|MANAGED-CARE-PLAN-ID|Managed Care Plan ID|Mandatory|The man 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 Eligible File".
https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-managedcareplan-in-the-eligible-file-managed-care/

See T-MSIS Guidance Document, "CMS Guidance: Preliminary guidance for Primary Care Ca Management Reporting".
https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/cms-guidance-primary-care-case-management-reporting-updated/|N/A|ELG00014|MANAGED-CARE-PARTICIPATION|X(1 42|53|1. Value must be 12 characters or less
2. Value must not contain a pipe or asterisk symbol
3. Value reported must match the value reported on State Plan Identification Number (MCR.002.019)
4. Mandatory

ELG193|ELG.014.193|MANAGED-CARE-PLAN-TYPE|Managed Care Plan Type|Mandatory|A m
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 Transporta
(NEMT) Prepaid Ambulatory Health Plans (PAHPs) in the T-MSIS Managed Care File"
https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-nonemergency-
medical-transportation-nemt-prepaid-ambulatory-health-plans-pahps-in-the-tmsis-manage
care-filemanaged-care/

See T-MSIS Guidance Document, "CMS Guidance: Best Practice for Reporting Managed Car
Plan Type in the T-MSIS Managed Care File"
https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-managedcareplan
in-the-t-msis-managed-care-file-managed-care/|MANAGED-CARE-PLAN-TYPE|ELG00014|
MANAGED-CARE-PARTICIPATION|X(2)|6|54|55|1. Value must be 2 characters
2. Value must be in Managed Care Plan Type List (VVL)
3. Mandatory
4. Value must not be populated when Managed Care Plan ID (ELG.014.192) is not populate
5. Value must equal the Managed Care Plan Type (MCR.002.024) associated with the State
Identification Number (MCR.002.018)

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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident
MSIS Identification Numbers are a unique "key" value used to maintain referential integrity
data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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|ELG00015|ETHNICITY-INFORMATION|X(20)|4|22|41|1
Value must be 20 characters or less
2. 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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique "key" value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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|ELG00016|RACE-INFORMATION|X(20)|4|22|41|1. Valu must be 20 characters or less
2. 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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique "key" value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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|ELG00017|DISABILITY-INFORMATION|X(20)|4|22|41|1 Value must be 20 characters or less
2. 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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique "key" value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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|ELG00018|1115A-DEMONSTRATION-INFORMATION|X 4|22|41|1. Value must be 20 characters or less
2. 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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique "key" value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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-blog/entry/4757
N/A|ELG00020|HCBS-CHRONIC-CONDITIONS-NON-HEALTH-HOME|X(20)|4|22|41|1. Value m be 20 characters or less
2. 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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique "key" value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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|ELG00021|ENROLLMENT-TIME-SPAN-SEGMENT|X(20) 22|41|1. Value must be 20 characters or less
2. 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. Value may be an SSN, temporary SSN or State-assigned eligible individual ident MSIS Identification Numbers are a unique "key" value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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|ELG00022|ELG-IDENTIFIERS|X(20)|4|22|41|1. Value m be 20 characters or less
2. Mandatory

ELG282|ELG.023.282|RECORD-ID|Record ID|Mandatory|The Record ID represents the type segment being reported. The Record ID communicates how the contents of a given row of should be interpreted depending on which segment type the Record ID represents. Each ty of segment collects different data elements, so each segment type has a distinct layout. T first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th 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 receive 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 recor within the submission file.|N/A|ELG00023|SOGI|9(11)|3|11|21|1. Value must be 11 digits or 2. Value must be unique within record segment over all records associated with a given Re 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 ident MSIS Identification Numbers are a unique "key" value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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 th
response from the beneficiary to an optional question posed to them on their Medicaid or C
application regarding the individual’s sex assigned at birth (e.g., according to an original b
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 an
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.
more information, see https://www.medicaid.gov/sites/default/files/2023-11/cib11092023.p
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 Te
Conditional|This is the response from the beneficiary to an optional question posed to them
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 reflec
by the values available for Sex Assigned at Birth.|N/A|ELG00023|SOGI|X(100)|6|43|142|1. V
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 fr
the beneficiary to an optional question posed to them on their Medicaid or CHIP application
regarding the individual’s gender identify.T-MSIS does not define or maintain these questio
or responses. They are defined and maintained via the CMS single streamlined application
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.
more information, see https://www.medicaid.gov/sites/default/files/2023-11/cib11092023.p
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|Condition
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 n
reflected by the values available for Gender Identity.|N/A|ELG00023|SOGI|X(100)|8|144|24
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 resp
from the beneficiary to an optional question posed to them on their Medicaid or CHIP
application regarding the individual’s sexual orientation. T-MSIS does not define or maintai
these questions or responses. They are defined and maintained via the CMS single stream
application and state Medicaid and CHIP agencies. T-MSIS is intended to reflect those sour
and may be updated periodically as necessary to align with national standards and commo
practices. For more information, see
https://www.medicaid.gov/sites/default/files/2023-11/cib11092023.pdf.|SEXUAL-ORIENTATI
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 ther
their Medicaid or CHIP application regarding the individual’s sexual orientation if their resp
is not reflected by the values available for Sexual Orientation.|N/A|ELG00023|SOGI|X(100)|
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 da
which all of the other data elements in the same segment were effective.|N/A|ELG00023|S
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|SOG
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|
860|1. Value must be 500 characters or less
2. Value must not contain a pipe or asterisk symbols
3. Situational

FTX002|FTX.001.002|DATA-DICTIONARY-VERSION|Data Dictionary Version|Mandatory|A da element to capture the version of the T-MSIS data dictionary that was used to build the file the version number specified on the Cover Sheet of the data dictionary.|DATA-DICTIONARY VERSION|FTX00001|FILE-HEADER-RECORD-FTX|X(10)|2|9|18|1. Value must be 10 characte less 2. Value must be in Data Dictionary Version List (VVL) 3. Value must not include the pipe ("|") symbol 4. Mandatory
FTX006|FTX.001.006|FILE-NAME|File Name|Mandatory|A code to identify the subject area t which the records in its file relate. Each T-MSIS submission file should only contain records one subject area (i.e., Eligible, Third-party liability, Provider, Managed Care Plan Informatic Inpatient, Long-Term Care, Other, Pharmacy Claim, and Financial Transactions).|N/A|FTX00 FILE-HEADER-RECORD-FTX|X(8)|6|32|39|1. Value must equal "FINTRANS" 2. Mandatory
FTX020|FTX.002.020|ICN-ORIG|Original ICN|Conditional|A unique item control number assi by the states payment system that identifies an original or adjustment claim/transaction.|N FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(50)|4|22|71|1. Value must be 50 characters or 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 numb assigned by the state’s payment system that identifies the adjustment claim/transaction fo original item control number.|N/A|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(50)|5|72|121 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
N/A

FTX023|FTX.002.023|ADJUSTMENT-IND|Adjustment Indicator|Conditional|Indicates the type
adjustment record.|ADJUSTMENT-IND|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(1)|6|122
1. Value must be 1 character
2. Value must be in Adjustment Indicator List (VVL)
3. Conditional

FTX026|FTX.002.026|CHECK-EFF-DATE|Check Effective Date|Conditional|The date a check
issued to the payee. In the case of electronic funds transfer, it is the date the transfer is m
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"

FTX028|FTX.002.028|PAYER-ID|Payer ID|Mandatory|This is the identifier that corresponds w
the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking th
action of either making a payment or taking a recoupment, as opposed to the payee who i
object of the transaction. The payer is the entity that is either making a payment or recoup
a payment from another entity or individual. The payee is the individual or entity that is ei
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 indica
what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid
CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted a
submitting state code.|PAYER-ID-TYPE|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(2)|12|19
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)

FTX033|FTX.002.033|PAYEE-ID|Payee Identfier|Mandatory|This is the identifier that corresp
with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual c
entity that is either receiving a payment or having a previous payment recouped. The pay
the object of the transaction, as opposed to the payer who is the subject taking the action
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 tha
indicates what type of ID the payee ID is. For example, if the payee ID represents a provid
then the payee ID type will indicate that the payee ID should be interpreted as a provider I
PAYEE-ID-TYPE |FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(2)|17|431|432|1. Value must b
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

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 th individual or entity that is either receiving a payment or having a previous payment recou The payee is the object of the transaction, as opposed to the payer who is the subject taki 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 character less
2. Mandatory
3. If Payee Tax ID Type equals "01", then value must be 9-digits and meet the requirement a valid SSN per SSA requirements

FTX039|FTX.002.039|PAYEE-TAX-ID-TYPE|Payee Tax ID Type|Mandatory|This is a qualifier t indicates what type of tax ID the payee tax ID is. For example, if the payee tax ID represer SSN, then the payee tax ID type will indicate that the payee tax ID should be interpreted a SSN.|PAYEE-TAX-ID-TYPE|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(2)|22|665|666|1. Valu 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 PAYE 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

FTX042|FTX.002.042|MSIS-IDENTIFICATION-NUM|MSIS Identification Number|Mandatory|A s
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 da
distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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|8
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 Enroll
Time Span where the Capitation Period Start Date is equal to or greater than Enrollment St
Date and Capitation Period End Date is less than or equal to Enrollment End Date

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)
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 se
is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM
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 b
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
12. Conditional
13. 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 for
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
service value is.|MBESCBES-FORM|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(50)|30|906|
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|Indicate
group of MBES/CBES forms that this payment applies to (e.g., the CMS-64.9 Base form is fo
Title XIX-funded Medicaid, the CMS-64.21 form is for Title XXI-funded Medicaid-expansion C
(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. Val
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 wa
ID number assigned during the state submission and CMS approval process. Waiver IDs sh
actually only be the "core" part of the waiver IDs, without including suffixes for renewals o
amendments.|N/A|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(20)|32|961|980|1. Value mu
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 Wai
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 inclu
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 follow
by a period (.), the associated Waiver Type value must be in [02-20,32,33]
6. Conditional

FTX051|FTX.002.051|FUNDING-CODE|Funding Code|Conditional|A code to indicate the sou
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 Type of Claim is in [3,C,W], then value must be populated
4. Conditional

FTX055|FTX.002.055|SPA-NUMBER|SPA Number|Conditional|State plan amendment (SPA) I
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 th
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 =
Situational entry for specific SPA types|N/A|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(15
990|1004|1. Value must be 15 characters or less
2. Conditional

FTX064|FTX.003.064|RECORD-ID|Record ID|Mandatory|The Record ID represents the type o
segment being reported. The Record ID communicates how the contents of a given row of
should be interpreted depending on which segment type the Record ID represents. Each ty
of segment collects different data elements so each segment type has a distinct layout. Th
first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th
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 b
exactly 8 characters
2. Mandatory
3. Value must be in Record ID List (VVL)
4. Value must equal "FTX00003"

FTX067|FTX.003.067|ICN-ORIG|Original ICN|Mandatory|A unique item control number assig
by the states payment system that identifies an original or adjustment claim/transaction.|N
FTX00003|INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT|X(50)|4|22|71|1. Value mu
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 numb
assigned by the state’s payment system that identifies the adjustment claim/transaction fo
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

N/A
FTX070|FTX.003.070|ADJUSTMENT-IND|Adjustment Indicator|Conditional|Indicates the type 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. Conditional
FTX075|FTX.003.075|PAYER-ID|Payer ID|Mandatory|This is the identifier that corresponds w the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking th action of either making a payment or taking a recoupment, as opposed to the payee who i object of the transaction. The payer is the entity that is either making a payment or recoup a payment from another entity or individual. The payee is the individual or entity that is ei 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 less 2. Mandatory
FTX076|FTX.003.076|PAYER-ID-TYPE|Payer ID Type|Mandatory|This is a qualifier that indica what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted a submitting state code.|PAYER-ID-TYPE|FTX00003|INDIVIDUAL-HEALTH-INSURANCE-PREMIU 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)

FTX078|FTX.003.078|PAYEE-ID|Payee Identfier|Mandatory|This is the identifier that corresp
with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual c
entity that is either receiving a payment or having a previous payment recouped. The pay
the object of the transaction, as opposed to the payer who is the subject taking the action
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
less
2. Mandatory

FTX079|FTX.003.079|PAYEE-ID-TYPE |Payee Identifier Type|Mandatory|This is a qualifier tha
indicates what type of ID the payee ID is. For example, if the payee ID represents a provid
then the payee ID type will indicate that the payee ID should be interpreted as a provider I
PAYEE-ID-TYPE |FTX00003|INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT|X(2)|15|32
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

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 th individual or entity that is either receiving a payment or having a previous payment recou The payee is the object of the transaction, as opposed to the payer who is the subject taki 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 requirement a valid SSN per SSA requirements

FTX084|FTX.003.084|INSURANCE-CARRIER-ID-NUM|Insurance Carrier Identification Numbe Mandatory| The state-assigned identification number of the Third Party Liability (TPL) Entit N/A|FTX00003|INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT|X(12)|20|563|574|1. V 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 num 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 s
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 da
distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for informatio
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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 Enroll
Time Span where the Payment Period Start Date is equal to or greater than Enrollment Sta
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 num
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
less
2. Conditional

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 se
is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM
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|70
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
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
service value is.|MBESCBES-FORM|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

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 wa ID number assigned during the state submission and CMS approval process. Waiver IDs sh actually only be the "core" part of the waiver IDs, without including suffixes for renewals o amendments.|N/A|FTX00003|INDIVIDUAL-HEALTH-INSURANCE-PREMIUM-PAYMENT|X(20)|3 709|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 Wai 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 inclu 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 follow by a period (.), the associated Waiver Type value must be in [02-20,32,33]
6. Conditional

FTX099|FTX.003.099|SPA-NUMBER|SPA Number|Conditional|State plan amendment (SPA) I 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 th 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 = 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

FTX105|FTX.004.105|RECORD-ID|Record ID|Mandatory|The Record ID represents the type o segment being reported. The Record ID communicates how the contents of a given row of should be interpreted depending on which segment type the Record ID represents. Each ty of segment collects different data elements so each segment type has a distinct layout. Th first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th 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 exactly 8 characters
2. Mandatory
3. Value must be in Record ID List (VVL)
4. Value must equal "FTX00004"

FTX108|FTX.004.108|ICN-ORIG|Original ICN|Mandatory|A unique item control number assig by the states payment system that identifies an original or adjustment claim/transaction.|N 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 numb assigned by the state’s payment system that identifies the adjustment claim/transaction fo original item control number.|N/A|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X(50)| 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
N/A
FTX111|FTX.004.111|ADJUSTMENT-IND|Adjustment Indicator|Conditional|Indicates the type adjustment record.|ADJUSTMENT-IND|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X(122|122|1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Conditional

FTX116|FTX.004.116|PAYER-ID|Payer ID|Mandatory|This is the identifier that corresponds w
the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking th
action of either making a payment or taking a recoupment, as opposed to the payee who i
object of the transaction. The payer is the entity that is either making a payment or recoup
a payment from another entity or individual. The payee is the individual or entity that is ei
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 indica
what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid
CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted a
submitting state code.|PAYER-ID-TYPE|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X
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)

FTX119|FTX.004.119|PAYEE-ID|Payee Identfier|Mandatory|This is the identifier that corresp
with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual o
entity that is either receiving a payment or having a previous payment recouped. The pay
the object of the transaction, as opposed to the payer who is the subject taking the action
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 tha indicates what type of ID the payee ID is. For example, if the payee ID represents a provid then the payee ID type will indicate that the payee ID should be interpreted as a provider I PAYEE-ID-TYPE |FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X(2)|15|329|330|1. Valu 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

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 th individual or entity that is either receiving a payment or having a previous payment recou The payee is the object of the transaction, as opposed to the payer who is the subject taki 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 requirement a valid SSN per SSA requirements

FTX123|FTX.004.123|PAYEE-TAX-ID-TYPE|Payee Tax ID Type|Mandatory|This is a qualifier t indicates what type of tax ID the payee tax ID is. For example, if the payee tax ID represen SSN, then the payee tax ID type will indicate that the payee tax ID should be interpreted a SSN.|PAYEE-TAX-ID-TYPE|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X(2)|18|461|4 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 PAYE 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 les 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 Numbe 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 n 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 num 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 co 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 ident MSIS Identification Numbers are a unique “key” value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for informatio reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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 membe a private group policy may not be eligible for Medicaid or CHIP, though at least one memb the group policy must be eligible for Medicaid or CHIP. There should be one FTX00004 segm for each member of the group policy for which the premium assistance payment is being p regardless of whether the member of the group policy was eligible for and enrolled in Med 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 Enroll Time Span where the Premium Period Start Date is equal to or greater than Enrollment Sta 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 a 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 insur policy but not eligible for Medicaid or CHIP. It’s also possible that one or more members of group insurance policy do not have an SSN. If a member of a group insurance policy does n 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 num 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

FTX131|FTX.004.131|POLICY-OWNER-CODE|Policy Owner Code|Conditional|This code ident
the relationship of the policy holder to the Medicaid/CHIP beneficiary.|POLICY-OWNER-COD
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

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 se
is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM
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. Valu
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)
11. If Policy Owner Code equals "01", then value must be populated
12. Conditional
13. 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 for
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
service value is.|MBESCBES-FORM|FTX00004|GROUP-INSURANCE-PREMIUM-PAYMENT|X(50
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

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 wa
ID number assigned during the state submission and CMS approval process. Waiver IDs sh
actually only be the "core" part of the waiver IDs, without including suffixes for renewals o
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 Wai
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 includ
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 follow
by a period (.), the associated Waiver Type value must be in [02-20,32,33]
6. Conditional

FTX149|FTX.005.149|RECORD-ID|Record ID|Mandatory|The Record ID represents the type o
segment being reported. The Record ID communicates how the contents of a given row of
should be interpreted depending on which segment type the Record ID represents. Each ty
of segment collects different data elements so each segment type has a distinct layout. Th
first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th
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 exactly 8 characters
2. Mandatory
3. Value must be in Record ID List (VVL)
4. Value must equal "FTX00005"

FTX152|FTX.005.152|ICN-ORIG|Original ICN|Mandatory|A unique item control number assig by the states payment system that identifies an original or adjustment claim/transaction.|N 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 numb assigned by the state’s payment system that identifies the adjustment claim/transaction fo original item control number.|N/A|FTX00005|COST-SHARING-OFFSET|X(50)|5|72|121|1. Valu 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
N/A
FTX155|FTX.005.155|ADJUSTMENT-IND|Adjustment Indicator|Conditional|Indicates the type 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. Conditional

FTX160|FTX.005.160|PAYER-ID|Payer ID|Mandatory|This is the identifier that corresponds w
the payer's role in relation to the Medicaid/CHIP system. The payer is the subject taking th
action of either making a payment or taking a recoupment, as opposed to the payee who i
object of the transaction. The payer is the entity that is either making a payment or recoup
a payment from another entity or individual. The payee is the individual or entity that is ei
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
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 indica
what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid
CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted a
submitting state code.|PAYER-ID-TYPE|FTX00005|COST-SHARING-OFFSET|X(2)|12|197|198|
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)

FTX163|FTX.005.163|PAYEE-ID|Payee Identfier|Mandatory|This is the identifier that corresp
with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual o
entity that is either receiving a payment or having a previous payment recouped. The pay
the object of the transaction, as opposed to the payer who is the subject taking the action
either making a payment or taking a recoupment.

For beneficiary Cost Sharing Offset, the beneficiary is always the payee. |N/A|FTX00005|CO
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 tha indicates what type of ID the payee ID is. For example, if the payee ID represents a provid then the payee ID type will indicate that the payee ID should be interpreted as a provider I 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

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 previou payment recouped. The payee is the object of the transaction, as opposed to the payer wh 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 les
2. Mandatory
3. If Payee Tax ID Type equals "01", then value must be 9-digits and meet the requirement a valid SSN per SSA requirements

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 PAYE TAX-ID-TYPE was reported with a payee tax ID type of "Other".|N/A|FTX00005|COST-SHARI 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

FTX172|FTX.005.172|INSURANCE-PLAN-ID|Insurance Plan Identifier|Conditional|The ID num 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 s
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 da
distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for informatio
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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
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 Enroll
Time Span where the Coverage Period Start Date is equal to or greater than Enrollment Sta
Date and Coverage Period End Date is less than or equal to Enrollment End Date

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 se
is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM
21, etc.) that states use to report their expenditures and request federal financial
participation.|221.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 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 service value is.|MBESCBES-FORM|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

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 wa ID number assigned during the state submission and CMS approval process. Waiver IDs sh actually only be the "core" part of the waiver IDs, without including suffixes for renewals o amendments.|N/A|FTX00005|COST-SHARING-OFFSET|X(20)|31|879|898|1. Value must be 2 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 Wai 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 inclu 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 follow by a period (.), the associated Waiver Type value must be in [02-20,32,33]
6. Conditional

FTX186|FTX.005.186|SPA-NUMBER|SPA Number|Conditional|State plan amendment (SPA) I 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 th 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 = 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

FTX192|FTX.006.192|RECORD-ID|Record ID|Mandatory|The Record ID represents the type
segment being reported. The Record ID communicates how the contents of a given row of
should be interpreted depending on which segment type the Record ID represents. Each ty
of segment collects different data elements so each segment type has a distinct layout. Th
first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th
segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).|RECORD-ID
FTX00006|VALUE-BASED-PAYMENT|X(8)|1|1|8|1. Value must be exactly 8 characters
2. Mandatory
3. Value must be in Record ID List (VVL)
4. Value must equal "FTX00005"

FTX195|FTX.006.195|ICN-ORIG|Original ICN|Mandatory|A unique item control number assig
by the states payment system that identifies an original or adjustment claim/transaction.|N
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 numb
assigned by the state’s payment system that identifies the adjustment claim/transaction fo
original item control number.|N/A|FTX00006|VALUE-BASED-PAYMENT|X(50)|5|72|121|1. Va
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

N/A

FTX198|FTX.006.198|ADJUSTMENT-IND|Adjustment Indicator|Conditional|Indicates the type
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. Conditional

FTX203|FTX.006.203|PAYER-ID|Payer ID|Mandatory|This is the identifier that corresponds w
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 recoupm
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 anot
entity or individual. The payee is the individual or entity that is either receiving a payment
having a previous payment recouped.|N/A|FTX00006|VALUE-BASED-PAYMENT|X(30)|11|16
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 indica
what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid
CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted a
submitting state code.|PAYER-ID-TYPE|FTX00006|VALUE-BASED-PAYMENT|X(2)|12|197|198
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)

FTX206|FTX.006.206|PAYEE-ID|Payee Identfier|Mandatory|This is the identifier that corresp
with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual o
entity that is either receiving a payment or having a previous payment recouped. The pay
the object of the transaction, as opposed to the payer who is the subject taking the action
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 tha indicates what type of ID the payee ID is. For example, if the payee ID represents a provid then the payee ID type will indicate that the payee ID should be interpreted as a provider I 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

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 previou payment recouped. The payee is the object of the transaction, as opposed to the payer wh 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 les
2. Mandatory
3. If Payee Tax ID Type equals "01", then value must be 9-digits and meet the requirement a valid SSN per SSA requirements

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 ident MSIS Identification Numbers are a unique “key” value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for informatio reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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|78
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 Enroll 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

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 se is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM 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 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 service value is.|MBESCBES-FORM|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

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 wa ID number assigned during the state submission and CMS approval process. Waiver IDs sh actually only be the "core" part of the waiver IDs, without including suffixes for renewals o amendments.|N/A|FTX00006|VALUE-BASED-PAYMENT|X(20)|30|859|878|1. Value must be 2 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 Wai 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 inclu 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 follow by a period (.), the associated Waiver Type value must be in [02-20,32,33]
6. Conditional

FTX228|FTX.006.228|SPA-NUMBER|SPA Number|Conditional|State plan amendment (SPA) I 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 th 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 = Situational entry for specific SPA types|N/A|FTX00006|VALUE-BASED-PAYMENT|X(15)|36|88 902|1. Value must be 15 characters or less
2. Conditional

FTX236|FTX.007.236|RECORD-ID|Record ID|Mandatory|The Record ID represents the type
segment being reported. The Record ID communicates how the contents of a given row of
should be interpreted depending on which segment type the Record ID represents. Each ty
of segment collects different data elements so each segment type has a distinct layout. Th
first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th
segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).|RECORD-ID
FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|X(8)|1|1|8|1. Value must
exactly 8 characters
2. Mandatory
3. Value must be in Record ID List (VVL)
4. Value must equal "FTX00007"

FTX239|FTX.007.239|ICN-ORIG|Original ICN|Mandatory|A unique item control number assig
by the states payment system that identifies an original or adjustment claim/transaction.|N
FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|X(50)|4|22|71|1. Value m
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 numb
assigned by the state’s payment system that identifies the adjustment claim/transaction fo
original item control number.|N/A|FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYME
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

N/A

FTX242|FTX.007.242|ADJUSTMENT-IND|Adjustment Indicator|Conditional|Indicates the type
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. Conditional

FTX247|FTX.007.247|PAYER-ID|Payer ID|Mandatory|This is the identifier that corresponds w
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 recoupm
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 anot
entity or individual. The payee is the individual or entity that is either receiving a payment
having a previous payment recouped.|N/A|FTX00007|STATE-DIRECTED-PAYMENT-SEPARAT
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 indica
what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid
CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted 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)

FTX250|FTX.007.250|PAYEE-ID|Payee Identfier|Mandatory|This is the identifier that corresp
with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual o
entity that is either receiving a payment or having a previous payment recouped. The pay
the object of the transaction, as opposed to the payer who is the subject taking the action
either making a payment or taking a recoupment.|N/A|FTX00007|STATE-DIRECTED-PAYME
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 tha
indicates what type of ID the payee ID is. For example, if the payee ID represents a provid
then the payee ID type will indicate that the payee ID should be interpreted as a provider I
PAYEE-ID-TYPE |FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|X(2)|15|
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

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 PAYE
TAX-ID-TYPE was reported with a payee tax ID type of "Other".|N/A|FTX00007|STATE-DIREC
PAYMENT-SEPARATE-PAYMENT-TERM|X(100)|21|565|664|1. Value must be 100 characters
less
2. Value must be populated when Payee Tax Identifier Type equals "95"
3. Conditional

FTX259|FTX.007.259|PAYMENT-PERIOD-START-DATE|Payment Period Start Date|Mandatory
date representing the start of the time period that the payment is expected to be used by
provider. |N/A|FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|9(8)|23|76
772|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

FTX261|FTX.007.261|PAYMENT-PERIOD-TYPE|Payment Period Type|Mandatory|A qualifier t
identifies what the payment period begin and end dates represent. For example, the paym
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.|PAYMEN
PERIOD-TYPE|FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|X(2)|25|78
782|1. Value must be 2 characters
2. Value must be in Payment Period Type 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 se
is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM
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|9
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
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
service value is.|MBESCBES-FORM|FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYME
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

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 wa ID number assigned during the state submission and CMS approval process. Waiver IDs sh actually only be the "core" part of the waiver IDs, without including suffixes for renewals o amendments.|N/A|FTX00007|STATE-DIRECTED-PAYMENT-SEPARATE-PAYMENT-TERM|X(20) 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 Wai 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 inclu 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 follow by a period (.), the associated Waiver Type value must be in [02-20,32,33]
6. Conditional

FTX279|FTX.008.279|RECORD-ID|Record ID|Mandatory|The Record ID represents the type segment being reported. The Record ID communicates how the contents of a given row of should be interpreted depending on which segment type the Record ID represents. Each ty of segment collects different data elements so each segment type has a distinct layout. Th first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).|RECORD-I FTX00008|COST-SETTLEMENT-PAYMENT|X(8)|1|1|8|1. Value must be exactly 8 characters
2. Mandatory
3. Value must be in Record ID List (VVL)
4. Value must equal "FTX00008"

FTX282|FTX.008.282|ICN-ORIG|Original ICN|Mandatory|A unique item control number assig by the states payment system that identifies an original or adjustment claim/transaction.|N FTX00008|COST-SETTLEMENT-PAYMENT|X(50)|4|22|71|1. Value must be 50 characters or l
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 numb assigned by the state’s payment system that identifies the adjustment claim/transaction f original item control number.|N/A|FTX00008|COST-SETTLEMENT-PAYMENT|X(50)|5|72|121| 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
N/A
N/A
FTX285|FTX.008.285|ADJUSTMENT-IND|Adjustment Indicator|Conditional|Indicates the type adjustment record.|ADJUSTMENT-IND|FTX00008|COST-SETTLEMENT-PAYMENT|X(1)|6|122|1 1. Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Conditional
FTX288|FTX.008.288|CHECK-EFF-DATE|Check Effective Date|Conditional|The date a check issued to the payee. In the case of electronic funds transfer, it is the date the transfer is m 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"

FTX290|FTX.008.290|PAYER-ID|Payer ID|Mandatory|This is the identifier that corresponds w
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 recoupm
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 anot
entity or individual. The payee is the individual or entity that is either receiving a payment
having a previous payment recouped.|N/A|FTX00008|COST-SETTLEMENT-PAYMENT|X(30)|1
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 indica
what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid
CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted 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)

FTX293|FTX.008.293|PAYEE-ID|Payee Identfier|Mandatory|This is the identifier that corresp
with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual o
entity that is either receiving a payment or having a previous payment recouped. The pay
the object of the transaction, as opposed to the payer who is the subject taking the action
either making a payment or taking a recoupment.|N/A|FTX00008|COST-SETTLEMENT-PAYM
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 tha indicates what type of ID the payee ID is. For example, if the payee ID represents a provid then the payee ID type will indicate that the payee ID should be interpreted as a provider I PAYEE-ID-TYPE |FTX00008|COST-SETTLEMENT-PAYMENT|X(2)|15|329|330|1. Value must be 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

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 previou payment recouped. The payee is the object of the transaction, as opposed to the payer wh 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 less
2. Mandatory
3. If Payee Tax ID Type equals "01", then value must be 9-digits and meet the requirement a valid SSN per SSA requirements

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 PAYE 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

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 se
is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM
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
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
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
service value is.|MBESCBES-FORM|FTX00008|COST-SETTLEMENT-PAYMENT|X(50)|26|684|7
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

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 wa ID number assigned during the state submission and CMS approval process. Waiver IDs sh actually only be the "core" part of the waiver IDs, without including suffixes for renewals o amendments.|N/A|FTX00008|COST-SETTLEMENT-PAYMENT|X(20)|28|739|758|1. Value mus 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 Wai 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 inclu 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 follow by a period (.), the associated Waiver Type value must be in [02-20,32,33]
6. Conditional

FTX312|FTX.008.312|SPA-NUMBER|SPA Number|Conditional|State plan amendment (SPA) I 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 th 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 = Situational entry for specific SPA types|N/A|FTX00008|COST-SETTLEMENT-PAYMENT|X(15)| 767|781|1. Value must be 15 characters or less
2. Conditional

FTX318|FTX.009.318|RECORD-ID|Record ID|Mandatory|The Record ID represents the type o segment being reported. The Record ID communicates how the contents of a given row of should be interpreted depending on which segment type the Record ID represents. Each ty of segment collects different data elements so each segment type has a distinct layout. Th first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).|RECORD-ID FTX00009|FQHC-WRAP-PAYMENT|X(8)|1|1|8|1. Value must be exactly 8 characters
2. Mandatory
3. Value must be in Record ID List (VVL)
4. Value must equal "FTX00009"

FTX321|FTX.009.321|ICN-ORIG|Original ICN|Mandatory|A unique item control number assig by the states payment system that identifies an original or adjustment claim/transaction.|N 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 numb assigned by the state’s payment system that identifies the adjustment claim/transaction fo original item control number.|N/A|FTX00009|FQHC-WRAP-PAYMENT|X(50)|5|72|121|1. Valu 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
N/A
FTX324|FTX.009.324|ADJUSTMENT-IND|Adjustment Indicator|Conditional|Indicates the type adjustment record.|ADJUSTMENT-IND|FTX00009|FQHC-WRAP-PAYMENT|X(1)|6|122|122|1. V must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Conditional
FTX329|FTX.009.329|PAYER-ID|Payer ID|Mandatory|This is the identifier that corresponds w 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 recoupm 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 anot entity or individual. The payee is the individual or entity that is either receiving a payment having a previous payment recouped.|N/A|FTX00009|FQHC-WRAP-PAYMENT|X(30)|11|167| 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 indica
what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid
CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted 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)

FTX332|FTX.009.332|PAYEE-ID|Payee Identfier|Mandatory|This is the identifier that corresp
with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual c
entity that is either receiving a payment or having a previous payment recouped. The pay
the object of the transaction, as opposed to the payer who is the subject taking the action
either making a payment or taking a recoupment.|N/A|FTX00009|FQHC-WRAP-PAYMENT|X(
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 tha indicates what type of ID the payee ID is. For example, if the payee ID represents a provid then the payee ID type will indicate that the payee ID should be interpreted as a provider I 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

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 previou payment recouped. The payee is the object of the transaction, as opposed to the payer wh 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 requirement a valid SSN per SSA requirements

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 se
is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM
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
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
service value is.|MBESCBES-FORM|FTX00009|FQHC-WRAP-PAYMENT|X(50)|26|684|733|1. V
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

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 wa ID number assigned during the state submission and CMS approval process. Waiver IDs sh actually only be the "core" part of the waiver IDs, without including suffixes for renewals o 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 Wai 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 inclu 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 follow by a period (.), the associated Waiver Type value must be in [02-20,32,33]
6. Conditional

FTX357|FTX.095.357|RECORD-ID|Record ID|Mandatory|The Record ID represents the type segment being reported. The Record ID communicates how the contents of a given row of should be interpreted depending on which segment type the Record ID represents. Each ty of segment collects different data elements so each segment type has a distinct layout. Th first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th segment identifier padded with leading zeros (e.g., 00001, 00002, 00003, etc.).|RECORD-ID FTX00095 |MISCELLANEOUS-PAYMENT|X(8)|1|1|8|1. Value must be exactly 8 characters
2. Mandatory
3. Value must be in Record ID List (VVL)
4. Value must equal "FTX00095"

FTX360|FTX.095.360|ICN-ORIG|Original ICN|Mandatory|A unique item control number assig by the states payment system that identifies an original or adjustment claim/transaction.|M FTX00095 |MISCELLANEOUS-PAYMENT|X(50)|4|22|71|1. Value must be 50 characters or les
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 numb assigned by the state’s payment system that identifies the adjustment claim/transaction f 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
N/A
FTX363|FTX.095.363|ADJUSTMENT-IND|Adjustment Indicator|Conditional|Indicates the type adjustment record.|ADJUSTMENT-IND|FTX00095 |MISCELLANEOUS-PAYMENT|X(1)|6|122|12 Value must be 1 character 2. Value must be in Adjustment Indicator List (VVL) 3. Conditional
FTX368|FTX.095.368|PAYER-ID|Payer ID|Mandatory|This is the identifier that corresponds w 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 recoupm 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 anot entity or individual. The payee is the individual or entity that is either receiving a payment having a previous payment recouped.|N/A|FTX00095 |MISCELLANEOUS-PAYMENT|X(30)|11 196|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 indica
what type of ID the payer ID is. For example, if the payer ID represents the state Medicaid
CHIP agency, then the payer ID type will indicate that the payer ID should be interpreted a
submitting state code.|PAYER-ID-TYPE|FTX00095 |MISCELLANEOUS-PAYMENT|X(2)|12|197|
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)

FTX373|FTX.095.373|PAYEE-ID|Payee Identfier|Mandatory|This is the identifier that corresp
with the payee's role in relation to the Medicaid/CHIP system. The payee is the individual o
entity that is either receiving a payment or having a previous payment recouped. The pay
the object of the transaction, as opposed to the payer who is the subject taking the action
either making a payment or taking a recoupment.|N/A|FTX00095 |MISCELLANEOUS-PAYME
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 tha
indicates what type of ID the payee ID is. For example, if the payee ID represents a provid
then the payee ID type will indicate that the payee ID should be interpreted as a provider I
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

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 previou
payment recouped. The payee is the object of the transaction, as opposed to the payer wh
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 o
2. Mandatory
3. If Payee Tax ID Type equals "01", then value must be 9-digits and meet the requirement
a valid SSN per SSA requirements

FTX382|FTX.095.382|INSURANCE-CARRIER-ID-NUM|Insurance Carrier Identification Numbe
Conditional| The state-assigned identification number of the Third Party Liability (TPL) Entit
N/A|FTX00095 |MISCELLANEOUS-PAYMENT|X(12)|25|867|878|1. Value must be 12 characte
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 ident MSIS Identification Numbers are a unique “key” value used to maintain referential integrity data distributed over multiples files, segments and reporting periods. See T-MSIS Guidance Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for informatio reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe 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|
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 Enroll Time Span where the Payment Period Start Date is equal to or greater than Enrollment Sta Date and Period Period End Date is less than or equal to Enrollment End Date

FTX386|FTX.095.386|PAYMENT-PERIOD-TYPE|Payment Period Type|Mandatory|A qualifier th identifies what the payment period begin and end dates represent. For example, the paym 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.|PAYMEN 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

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 se
is the line item from the MBES/CBES expenditure form (e.g., CMS-64 Base, CMS-64.21U, CM
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
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
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
service value is.|MBESCBES-FORM|FTX00095 |MISCELLANEOUS-PAYMENT|X(50)|35|1122|11
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

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 wa ID number assigned during the state submission and CMS approval process. Waiver IDs sh actually only be the "core" part of the waiver IDs, without including suffixes for renewals o amendments.|N/A|FTX00095 |MISCELLANEOUS-PAYMENT|X(20)|37|1177|1196|1. Value mu
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 Wai 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 inclu 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 follow by a period (.), the associated Waiver Type value must be in [02-20,32,33]
6. Conditional

FTX400|FTX.095.400|SPA-NUMBER|SPA Number|Conditional|State plan amendment (SPA) I 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 th 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 = 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

MCR002|MCR.001.002|DATA-DICTIONARY-VERSION|Data Dictionary Version|Mandatory|A d element to capture the version of the T-MSIS data dictionary that was used to build the file the version number specified on the Cover Sheet of the data dictionary.|DATA-DICTIONARY VERSION|MCR00001|FILE-HEADER-RECORD-MANAGED-CARE|X(10)|2|9|18|1. Value must be characters or less
2. Value must be in Data Dictionary Version List (VVL)
3. Value must not include the pipe ("|") symbol
4. Mandatory

MCR006|MCR.001.006|FILE-NAME|File Name|Mandatory|A code to identify the subject area which the records in its file relate. Each T-MSIS submission file should only contain records one subject area (i.e., Eligible, Third-party liability, Provider, Managed Care Plan Informatio Inpatient, Long-Term Care, Other, Pharmacy Claim, and Financial Transactions).|N/A| MCR00001|FILE-HEADER-RECORD-MANAGED-CARE|X(8)|6|32|39|1. Value must equal "MNGDCARE"
2. Mandatory

MCR008|MCR.001.008|DATE-FILE-CREATED|Date File Created|Mandatory|The date on whic
file was created.|N/A|MCR00001|FILE-HEADER-RECORD-MANAGED-CARE|9(8)|8|42|49|1. Th
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

MCR020|MCR.002.020|MANAGED-CARE-CONTRACT-EFF-DATE|Managed Care Contract Effe
Date|Mandatory|The start date of the managed care contract period with the state.|N/A|
MCR00002|MANAGED-CARE-MAIN|9(8)|5|34|41|1. The date must be a valid calendar date i
form "CCYYMMDD"
2. Mandatory
3. Value must occur before Managed Care Contract End Date (MCR.002.021)

MCR024|MCR.002.024|MANAGED-CARE-PLAN-TYPE|Managed Care Plan Type|Mandatory|Th
type of managed care plan that corresponds to the State Plan Identification Number. The v
reported in this data element should match the Managed Care Plan Type value reported on
Eligible file for the corresponding managed care plan number. Assign plan type value "15"
plans that primarily cover non-emergency medical transportation (NEMT).

See T-MSIS Guidance Document, "CMS Guidance: Best Practice for Reporting Non-Emergen
Medical Transportation (NEMT) Prepaid Ambulatory Health Plans (PAHPs) in the T-MSIS
Managed Care File"
https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-nonemergency-
medical-transportation-nemt-prepaid-ambulatory-health-plans-pahps-in-the-tmsis-manage
care-filemanaged-care/

See T-MSIS Guidance Document, "CMS Guidance: Best Practice for Reporting Managed Car
Plan Type in the T-MSIS Managed Care File"
https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-managedcareplan
in-the-t-msis-managed-care-file-managed-care/|MANAGED-CARE-PLAN-TYPE|MCR00002|
MANAGED-CARE-MAIN|X(2)|9|106|107|1. Value must be 2 characters
2. Value must be in Managed Care Plan Type List (VVL)
3. Mandatory

MCR028|MCR.002.028|PERCENT-BUSINESS|Percent Business|Mandatory|The percentage of
managed care entity's total revenue that is derived from contracts with Medicare (Part C a
D) in the state and State Medicaid agency contract(s) prior calendar year. Include Medicaid
Medicare in calculation of percentage of business in public programs for IRS health insurer
exemption as required in ACA.|N/A|MCR00002|MANAGED-CARE-MAIN|9(3)|13|113|115|1. V
must be between 000 and 100 inclusively
2. Mandatory

MCR029|MCR.002.029|MANAGED-CARE-SERVICE-AREA|Managed Care Service Area|Manda
Identifies the geographic unit under which the managed care entity is under contract to pr
services. The value reported in Managed Care Service Area should represent the geograph
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/tmsis/dataguide/t-msis-coding-blog/reporting-
managedcareservicearea-in-the-managed-care-file-managed-care/|MANAGED-CARE-SERVI
AREA|MCR00002|MANAGED-CARE-MAIN|X(1)|14|116|116|1. Value must be 1 character
2. Value must be in Managed Care Service Area List (VVL)
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

MCR047|MCR.003.047|MANAGED-CARE-ZIP-CODE|Managed Care ZIP Code|Mandatory|U.S.
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)|1
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

MCR051|MCR.003.051|MANAGED-CARE-FAX-NUMBER|Managed Care Fax Number|Conditio
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. Value must be 10-dig
number
2. Conditional

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/tmsis/dataguide/t-msis-coding-blog/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. Value must be 30 characters or less
2. Value must be in Managed Care Service Area Name List (VVL)
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
4. Value must not contain a pipe or asterisk symbol
5. Conditional
6. If associated Managed Care Service Area (MCR.002.029) equals "5" (zipcode), then value must be a 5-digit zipcode
7. If associated Managed Care Service Area (MCR.002.029) equals "2" (county code), then value must be a 3-digit number

MCR067|MCR.005.067|OPERATING-AUTHORITY|Operating Authority|Mandatory|The type of operating authority through which the managed care entity receives its contract authority. 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/tmsis/dataguide/t-msis-coding-blog/reporting-managedcareplan-in-the-t-msis-managed-care-file-managed-care/|OPERATING-AUTHORITY|MCR00005|MANAGED-CARE-OPERATING-AUTHORITY|X(2)|5|34|35|1. Value must be 2 characters
2. Value must be in Operating Authority List (VVL)
3. Mandatory

MCR114|MCR.010.114|RECORD-ID|Record ID|Mandatory|The Record ID represents the type segment being reported. The Record ID communicates how the contents of a given row of should be interpreted depending on which segment type the Record ID represents. Each ty of segment collects different data elements so each segment type has a distinct layout. Th first 3 characters identify the relevant file (e.g., ELG, PRV, CIP, etc.). The last 5 digits are th 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"

MCR119|MCR.010.119|MANAGED-CARE-PLAN-ID|Managed Care Plan ID|Mandatory|A data element to capture the various IDs used to identify a managed care plan. The specific type identifier is defined in the corresponding value in the Managed Care Plan Identifier Type da 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

PRV002|PRV.001.002|DATA-DICTIONARY-VERSION|Data Dictionary Version|Mandatory|A da element to capture the version of the T-MSIS data dictionary that was used to build the file the version number specified on the Cover Sheet of the data dictionary.|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
4. Mandatory

PRV006|PRV.001.006|FILE-NAME|File Name|Mandatory|A code to identify the subject area t which the records in its file relate. Each T-MSIS submission file should only contain records one subject area (i.e., Eligible, Third-party liability, Provider, Managed Care Plan Informatic Inpatient, Long-Term Care, Other, Pharmacy Claim, and Financial Transactions).|N/A|PRV00 FILE-HEADER-RECORD-PROVIDER|X(8)|6|32|39|1. Value must equal "PROVIDER"
2. 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 t
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
2. Value must be 2 characters
3. Mandatory
4. (Individual) If value equals "03", then Provider First Name (PRV.002.028) must be popula
5. (Individual) NPPES Entity Type Code associate with this NPI must equal "1" (Individual)
6. (Individual) If value equals "03", then Provider Last Name (PRV.002.030) must be popula
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) n
not be populated
10. (Organization) If value does not equal "03", then Provider Middle Initial (PRV.002.029) n
not be populated
11. (Organization) NPPES Entity Type Code associate with this NPI must equal "2"
(Organization)

PRV052|PRV.003.052|ADDR-ZIP-CODE|Provider ZIP Code|Mandatory|U.S. ZIP Code compon
of an address associated with a given entity (e.g. person, organization, agency, etc.)|ZIP-C
PRV00003|PROV-LOCATION-AND-CONTACT-INFO|X(9)|14|284|292|1. Value may only be 5 d
(0-9) (Example: 91320) or 9 digits (0-9) (Example: 913200011)
2. Value must be in ZIP Code List (VVL)
3. Mandatory

PRV056|PRV.003.056|ADDR-BORDER-STATE-IND|Address Border State Indicator|Mandatory
code identify an out of state provider enrolled with the state (The provider location is out o
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. Va
must be 1 character
2. Value must be in Address Border State Indicator List (VVL)
3. Mandatory

PRV068|PRV.004.068|LICENSE-ISSUING-ENTITY-ID|License Issuing Entity ID|Mandatory|A fr
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
the CLIA accreditation body's name. -If associated License Type is equal to 1 and issuing
authority is a State, then value must be ANSI State abbreviation code.- If associated Licens
Type is equal to 1 and issuing authority is a county, then value must be a 5-digit, concater
code consisting of the ANSI state code plus the ANSI county code.A list of codes can be fou
here: https://www.nrcs.usda.gov/wps/portal/nrcs/detail/national/home/?cid=nrcs143_0136
associated License Type is equal to 1 and issuing authority is a municipality, then enter a t
string with the name of the municipality. -If associated License Type is equal to 3, then ent
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 accredit
body's name.|N/A|PRV00004|PROV-LICENSING-INFO|X(60)|9|74|133|1. Value must be 60
characters or less
2. Value must not contain a pipe or asterisk symbol
3. Mandatory
4. If associated License Type equals "2", then value must equal "DEA"

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/tmsis/dataguide/t-msis-coding-blog/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-CLASSIFICA
TYPE|PRV00006|PROV-TAXONOMY-CLASSIFICATION|X(1)|5|52|52|1. Value must be 1 charac
2. Value must be in Provider Classification Type List (VVL)
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 eleme Beds should not be counted twice under different bed types. See T-MSIS Guidance Docume "CMS Guidance: Best Practice for Reporting Provider Bed Information in the T-MSIS Provide File".
https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-provider-bed-information-in-the-tmsis-provider-file-provider/|N/A|PRV00010|PROV-BED-TYPE-INFO|9(5)|9 78|1. Value must be 5 digits or less
2. Mandatory

TPL002|TPL.001.002|DATA-DICTIONARY-VERSION|Data Dictionary Version|Mandatory|A dat element to capture the version of the T-MSIS data dictionary that was used to build the file the version number specified on the Cover Sheet of the data dictionary.|DATA-DICTIONARY VERSION|TPL00001|FILE-HEADER-RECORD-TPL|X(10)|2|9|18|1. Value must be 10 character less
2. Value must be in Data Dictionary Version List (VVL)
3. Value must not include the pipe ("|") symbol
4. Mandatory

TPL006|TPL.001.006|FILE-NAME|File Name|Mandatory|A code to identify the subject area t which the records in its file relate. Each T-MSIS submission file should only contain records one subject area (i.e., Eligible, Third-party liability, Provider, Managed Care Plan Informatio Inpatient, Long-Term Care, Other, Pharmacy Claim, and Financial Transactions).|N/A|TPL00 FILE-HEADER-RECORD-TPL|X(8)|6|32|39|1. Value must equal "TPL-FILE"
2. Mandatory

TPL008|TPL.001.008|DATE-FILE-CREATED|Date File Created|Mandatory|The date on which file was created.|N/A|TPL00001|FILE-HEADER-RECORD-TPL|9(8)|8|42|49|1. The date must b 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

TPL019|TPL.002.019|MSIS-IDENTIFICATION-NUM|MSIS Identification Number|Mandatory|A s
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 da
distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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|TPL00002|TPL-MEDICAID-ELIGIBLE-PERSON-MAIN|X(2
22|41|1. Value must be 20 characters or less
2. Mandatory

TPL020|TPL.002.020|TPL-HEALTH-INSURANCE-COVERAGE-IND|TPL Health Insurance Covera
Indicator|Mandatory|A flag to indicate that the Medicaid/CHIP eligible person has some form
third party insurance coverage.|TPL-HEALTH-INSURANCE-COVERAGE-IND|TPL00002|TPL-
MEDICAID-ELIGIBLE-PERSON-MAIN|X(1)|5|42|42|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)
4. Mandatory
5. When value equals "1", there must be one corresponding TPL Medicaid Eligible Person H
Insurance Coverage Information (TPL.003) segment with the same MSIS ID

TPL032|TPL.003.032|MSIS-IDENTIFICATION-NUM|MSIS Identification Number|Mandatory|A s
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 da
distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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|TPL00003|TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-
INSURANCE-COVERAGE-INFO|X(20)|4|22|41|1. Value must be 20 characters or less
2. Mandatory

TPL066|TPL.005.066|MSIS-IDENTIFICATION-NUM|MSIS Identification Number|Mandatory|A s
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 da
distributed over multiples files, segments and reporting periods. See T-MSIS Guidance
Document, "CMS Guidance: Reporting Shared MSIS Identification Numbers" for information
reporting the MSIS Identification Numbers ID for pregnant women, unborn children, mothe
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|TPL00005|TPL-MEDICAID-ELIGIBLE-OTHER-THIRD-PAR
COVERAGE-INFORMATION|X(20)|4|22|41|1. Value must be 20 characters or less
2. Mandatory

TPL082|TPL.006.082|INSURANCE-CARRIER-ZIP-CODE|Insurance Carrier ZIP Code|Situationa
ZIP Code for the location being captured on the TPL Entity Contact Information record.|ZIP-
CODE|TPL00006|TPL-ENTITY-CONTACT-INFORMATION|X(9)|11|246|254|1. Value may only b
digits (0-9) (Example: 91320) or 9 digits (0-9) (Example: 913200011)
2. Value must be in ZIP Code List (VVL)
3. Situational

2|CIP002|CIP.001.002|DATA-DICTIONARY-VERSION|Data Dictionary Version|Mandatory|A da
element to capture the version of the T-MSIS data dictionary that was used to build the file
DATA-DICTIONARY-VERSION|CIP00001|FILE-HEADER-RECORD-IP|X(10)|2|9|18|1. Value mus
10 characters or less
2. Value must be in Data Dictionary Version List (VVL)
3. Value must not include the pipe ("|") symbol
4. Mandatory

5|CIP005|CIP.001.005|DATA-MAPPING-DOCUMENT-VERSION|Data Mapping Document Versi
Mandatory|Identifies the version of the T-MSIS data mapping document used to build a sta
submission file.|N/A|CIP00001|FILE-HEADER-RECORD-IP|X(9)|5|23|31|1. Value must be 9
characters or less
2. Mandatory

77|CIP126|CIP.002.126|FUNDING-CODE|Funding Code|Conditional|A code to indicate the so
of non-federal share funds.|FUNDING-CODE|CIP00002|CLAIM-HEADER-RECORD-IP|X(2)|62|4
488|1. Value must be 1 character
2. Value must be in Funding Code List (VVL)
3. If Type of Claim is not in [3,C,W], then value must be populated
4. Conditional

86|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 combin
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)|71|527|533|1. Value r
be a positive integer
2. Value must be between 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 c
5. Value must be 7 digits or less
6. Value is required if the associated Type of Service (CIP.002.257) in
[001,058,060,084,086,090,091,092,093]
7. Value is required if at least one associated Revenue Code (CIP.003.245) in [100-219]

143|CIP196|CIP.002.196|MEDICARE-HIC-NUM|Medicare HIC Number|Conditional|The Medica
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 t
Medicare Beneficiary Identifier (MBI) over the course of 2018 and 2019. HICN continue to b
used by Medicare for limited administrative purposes after 2019 but starting in 2020 the M
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|CIP000
CLAIM-HEADER-RECORD-IP|X(12)|128|1014|1025|1. 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
be populated
5. Value must be populated when Crossover Indicator (CIP.002.023) equals "1" and Medica
Beneficiary Identifier (CIP.002.222) is not populated

199|CIP237|CIP.003.237|LINE-NUM-ORIG|Original Line Number|Mandatory|A unique numbe
identify the transaction line number that is being reported on the original claim.|N/A|CIP00
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. Value must be one or greater

208|CIP249|CIP.003.249|REVENUE-CENTER-QUANTITY-ACTUAL|Revenue Center Quantity A
Mandatory|On facility claims/encounters, this field is to capture the actual service quantity
revenue code category, e.g., number of days in a particular type of accommodation, pints
blood, etc. However, when HCPCS codes are required for services, the units are equal to th
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|16|187|
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
123456.789
3. Mandatory

209|CIP250|CIP.003.250|REVENUE-CENTER-QUANTITY-ALLOWED|Revenue Center Quantity
Allowed|Conditional|On facility claims/encounters, this field is to capture maximum allowab
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
units are equal to the number of times the procedure/service being reported was allowed.
field is only applicable when the service being billed can be quantified in discrete units, e.g
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|17|19
204|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
123456.789
3. Conditional

215|CIP257|CIP.003.257|TYPE-OF-SERVICE|Type of Service|Mandatory|A code to categorize
services provided to a Medicaid or CHIP enrollee.|TYPE-OF-SERVICE-IP|CIP00003|CLAIM-LIN
RECORD-IP|X(3)|23|259|261|1. Value must be 3 characters
2. Mandatory
3. Value must be in Type of Service IP List (VVL)
4. If Sex (ELG.002.023) equals "M", then value must not equal "086"

225|CIP278|CIP.003.278|NDC-QUANTITY|NDC Quantity|Conditional|This field is to capture t
actual quantity of the National Drug Code being prescribed on the claim/encounter.|N/A|
CIP00003|CLAIM-LINE-RECORD-IP|S9(9)V(9)|33|343|360|1. Value may include up to 9 digits
the left of the decimal point, and 9 digits to the right e.g. 123456789.123456789
2. Conditional

256|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 th file.|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
4. Mandatory

259|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 bu state submission file.|N/A|CLT00001|FILE-HEADER-RECORD-LT|X(9)|5|23|31|1. Value must characters or less
2. Mandatory

310|CLT076|CLT.002.076|FUNDING-CODE|Funding Code|Conditional|A code to indicate the source of non-federal share funds.|FUNDING-CODE|CLT00002|CLAIM-HEADER-RECORD-LT|X 41|364|365|1. Value must be 1 character
2. Value must be in Funding Code List (VVL)
3. If Type of Claim is not in [3,C,W], then value must be populated
4. Conditional

368|CLT140|CLT.002.140|MEDICARE-HIC-NUM|Medicare HIC Number|Conditional|The Medi 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 t Medicare Beneficiary Identifier (MBI) over the course of 2018 and 2019. HICN continue to b used by Medicare for limited administrative purposes after 2019 but starting in 2020 the M 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|CLT00 CLAIM-HEADER-RECORD-LT|X(12)|99|803|814|1. 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 be populated
5. Value must be populated when Crossover Indicator (CLT.002.023) equals "1" and Medica Beneficiary Identifier (CLT.002.168) is not populated

426|CLT190|CLT.003.190|LINE-NUM-ORIG|Original Line Number|Mandatory|A unique numb
identify the transaction line number that is being reported on the original claim.|N/A|CLT00
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. Value must be one or greater

435|CLT202|CLT.003.202|REVENUE-CENTER-QUANTITY-ACTUAL|Revenue Center Quantity
Actual|Mandatory|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
units are equal to the number of times the procedure/service being reported was performe
For CLAIMOT claims/encounter records use Service Quantity Actual and CLAIMRX
claims/encounter records use the Prescription Quantity Actual field|N/A|CLT00003|CLAIM-L
RECORD-LT|S9(6)V999|16|187|195|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
123456.789
3. Mandatory

436|CLT203|CLT.003.203|REVENUE-CENTER-QUANTITY-ALLOWED|Revenue Center Quantit
Allowed|Conditional|On facility claims/encounters, this field is to capture maximum allowab
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
units are equal to the number of times the procedure/service being reported was allowed.
field is only applicable when the service being billed can be quantified in discrete units, e.g
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|17|1
204|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
123456.789
3. Conditional

444|CLT211|CLT.003.211|TYPE-OF-SERVICE|Type of Service|Mandatory|A code to categoriz
services provided to a Medicaid or CHIP enrollee.|TYPE-OF-SERVICE-LT|CLT00003|CLAIM-LI
RECORD-LT|X(3)|25|285|287|1. Value must be 3 characters
2. Mandatory
3. Value must be in Type of Service LT List (VVL)

454|CLT230|CLT.003.230|NDC-QUANTITY|NDC Quantity|Conditional|This field is to capture actual quantity of the National Drug Code being prescribed on the claim/encounters.|N/A|CLT00003|CLAIM-LINE-RECORD-LT|S9(9)V(9)|35|360|377|1. Value may include up to 9 digit the left of the decimal point, and 9 digits to the right e.g. 123456789.123456789
2. Conditional

483|COT002|COT.001.002|DATA-DICTIONARY-VERSION|Data Dictionary Version|Mandatory data element to capture the version of the T-MSIS data dictionary that was used to build th file.|DATA-DICTIONARY-VERSION|COT00001|FILE-HEADER-RECORD-OT|X(10)|2|9|18|1. Valu 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

486|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 bu state submission file.|N/A|COT00001|FILE-HEADER-RECORD-OT|X(9)|5|23|31|1. Value must characters or less
2. Mandatory

533|COT062|COT.002.062|FUNDING-CODE|Funding Code|Conditional|A code to indicate the source of non-federal share funds.|FUNDING-CODE|COT00002|CLAIM-HEADER-RECORD-OT 37|344|345|1. Value must be 1 character
2. Value must be in Funding Code List (VVL)
3. If Type of Claim is not in [3,C,W], then value must be populated
4. Conditional

583|COT114|COT.002.114|BILLING-PROV-TAXONOMY|Billing Provider Taxonomy|Conditiona taxonomy code for the provider billing for the service.|PROV-TAXONOMY|COT00002|CLAIM-HEADER-RECORD-OT|X(12)|87|704|715|1. Value must be in Provider Taxonomy List (VVL)
2. Value must be 12 characters or less
3. Conditional

588|COT122|COT.002.122|MEDICARE-HIC-NUM|Medicare HIC Number|Conditional|The Med
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 t
Medicare Beneficiary Identifier (MBI) over the course of 2018 and 2019. HICN continue to b
used by Medicare for limited administrative purposes after 2019 but starting in 2020 the M
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|COT00
CLAIM-HEADER-RECORD-OT|X(12)|92|760|771|1. 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
be populated
5. Value must be populated when Crossover Indicator (COT.002.023) equals "1" and Medic
Beneficiary Identifier (COT.002.147) is not populated

639|COT160|COT.003.160|LINE-NUM-ORIG|Original Line Number|Mandatory|A unique numb
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. Value must be one or greater

659|COT183|COT.003.183|SERVICE-QUANTITY-ACTUAL|Service Quantity Actual|Mandatory|
quantity of a service or product that is rendered for a specific date of service or billing time
span as reported by revenue code or procedure code on the claim/encounter line. For use
CLAIMOT claims. For CLAIMRX claims/encounters, use the Prescription Quantity Actual field
CLAIMIP and CLAIMLT claims/encounters, use the Revenue Center Quantity Actual field.|N/A
COT00003|CLAIM-LINE-RECORD-OT|S9(8)V999|27|298|308|1. Value may include up to 8 di
to the left of the decimal point, and 3 digits to the right e.g. 12345678.999
2. Mandatory

660|COT184|COT.003.184|SERVICE-QUANTITY-ALLOWED|Service Quantity Allowed|Conditio
The maximum allowable quantity of a service that may be rendered per date of service or
month. For use with CLAIMOT claims/encounters. For CLAIMIP and CLAIMLT claims/encount
use the Revenue Center Quantity Allowed field. NOTE: One prescription for 100 250 milligr
tablets results in Service Quantity Allowed = 100. This field is only applicable when the ser
being billed can be quantified in discrete units, e.g., a number of visits or the number of un
of a prescription/refill that were filled. For prescriptions/refills, use the Medicaid Drug Reba
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.|N/A|COT00003|CLAIM-LINE-RECORD-OT|
S9(8)V999|28|309|319|1. Value may include up to 8 digits to the left of the decimal point,
digits to the right e.g. 12345678.999
2. Conditional

661|COT186|COT.003.186|TYPE-OF-SERVICE|Type of Service|Mandatory|A code to categori
the services provided to a Medicaid or CHIP enrollee.|TYPE-OF-SERVICE-OT|COT00003|CLAI
LINE-RECORD-OT|X(3)|29|320|322|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"

663|COT188|COT.003.188|HCBS-TAXONOMY|HCBS Taxonomy|Conditional|A code to classif
home and community based services listed on the claim into the HCBS taxonomy. The HCB
Taxonomic classification system was adopted by CMS in August 2012.

To acknowledge state variation, services and categories are defined based on the minimu
definition necessary to establish mutually distinct categories and services. Some services
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 toilet

Some of the services reflected by the HCBS Taxonomy including, but not limited to person
care, case management, home health aide, and physician services, may (and in some cas
must) also be covered under the Medicaid State Plan. The definitions below only define the
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 servic
“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
service in the taxonomy. If one is not sure how to map a state’s service to the taxonomy, c
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.|HCBS
TAXONOMY|COT00003|CLAIM-LINE-RECORD-OT|X(5)|31|324|328|1. Value must be 5 charac
or less
2. Value must be in HCBS Taxonomy Code List (VVL)
3. Conditional

694|COT225|COT.003.225|NDC-QUANTITY|NDC Quantity|Conditional|This field is to capture
actual quantity of the National Drug Code being prescribed on the claim/encounters.|N/A|
COT00003|CLAIM-LINE-RECORD-OT|S9(9)V(9)|62|777|794|1. Value may include up to 9 dig
the left of the decimal point, and 9 digits to the right e.g. 123456789.123456789
2. Conditional

734|CRX002|CRX.001.002|DATA-DICTIONARY-VERSION|Data Dictionary Version|Mandatory
data element to capture the version of the T-MSIS data dictionary that was used to build th
file.|DATA-DICTIONARY-VERSION|CRX00001|FILE-HEADER-RECORD-RX|X(10)|2|9|18|1. Valu
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

737|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 bu state submission file.|N/A|CRX00001|FILE-HEADER-RECORD-RX|X(9)|5|23|31|1. Value must characters or less
2. Mandatory

781|CRX053|CRX.002.053|FUNDING-CODE|Funding Code|Conditional|A code to indicate the source of non-federal share funds.|FUNDING-CODE|CRX00002|CLAIM-HEADER-RECORD-RX 34|324|325|1. Value must be 1 character
2. Value must be in Funding Code List (VVL)
3. If Type of Claim is not in [3,C,W], then value must be populated
4. Conditional

803|CRX079|CRX.002.079|MEDICARE-HIC-NUM|Medicare HIC Number|Conditional|The Med 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 t Medicare Beneficiary Identifier (MBI) over the course of 2018 and 2019. HICN continue to b used by Medicare for limited administrative purposes after 2019 but starting in 2020 the M 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|CRX00 CLAIM-HEADER-RECORD-RX|X(12)|56|556|567|1. 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 be populated
5. Value must be populated when Crossover Indicator (CRX.002.023) equals "1" and Medic Beneficiary Identifier (CRX.002.105) is not populated

846|CRX114|CRX.003.114|LINE-NUM-ORIG|Original Line Number|Mandatory|A unique numb identify the transaction line number that is being reported on the original claim.|N/A|CRX0 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. Value must be one or greater

862|CRX131|CRX.003.131|PRESCRIPTION-QUANTITY-ALLOWED|Prescription Quantity Allow
Conditional|The maximum allowable quantity of a drug or service that may be dispensed p
prescription per date of service or per month. Quantity limits are applied to medications w
the majority of appropriate clinical utilizations will be addressed within the quantity allowe
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 Cent
Quantity Actual field. One prescription for 100 250 milligram tablets results in Prescription
Quantity Allowed =100.|N/A|CRX00003|CLAIM-LINE-RECORD-RX|S9(9)V(9)|23|290|307|1. V
may include up to 9 digits to the left of the decimal point, and 9 digits to the right e.g.
123456789.123456789
2. When populated, corresponding Unit of Measure must be populated
3. Conditional

863|CRX132|CRX.003.132|PRESCRIPTION-QUANTITY-ACTUAL|Prescription Quantity Actual|
Mandatory|The quantity of a drug that is dispensed for a prescription as reported by Natio
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|CL
LINE-RECORD-RX|S9(9)V(9)|24|308|325|1. Value may include up to 9 digits to the left of th
decimal point, and 9 digits to the right e.g. 123456789.123456789
2. Mandatory

865|CRX134|CRX.003.134|TYPE-OF-SERVICE|Type of Service|Mandatory|A code to categori
the services provided to a Medicaid or CHIP enrollee.|TYPE-OF-SERVICE-RX|CRX00003|CLAI
LINE-RECORD-RX|X(3)|26|328|330|1. Value must be 3 characters
2. Mandatory
3. Value must be in Type of Service RX List (VVL)

867|CRX136|CRX.003.136|HCBS-TAXONOMY|HCBS Taxonomy|Conditional|A code to classif
home and community based services listed on the claim into the HCBS taxonomy. The HCB
Taxonomic classification system was adopted by CMS in August 2012.

To acknowledge state variation, services and categories are defined based on the minimu
definition necessary to establish mutually distinct categories and services. Some services
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 toilet

Some of the services reflected by the HCBS Taxonomy including, but not limited to person
care, case management, home health aide, and physician services, may (and in some cas
must) also be covered under the Medicaid State Plan. The definitions below only define the
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 servic
“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
service in the taxonomy. If one is not sure how to map a state’s service to the taxonomy, c
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.|HCBS
TAXONOMY|CRX00003|CLAIM-LINE-RECORD-RX|X(5)|28|332|336|1. Value must be 5 charac
or less
2. Value must be in HCBS Taxonomy Code List (VVL)
3. Conditional

874|CRX143|CRX.003.143|DRUG-UTILIZATION-CODE|Drug Utilization Code|Mandatory|A co
indicating the conflict, intervention and outcome of a prescription presented for fulfillment
T-MSIS Drug Utilization Code data element is composite field comprised of three distinct N
data elements: 'Reason for Service Code' (439-E4); 'Professional Service Code' (440-E5); a
'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 r
in different coverage, pricing, patient financial responsibility, drug utilization review outcor
or if the information affects payment for, or documentation of, professional pharmacy serv
The NCPDP 'Reasons of Service Code' (bytes 1 and 2 of the T-MSIS DRUG-UTILIZATION-COD
explains whether the pharmacist filled the prescription, filled part of the prescription, etc.
NCPDP 'Professional Service Code' (bytes 3 and 4 of the T-MSIS Drug Utilization Code) desc
what the pharmacist did for the patient. The NCPDP 'Result of Service Code' (bytes 5 and 6
the T-MSIS Drug Utilization Code) describes the action the pharmacist took in response to
conflict or the result of a pharmacist's professional service. Because the T-MSIS Drug Utiliz
Code data element is a composite field, it is necessary for the state to populate all six byte
any of the three NCPDP fields has a value. In such situations, use 'spaces' as placeholders
not applicable codes.|DRUG-UTILIZATION-CODE-E4, DRUG-UTILIZATION-CODE-E5, DRUG-
UTILIZATION-CODE-E6|CRX00003|CLAIM-LINE-RECORD-RX|X(6)|35|368|373|1. Value must b
characters or less
2. Characters 1 and 2 (2-character string) must be in Drug Utilization Reason for Service C
List (VVL)
3. Characters 3 and 4 (2-character string) must be in Drug Utilization Professional Service
List (VVL)
4. Characters 5 and 6 (2-character string) must be in Drug Utilization Result of Service Cod
List (VVL)
5. Mandatory

921|ELG002|ELG.001.002|DATA-DICTIONARY-VERSION|Data Dictionary Version|Mandatory|
data element to capture the version of the T-MSIS data dictionary that was used to build th
file.|DATA-DICTIONARY-VERSION|ELG00001|FILE-HEADER-RECORD-ELIGIBILITY|X(10)|2|9|18
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

924|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 bu
state submission file.|N/A|ELG00001|FILE-HEADER-RECORD-ELIGIBILITY|X(9)|5|23|31|1. Val
must be 9 characters or less
2. Mandatory

968|ELG050|ELG.003.050|MEDICARE-HIC-NUM|Medicare HIC Number|Conditional|The Medi
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 t
Medicare Beneficiary Identifier (MBI) over the course of 2018 and 2019. HICN continue to b
used by Medicare for limited administrative purposes after 2019 but starting in 2020 the M
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|ELG00
VARIABLE-DEMOGRAPHICS-ELIGIBILITY|X(12)|20|126|137|1. Value must be 12 characters o
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
populated.
5. (Medicare Enrolled) if associated Dual Eligible Code (ELG.005.085) value is in
[01,02,03,04,05,06,08,09,10], then value for either HICN or MBI is mandatory and must be
provided

981|ELG066|ELG.004.066|ELIGIBLE-ADDR-LN1|Eligible Address Line 1|Mandatory|The first l
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|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. Mandatory

991|ELG076|ELG.004.076|ELIGIBLE-ADDR-END-DATE|Eligible Address End Date|Mandatory
last calendar day on which all of the other data elements in the same segment were effect
N/A|ELG00004|ELIGIBLE-CONTACT-INFORMATION|9(8)|16|384|391|1. The date must be a v
calendar date in the form "CCYYMMDD"
2. Value must be 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]

998|ELG085|ELG.005.085|DUAL-ELIGIBLE-CODE|Dual Eligible Code|Mandatory|Indicates coverage for individuals entitled to Medicare (Part A and/or B benefits) and eligible for som category of Medicaid benefits.|DUAL-ELIGIBLE-CODE|ELG00005|ELIGIBILITY-DETERMINANT X(2)|6|54|55|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 Elig 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 Medicar 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"

1009|ELG097|ELG.005.097|RESTRICTED-BENEFITS-CODE|Restricted Benefits Code|Mandat
flag that indicates the scope of Medicaid or CHIP benefits to which an individual is entitled
RESTRICTED-BENEFITS-CODE|ELG00005|ELIGIBILITY-DETERMINANTS|X(1)|17|79|79|1. Valu
must be 1 character
2. Value must be in Restricted Benefits Code List (VVL)
3. (Restricted Benefits) if value equals "3" and Dual Eligible Code (ELG.005.085) value equ
"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 equ
"06", then Eligibility Group (ELG.005.087) must be "26"
5. (Restricted Benefits) if value equals "1" and Dual Eligible Code (ELG.005.085) value equ
"02", then Eligibility Group (ELG.005.087) must be "23"
6. (Restricted Benefits) if value equals "1" and Dual Eligible Code (ELG.005.085) value equ
"04", then Eligibility Group (ELG.005.087) must be "25"
7. (Restricted Benefits) if value equals "3", then Dual Eligible Code (ELG.005.085) cannot b
"00"
8. Mandatory
9. If value is "6" then Eligibility Group(ELG.DE.087) must be in [35,70]
10. If value is in [1,7] then Eligibility Group (EGL.DE.087) must be in [72,73,74,75] and Sta
Plan Option Type (ELG.DE.163) must equal "06"
11. (Restricted Pregnancy-Related) if value equals "4", then associated Sex (ELG.002.023)
value must be "F"
12. (Non-Citizen) if value equals "2", then associated Citizenship Indicator (ELG.003.040) v
must not be equal to "1"
13. If value is "D", there must be a corresponding MFP enrollment segment (ELG00010) wi
Effective and End dates that are within the timespan of this segment
14. (Restricted Benefits) if value equals "3" and Dual Eligible Code (ELG.005.085) value eq
"01", then Eligibility Group (ELG.005.087) must be "23"
15. (Restricted Benefits) if value equals "3" and Dual Eligible Code (ELG.005.085) value eq
"03", then Eligibility Group (ELG.005.087) must be "25"
16. (Restricted Benefits) if value is "G", then Dual Eligible Code (ELG.005.085) must be in

1012|ELG100|ELG.005.100|ELIGIBILITY-DETERMINANT-END-DATE|Eligibility Determinant En
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)|20|89|96|1. The d
must be a valid calendar date in the form "CCYYMMDD"
2. Value must be 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]

1013|ELG274|ELG.005.274|ELIGIBILITY-REDETERMINATION-DATE|Eligibility Redeterminatio
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
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 t
perform a renewal or redetermination of the individual's eligibility. |N/A|ELG00005|ELIGIBIL
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

1020|ELG281|ELG.005.281|ELIGIBILITY-TERMINATION-REASON-OTHER-TYPE-TEXT|Eligibility Termination Reason Other Type Text|Conditional|Value must be populated with a state-spe 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 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

1029|ELG110|ELG.006.110|HEALTH-HOME-SPA-PARTICIPATION-END-DATE|Health Home SP Participation End Date|Mandatory|The last calendar day on which all of the other data elem in the same segment were effective.|N/A|ELG00006|HEALTH-HOME-SPA-PARTICIPATION-INFORMATION|9(8)|8|250|257|1. The date must be a valid calendar date in the form "CCYYMMDD"
2. Value must be 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]

1040|ELG122|ELG.007.122|HEALTH-HOME-SPA-PROVIDER-END-DATE|Health Home Spa Pro End Date|Mandatory|The last calendar day on which all of the other data elements in the s segment were effective.|N/A|ELG00007|HEALTH-HOME-SPA-PROVIDERS|9(8)|9|280|287|1. T date must be a valid calendar date in the form "CCYYMMDD"
2. Value must be 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]

1042|ELG124|ELG.007.124|STATE-NOTATION|State Notation|Situational|A free text field for submitting state to enter whatever information it chooses.|N/A|ELG00007|HEALTH-HOME-S 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. Situational

1050|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. The date must be a valid calendar date in the form "CCYYMMDD"
2. Value must be 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]

1059|ELG143|ELG.009.143|LOCKIN-END-DATE|Lockin End Date|Mandatory|The last calenda
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. The date must be a valid calendar date i
form "CCYYMMDD"
2. Value must be 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]

1061|ELG144|ELG.009.144|STATE-NOTATION|State Notation|Situational|A free text field for
submitting state to enter whatever information it chooses.|N/A|ELG00009|LOCK-IN-
INFORMATION|X(500)|10|93|592|1. Value must be 500 characters or less
2. Value must not contain a pipe or asterisk symbols
3. Situational

1072|ELG156|ELG.010.156|MFP-ENROLLMENT-END-DATE|MFP Enrollment End Date|Manda
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. The date must be a valid cale
date in the form "CCYYMMDD"
2. Value must be 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]

1078|ELG163|ELG.011.163|STATE-PLAN-OPTION-TYPE|State Plan Option Type|Mandatory|T
field specifies the State Plan Options in which the individual is enrolled. Use on occurrence
each State Plan Option enrollment.|STATE-PLAN-OPTION-TYPE|ELG00011|STATE-PLAN-OPTI
PARTICIPATION|X(2)|5|42|43|1. Value must be 2 characters
2. Value must be in State Plan Option Type List (VVL)
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"
4. Mandatory

1098|ELG185|ELG.013.185|LTSS-ELIGIBILITY-END-DATE|LTSS Eligibility End Date|Mandator
last calendar day on which all of the other data elements in the same segment were effect
N/A|ELG00013|LTSS-PARTICIPATION|9(8)|8|81|88|1. The date must be a valid calendar date
the form "CCYYMMDD"
2. Value must be 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]

1105|ELG193|ELG.014.193|MANAGED-CARE-PLAN-TYPE|Managed Care Plan Type|Mandato
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 Ca
File"
https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-nonemergency-
medical-transportation-nemt-prepaid-ambulatory-health-plans-pahps-in-the-tmsis-manage
care-filemanaged-care/

See T-MSIS Guidance Document, "CMS Guidance: Best Practice for Reporting Managed Car
Plan Type in the T-MSIS Managed Care File"
https://www.medicaid.gov/tmsis/dataguide/t-msis-coding-blog/reporting-managedcareplan
in-the-t-msis-managed-care-file-managed-care/|MANAGED-CARE-PLAN-TYPE|ELG00014|
MANAGED-CARE-PARTICIPATION|X(2)|6|54|55|1. Value must be 2 characters
2. Value must be in Managed Care Plan Type List (VVL)
3. Mandatory
4. Value must equal the Managed Care Plan Type (MCR.002.024) associated with the State
Identification Number (MCR.002.018)

1107|ELG197|ELG.014.197|MANAGED-CARE-PLAN-ENROLLMENT-END-DATE|Managed Care
Enrollment End Date|Mandatory|The last calendar day on which all of the other data eleme
in the same segment were effective.|N/A|ELG00014|MANAGED-CARE-PARTICIPATION|9(8)|8
71|1. The date must be a valid calendar date in the form "CCYYMMDD"
2. Value must be 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]

1115|ELG206|ELG.015.206|ETHNICITY-DECLARATION-END-DATE|Ethnicity Declaration End
Mandatory|The last calendar day on which all of the other data elements in the same segm
were effective.|N/A|ELG00015|ETHNICITY-INFORMATION|9(8)|7|51|58|1. The date must be
valid calendar date in the form "CCYYMMDD"
2. Value must be 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]

1134|ELG226|ELG.017.226|DISABILITY-TYPE-END-DATE|Disability Type End Date|Mandator
last calendar day on which all of the other data elements in the same segment were effect
N/A|ELG00017|DISABILITY-INFORMATION|9(8)|7|52|59|1. The date must be a valid calenda
date in the form "CCYYMMDD"
2. Value must be 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]

1142|ELG235|ELG.018.235|1115A-END-DATE|1115A End Date|Mandatory|The last calenda
on which all of the other data elements in the same segment were effective.|N/A|ELG0001
1115A-DEMONSTRATION-INFORMATION|9(8)|7|51|58|1. The date must be a valid calendar
in the form "CCYYMMDD"
2. Value must be 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]

1150|ELG244|ELG.020.244|HCBS-CHRONIC-CONDITION-NON-HEALTH-HOME-END-DATE|HC
Chronic Condition Non Health Home End Date|Mandatory|The last calendar day on which a
the other data elements in the same segment were effective.|N/A|ELG00020|HCBS-CHRON
CONDITIONS-NON-HEALTH-HOME|9(8)|7|53|60|1. The date must be a valid calendar date i
form "CCYYMMDD"
2. Value must be 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]

1158|ELG254|ELG.021.254|ENROLLMENT-END-DATE|Enrollment End Date|Mandatory|The l
calendar day on which all of the other data elements in the same segment were effective.|
ELG00021|ENROLLMENT-TIME-SPAN-SEGMENT|9(8)|7|51|58|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]

1166|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 segr
were effective.|N/A|ELG00022|ELG-IDENTIFIERS|9(8)|7|61|68|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]

1185|FTX002|FTX.001.002|DATA-DICTIONARY-VERSION|Data Dictionary Version|Mandatory
data element to capture the version of the T-MSIS data dictionary that was used to build th
file.|DATA-DICTIONARY-VERSION|FTX00001|FILE-HEADER-RECORD-FTX|X(10)|2|9|18|1. Valu
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

1188|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 bu state submission file.|N/A|FTX00001|FILE-HEADER-RECORD-FTX|X(9)|5|23|31|1. Value must 9 characters or less
2. Mandatory

1204|FTX023|FTX.002.023|ADJUSTMENT-IND|Adjustment Indicator|Mandatory|Indicates the type of adjustment record.|ADJUSTMENT-IND|FTX00002|INDIVIDUAL-CAPITATION-PMPM|X(1 122|122|1. Value must be 1 character
2. Value must be in Adjustment Indicator List (VVL)
3. Mandatory

1213|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 coordinati 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 charac or less
2. Value must be populated when Payer MCR Plan Type equals "95"
3. Conditional

1224|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 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|FTX000 INDIVIDUAL-CAPITATION-PMPM|9(8)|26|887|894|1. The date must be a valid calendar date 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

1232|FTX051|FTX.002.051|FUNDING-CODE|Funding Code|Conditional|A code to indicate th source of non-federal share funds.|FUNDING-CODE|FTX00002|INDIVIDUAL-CAPITATION-PMP 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

1233|FTX052|FTX.002.052|FUNDING-SOURCE-NONFEDERAL-SHARE|Funding Source Nonfed
Share|Conditional|A code to indicate the type of non-federal share used by the state to fina
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

1249|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

1275|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-INSURA
PREMIUM-PAYMENT|X(2)|32|731|732|1. Value must be 1 character
2. Value must be in Funding Code List (VVL)
3. Mandatory

1288|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

1317|FTX140|FTX.004.140|FUNDING-CODE|Funding Code|Conditional|A code to indicate th
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

1330|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
1. Value must be 1 character
2. Value must be in Adjustment Indicator List (VVL)
3. Mandatory

1349|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 the calendar month of beneficiary enrollment in the managed care plan to which the off-se 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 payme that is now being returned to them.|N/A|FTX00005|COST-SHARING-OFFSET|9(8)|25|805|81
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

1357|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) 901|902|1. Value must be 1 character
2. Value must be in Funding Code List (VVL)
3. Mandatory

1371|FTX198|FTX.006.198|ADJUSTMENT-IND|Adjustment Indicator|Mandatory|Indicates the type of adjustment record.|ADJUSTMENT-IND|FTX00006|VALUE-BASED-PAYMENT|X(1)|6|12 122|1. Value must be 1 character
2. Value must be in Adjustment Indicator List (VVL)
3. Mandatory

1397|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(2 881|882|1. Value must be 1 character
2. Value must be in Funding Code List (VVL)
3. Mandatory

1413|FTX242|FTX.007.242|ADJUSTMENT-IND|Adjustment Indicator|Mandatory|Indicates the type of adjustment record.|ADJUSTMENT-IND|FTX00007|STATE-DIRECTED-PAYMENT-SEPAR PAYMENT-TERM|X(1)|6|122|122|1. Value must be 1 character
2. Value must be in Adjustment Indicator List (VVL)
3. Mandatory

1430|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 expecte 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"

1440|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-PAYMENT-TERM|X(2)|33|963|964|1. Value must be 1 character
2. Value must be in Funding Code List (VVL)
3. Mandatory

1454|FTX285|FTX.008.285|ADJUSTMENT-IND|Adjustment Indicator|Mandatory|Indicates the type of adjustment record.|ADJUSTMENT-IND|FTX00008|COST-SETTLEMENT-PAYMENT|X(1)|122|122|1. Value must be 1 character
2. Value must be in Adjustment Indicator List (VVL)
3. Mandatory

1470|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 "CCYYMM
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

1478|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

1491|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|
1. Value must be 1 character
2. Value must be in Adjustment Indicator List (VVL)
3. Mandatory

1507|FTX340|FTX.009.340|WRAP-PERIOD-START-DATE|Wrap Period Start Date|Mandatory|T
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 F wrap payment begin date would be March 1 of that year.|N/A|FTX00009|FQHC-WRAP-PAYM 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

1515|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)|3
761|762|1. Value must be 1 character
2. Value must be in Funding Code List (VVL)
3. Mandatory

1528|FTX363|FTX.095.363|ADJUSTMENT-IND|Adjustment Indicator|Mandatory|Indicates the
type of adjustment record.|ADJUSTMENT-IND|FTX00095 |MISCELLANEOUS-PAYMENT|X(1)|6
122|1. Value must be 1 character
2. Value must be in Adjustment Indicator List (VVL)
3. Mandatory

1561|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|
39|1199|1200|1. Value must be 1 character
2. Value must be in Funding Code List (VVL)
3. Mandatory

1572|MCR002|MCR.001.002|DATA-DICTIONARY-VERSION|Data Dictionary Version|Mandato
data element to capture the version of the T-MSIS data dictionary that was used to build th
file.|DATA-DICTIONARY-VERSION|MCR00001|FILE-HEADER-RECORD-MANAGED-CARE|X(10)|
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

1575|MCR005|MCR.001.005|DATA-MAPPING-DOCUMENT-VERSION|Data Mapping Documen
Version|Mandatory|Identifies the version of the T-MSIS data mapping document used to bu
state submission file.|N/A|MCR00001|FILE-HEADER-RECORD-MANAGED-CARE|X(9)|5|23|31|
Value must be 9 characters or less
2. Mandatory

1597|MCR027|MCR.002.027|CORE-BASED-STATISTICAL-AREA-CODE|Core Based Statistical Code|Mandatory|A code signifying whether the Managed Care Organization's (MCO) servic area falls into one or more metropolitan or micropolitan statistical areas. Whenever a serv area straddles two types of areas (e.g., metropolitan and micropolitan, metropolitan and n 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 t U.S. Office of Management and Budget (OMB). The term "Core Based Statistical Area" (CBS a collective term for both metro and micro areas. A metro area contains a core urban area 50,000 or more population, and a micro area contains an urban core of at least 10,000 (bu 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 tha have a high degree of social and economic integration (as measured by commuting to wor with the urban core. The U.S. Office of Management and Budget (OMB) defines metropolita 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. Betw 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.
http://www.whitehouse.gov/sites/default/files/omb/assets/bulletins/b10-02.pdf|CORE-BASE STATISTICAL-AREA-CODE|MCR00002|MANAGED-CARE-MAIN|X(1)|12|112|112|1. Value must character
2. Value must be in Core Based Statistical Area Code List (VVL)
3. Mandatory

1601|MCR031|MCR.002.031|MANAGED-CARE-MAIN-REC-END-DATE|Managed Care Main Re End Date|Mandatory|The last calendar day on which all of the other data elements in the s segment were effective.|N/A|MCR00002|MANAGED-CARE-MAIN|9(8)|16|125|132|1. The dat 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]

1609|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 the other data elements in the same segment were effective.|N/A|MCR00003|MANAGED-C LOCATION-AND-CONTACT-INFO|9(8)|7|57|64|1. The date must be a valid calendar date in t 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]

1628|MCR060|MCR.004.060|MANAGED-CARE-SERVICE-AREA-END-DATE|Managed Care Ser
Area End Date|Mandatory|The last calendar day on which all of the other data elements in
same segment were effective.|N/A|MCR00004|MANAGED-CARE-SERVICE-AREA|9(8)|7|72|79
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]

1637|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 elemen
the same segment were effective.|N/A|MCR00005|MANAGED-CARE-OPERATING-AUTHORITY
9(8)|8|64|71|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]

1645|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 eleme
in the same segment were effective.|N/A|MCR00006|MANAGED-CARE-PLAN-POPULATION-
ENROLLED|9(8)|7|44|51|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 Effective Date value
3. Mandatory
4. Value of the CC component must be in [19,20,99]

1653|MCR088|MCR.007.088|DATE-ACCREDITATION-END|Date Accreditation End|Mandatory
date when organization's accreditation ends.|N/A|MCR00007|MANAGED-CARE-ACCREDITAT
ORGANIZATION|9(8)|7|44|51|1. The date must be a valid calendar date in the form
"CCYYMMDD"
2. Value must be 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]

1659|MCR118|MCR.010.118|MANAGED-CARE-PLAN-OTHER-ID-TYPE|Managed Care Plan Oth
Type|Mandatory|A code to identify the kind of managed care identifier that is captured in t
Managed Care Identifier data element. The state should submit updates to T-MSIS whenev
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

1660|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 Pl
Identifier Type data element.|N/A|MCR00010|MANAGED-CARE-ID|X(30)|6|36|65|1. Value m
be 30 characters
2. Value must not contain a pipe or asterisk symbol
3. Mandatory

1662|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-CA
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]

1665|PRV002|PRV.001.002|DATA-DICTIONARY-VERSION|Data Dictionary Version|Mandatory
data element to capture the version of the T-MSIS data dictionary that was used to build th
file.|DATA-DICTIONARY-VERSION|PRV00001|FILE-HEADER-RECORD-PROVIDER|X(10)|2|9|18
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

1668|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 bu
state submission file.|N/A|PRV00001|FILE-HEADER-RECORD-PROVIDER|X(9)|5|23|31|1. Valu
must be 9 characters or less
2. Mandatory

1707|PRV044|PRV.003.044|PROV-LOCATION-AND-CONTACT-INFO-EFF-DATE|Provider Locat
and Contact Info Effective Date|Mandatory|The first calendar day on which all of the other
elements in the same segment were effective.|N/A|PRV00003|PROV-LOCATION-AND-CONT
INFO|9(8)|6|57|64|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 [19,19,99]

1708|PRV045|PRV.003.045|PROV-LOCATION-AND-CONTACT-INFO-END-DATE|Provider Locat
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-CONTA
INFO|9(8)|7|65|72|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 [19,20,99]

1710|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|7
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. Mandatory

1787|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.|
PRV00010|PROV-BED-TYPE-INFO|9(8)|7|65|72|1. The date must be a valid calendar date in
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]

1792|TPL002|TPL.001.002|DATA-DICTIONARY-VERSION|Data Dictionary Version|Mandatory
data element to capture the version of the T-MSIS data dictionary that was used to build th
file.|DATA-DICTIONARY-VERSION|TPL00001|FILE-HEADER-RECORD-TPL|X(10)|2|9|18|1. Valu
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

1795|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 bu
state submission file.|N/A|TPL00001|FILE-HEADER-RECORD-TPL|X(9)|5|23|31|1. Value must
characters or less
2. Mandatory

1817|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 segn
were effective.|N/A|TPL00002|TPL-MEDICAID-ELIGIBLE-PERSON-MAIN|9(8)|11|113|120|1. Th
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]

1834|TPL049|TPL.003.049|INSURANCE-COVERAGE-END-DATE|Insurance Coverage End Dat
Mandatory|The last calendar day on which all of the other data elements in the same segn
were effective.|N/A|TPL00003|TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-
COVERAGE-INFO|9(8)|16|204|211|1. The date must be a valid calendar date in the form
"CCYYMMDD"
2. Value must be after or the same as the associated Effective Date value
3. Mandatory
4. Value of the CC component must be in [19,20,99]

1845|TPL060|TPL.004.060|INSURANCE-CATEGORIES-END-DATE|Insurance Categories End D
Mandatory|The last calendar day on which all of the other data elements in the same segn
were effective.|N/A|TPL00004|TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-
COVERAGE-CATEGORIES|9(8)|9|66|73|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 Effective Date value
3. Mandatory
4. Value of the CC component must be in [19,20,99]