Reporting Person-Level Separate CHIP Data to MSIS: A Guide for States

Programmer's Supplement

September 13, 2012

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Policy Research

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Contract Number:
HHSM-500-2005-000251

Task Number:
HHSM-500-T0002

Mathematica Reference Number:
06759-710

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CONTENTS

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ACRONYMS

CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
COBOL	Common business-oriented language
CPT	Current procedural terminology
CRVS	California Relative Value Study
DEA	Drug Enforcement Administration
DRG	Diagnosis-related group
EL	Eligible file
EPSDT	Early and periodic screening, diagnosis, and treatment
FIPS	Federal information processing standard
FPL	Federal poverty level
FQHC	Federally qualified health center
HCBS	Home and community-based services
HCPCS	Healthcare Common Procedural Coding System
HI	Health insurance
HIC	Health insurance claim
HIFA	Health Insurance Flexibility and Accountability
HIO	Health insurance organization
HMO	Health maintenance organization
HOA	Health Opportunity Account
ICD	International Classification of Diseases
ICF	Intermediate care facility
ICF-MR	Intermediate care facility for the mentally retarded
ID	Identification number
ILTC	Institutional long-term care
IP	Inpatient hospital claims file
IV	Intravenous
LT	Long-term care claims file
LTC	Long-term care
MC	Managed care

M-CHIP	Medicaid expansion Children's Health Insurance Program
MMIS	Medicaid Management Information System
MSIS	Medicaid Statistical Information System
NDC	National Drug Code
NF	Nursing facility
NPI	National provider identification number
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claim Committee
OT	Other, non-institutional claims file
PACE	Program for All-Inclusive Care for the Elderly
PCCM	Primary care case management
PHP	Prepaid health plan
POS	Place of service
PRTF	Psychiatric residential treatment facility
Q	Quarter
RBF	Restricted-benefits flag
RX	Prescription drug claims file
SSN	Social Security number
TA	Technical assistance
TANF	Temporary Assistance for Needy Families
TOS	Type of service
UB	Uniform billing
USPS	United States Postal Service

A. Purpose

There is a growing need for person-level enrollment, utilization, and payment data for the Children's Health Insurance Program (CHIP) so that states, the Centers for Medicare & Medicaid Services (CMS), and researchers can examine program transitions, access to services, and quality of care, among other priorities. Under CHIP, states have three options for covering individuals: (1) create Medicaid expansion CHIP (M-CHIP) programs by expanding Medicaid, (2) create separate CHIP programs, or (3) implement a combination of the two. According to CMS, 8 states (including the District of Columbia) operate M-CHIP programs, 17 operate separate CHIP programs, and 26 operate combination programs (Centers for Medicare & Medicaid Services 2011). Separate CHIP programs, including in combination states, frequently offer different benefits, deliver health care services through different providers, and utilize different information technology systems than do Medicaid or M-CHIP.

The Medicaid and CHIP Statistical Information System (MSIS) is the only standardized, national-level source of person-level Medicaid and CHIP data. Since 1999, states have been required to report complete Medicaid and M-CHIP enrollment and claims data to MSIS on a quarterly basis. However, states have only been able to report complete separate CHIP program data since October 2010. Three of the 43 states with separate CHIP programs currently do so.

In 2010, CMS contracted with Mathematica Policy Research to provide comprehensive technical assistance (TA) to states to help them report separate CHIP data. In 2012, Mathematica published "Reporting Person-Level Separate CHIP Data to MSIS: A Guide for States" (Hodges et al. 2012). That guide for state officials, which draws on TA experiences with over a dozen states, summarizes the MSIS data elements, enumerates reporting steps, and describes common reporting errors. This supplemental guide for programmers is intended to help them extract eligibility and claims records from state, vendor, and provider source systems,

including Medicaid Management Information Systems (MMIS), and convert them into the MSIS format. Programmers should use these guides along with the MSIS File Specifications and Data Dictionary (Centers for Medicare & Medicaid Services 2010); the state's eligibility, managed care, and waiver crosswalks; and input data layouts to develop code to report separate CHIP data in MSIS.

B. Using This Guide

The appendix includes five tables for mapping data from source system fields/elements to MSIS data elements. Each table corresponds to an MSIS file type: eligible (EL), which consists of enrollment records; inpatient (IP) claims; long-term care (LT) claims; other (OT) claims; and prescription drug (RX) claims.

These mapping tables provide information about the data elements in the order that they appear in the respective record layouts (please note that the tables do not include information about file header records because header records do not include CHIP-specific data). Each table has nine columns. The first four indicate the data element's name, field length, COBOL format, and position(s). The fifth column provides an example of properly formatted data for the element. These examples emphasize the difference between numeric and character formats. Numeric data should be left-filled with zeros where and when appropriate. Some numeric data elements contained within the four claims file types require positive or negative signs; the "COBOL Format" column denotes a signed element with the presence of "S" along with the numeric indicator. The sixth column—"Variable Notes"—provides a detailed description and, when applicable, a list of valid values for each data element, with three exceptions—the values specified by CMS for the "Type of Service," "Patient Status," and "Place of Service" elements are listed in the final three appendix tables. The seventh column provides space to indicate whether a state is currently reporting data to that field for separate CHIP enrollees. The eighth

column, “State Specification,” allows programmers to enter a state’s specifications for that field (please note that the appropriate values for separate CHIP programs could be different than those for Medicaid or M-CHIP). The last column, “Programmer Coding Notes,” allows the programmer to enter miscellaneous notes and references.

The tables can be used to map MMIS or other system field values to MSIS values when fields are directly comparable and to generate derived values for fields that may not be directly comparable. The National Drug Code (NDC), for example, is almost always directly comparable because it is a standard field used in most state systems, so in the last column programmers would make a note to use the NDC values from the source system. When MSIS data elements do not have corresponding or analogous fields in the MMIS or in other source systems, programmers may be able to derive them from other native sources. For example, the “Restricted-Benefits Flag (RBF)” data element does not appear directly in most state systems, so states generally identify the proper RBF values for enrollees from the “Maintenance Assistance Status/Basis of Eligibility,” “Eligibility Group,” “Dual Code,” and, possibly, “Plan Type” elements. An RBF value of 3, for instance, indicates that a person is eligible for Medicaid but is only entitled to partial benefits because of his or her status as a qualified Medicare beneficiary (MSIS “Dual Code” value = 1), a specified low-income Medicare beneficiary (MSIS “Dual Code” value = 3), a qualified disabled working individual (MSIS “Dual Code” value = 5) or a qualifying individual (MSIS “Dual Code” value = 6). Many states designate a specific eligibility group code for each of these partial dual groups. Therefore, a programmer could assign RBF value 3 to individuals with state-specific eligibility group codes corresponding to the partial dual-eligible groups, or to individuals who have already been assigned MSIS “Dual Code” values of 1, 3, 5, or 6. The programmer could use the same method to calculate values for all other derived data elements.

C. Available Assistance

States may contact Mathematica for assistance in using this guide, or with general questions about CHIP reporting to MSIS, by e-mailing ccamillo@mathematica-mpr.com.

References

Centers for Medicare & Medicaid Services. "Children's Health Insurance Program, Plan Activity as of September 22, 2011." 2011. Available at [http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/Downloads/Map-CHIP-Program-Designs-by-State-.pdf]. Accessed August 8, 2012.

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APPENDIX A

MSIS ELIGIBLE (EL) DATA FILE

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This file includes demographic and enrollment data.

DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
QUARTERLY FIELDS								
MSIS-IDENTIFICATION-NUMBER	20	X	01-20	123456789	The MSIS-IDENTIFICATION-NUMBER is the unique personal identification number assigned by the state. Some states use the enrollee's Social Security Number as the value for the MSIS-IDENTIFICATION-NUMBER. These states are classified as "SSN states" and should use the following procedures for entering the information into MSIS-IDENTIFICATION-NUMBER and SOCIAL-SECURITY-NUMBER: (1) if the SSN is unknown, set the MSIS-IDENTIFICATION-NUMBER equal to a temporary value and set the SOCIAL-SECURITY-NUMBER equal to 8-fill; (2) when the SSN becomes available, submit at least one eligibility record with the MSIS-IDENTIFICATION-NUMBER equal to the temporary value (established in (1)) and the SOCIAL-SECURITY-NUMBER equal to the person's SSN; (3) if the SSN is known when the person first enrolls, set the MSIS-IDENTIFICATION-NUMBER equal to spaces and set the SOCIAL-SECURITY-NUMBER equal to the SSN. “Non-SSN states” should use the following procedures: (1) set the MSIS-IDENTIFICATION-NUMBER equal to the permanent personal identification number (if the person re-enrolls, continue to use this permanent number), (2) set the SOCIAL-SECURITY-NUMBER equal to the person’s SSN (if known) or 9-fill (if the SSN is unknown). For more detailed guidance, refer to pages 18-19 of the MSIS File Specifications and Data Dictionary, Release 3.1.			
DATE-OF-BIRTH	8	9	21-28	19670312	This field uses a CCYYMMDD format.			
DATE-OF-DEATH	8	9	29-36	19670313	This field uses a CCYYMMDD format.			

[a] COBOL format values: X = Alphanumeric, left justified, padded to field length with spaces; 9 = Numeric, right justified and filled left with zeros; S9 = Signed, positive or negative embedded within the last significant digit

[b] Unless otherwise noted, 9-fill all missing data elements.

This file includes demographic and enrollment data.

DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
SEX-CODE	1	X	37-37	F	F = Female M = Male U = Unknown			
RACE-ETHNICITY-CODE	1	9	38-38	1	1 = White 2 = Black 3 = American Indian or Alaska Native 4 = Asian 5 = Hispanic or Latino 6 = Native Hawaiian or Pacific Islander 7 = Hispanic or Latino and One or More Races 8 = More than One Race 9 = Unknown			
SOCIAL-SECURITY-NUMBER	9	9	39-47	253981873	Refer to the instructions for MSIS-IDENTIFICATION-NUMBER noted above.			
COUNTY-CODE	3	9	48-50	037	This field uses Census-based FIPS codes. Values are primarily odd 3-character sequential. If the enrollee resides outside of the state, 0-fill.			
ZIP-CODE	5	9	51-55	91365	This field contains the zip code of the enrollee's place of residence (it must be a valid USPS zip code).			

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DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
TYPE-OF-RECORD	1	9	56-56	1	1 = Current 2 = Retroactive 3 = Correction			
FEDERAL-FISCAL-YEAR-QUARTER	5	9	57-61	20011	This field uses a CCYYQ format with CCYY representing the federal fiscal year and Q representing the quarter.			
QUARTERLY-DUAL-ELIGIBLE-FLAG	2	9	62-63		This is an obsolete field that should be left blank.			
HIC-NUMBER	12	X	64-75	123456789A	This field includes the enrollee's Medicare enrollment number. 8-fill when the individual is not enrolled in Medicare.			
MSIS-CASE-NUMBER	12	X	76-87	1045329867	This is the Case Number as of the last day of the reporting quarter. An individual's Case Number may change over time.			
RACE-CODE-1	1	9	88-88	1	0 = Non-White or Race Unknown 1 = White			

[a] COBOL format values: X = Alphanumeric, left justified, padded to field length with spaces; 9 = Numeric, right justified and filled left with zeros; S9 = Signed, positive or negative embedded within the last significant digit

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DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
RACE-CODE-2	1	9	89-89	0	0 = Non-Black or African-American or Race Unknown 1 = Black or African American			
RACE-CODE-3	1	9	90-90	0	0 = Non-American Indian or Alaska Native or Race Unknown 1 = American Indian or Alaska Native			
RACE-CODE-4	1	9	91-91	0	0 = Non-Asian or Race Unknown 1 = Asian			
RACE-CODE-5	1	9	92-92	0	0 = Non-Native Hawaiian or Other Pacific Islander or Race Unknown 1 = Native Hawaiian or Other Pacific Islander			
ETHNICITY-CODE	1	9	93-93	1	0 = Not Hispanic or Latino 1 = Hispanic or Latino 9 = Ethnicity Unknown			
FILLER	9	X	94-102		This is an obsolete field that should be left blank.			

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DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
MONTHLY FIELDS								
DAYS-OF-ELIGIBILITY	2	S9	Month 1: 103-104 Month 2: 194-195 Month 3: 285-286	+00	Per CMS instructions, this field should be 0-filled for separate CHIP enrollees.			
ELIGIBILITY-GROUP	6	X	Month 1: 105-110 Month 2: 196-201 Month 3: 287-292	10A01	The value for this data element must match one of the state-specific codes submitted by the state on its eligibility crosswalk. The state-specific codes are a composite of eligibility mapping factors, including the eligibility group code from the eligibility system. This data element is 0-filled for individuals who were not eligible for at least one day during the month.			
MAINTENANCE-ASSISTANCE-STATUS	1	X	Month 1: 111-111 Month 2: 202-202 Month 3: 293-293	0	This element should be 0-filled for separate CHIP enrollees.			
BASIS-OF-ELIGIBILITY	1	X	Month 1: 112-112 Month 2: 203-203 Month 3: 294-294	0	This element should be 0-filled for separate CHIP enrollees.			
HEALTH-INSURANCE	1	9	Month 1: 113-113 Month 2: 204-204 Month 3: 295-295	1	This field indicates whether the enrollee has private health insurance (HI). It does not include other public insurance, like Medicare or TRICARE. 1 = No private HI 2 = Third Party HI 3 = State HI 4 = Both 2 and 3 apply			
TANF-CASH-FLAG	1	9	Month 1: 114-114 Month 2: 205-205 Month 3: 296-296	2	CMS permits many states to omit this field from reporting. Programmers should verify whether their state reports this field before writing code for separate CHIP enrollees. 1 = No TANF 2 = TANF			

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This file includes demographic and enrollment data.

DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
RESTRICTED-BENEFITS-FLAG	1	X	Month 1: 115-115 Month 2: 206-206 Month 3: 297-297	1	1 = Full benefits 2 = Alien 3 = Partial Dual 4 = Pregnancy-related Services 5 = Other Restricted Benefits 6 = Family Planning Services 7 = Benchmark Equivalent Coverage 8 = Money Follows the Person 9 = Unknown A = PRTF Program B = HOA C = Separate CHIP Dental Coverage			
PLAN-TYPE-1	2	9	Month 1: 116-117 Month 2: 207-208 Month 3: 298-299	01	01 = HMO 02 = Dental MC 03 = Behavioral MC 04 = Prenatal/Delivery MC 05 = LTC MC 06 = PACE 07 = PCCM 08 = Other MC 88 = Individual is not enrolled in MC 99 = Unknown			
PLAN-ID-1	12	X	Month 1: 118-129 Month 2: 209-220 Month 3: 300-311	MED001356	This is an identifier that uniquely identifies a managed care plan that has also been reported in the state's managed care plan crosswalk. The ID should be the same as that reported on the corresponding claims files. The monthly PLAN-ID fields should be filled in sequence. If a person is enrolled on two managed care plans, for example, only the first and second set of monthly fields should be used. If the person is enrolled in only one plan, code PLAN-ID-1 and 8-fill PLAN-ID-2 through PLAN-ID-4.			
PLAN-TYPE-2	2	9	Month 1: 130-131 Month 2: 221-222 Month 3: 312-313	88	8-fill if the individual is enrolled in only one managed care plan.			

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This file includes demographic and enrollment data.

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PLAN-ID-2	12	X	Month 1: 132-143 Month 2: 223-234 Month 3: 314-325	888888888888	8-fill if the individual is enrolled in only one managed care plan.			
PLAN-TYPE-3	2	9	Month 1: 144-145 Month 2: 235-236 Month 3: 326-327	88	8-fill if the individual is enrolled in fewer than three managed care plans.			
PLAN-ID-3	12	X	Month 1: 146-157 Month 2: 237-248 Month 3: 328-339	888888888888	8-fill if the individual is enrolled in fewer than three managed care plans.			
PLAN-TYPE-4	2	9	Month 1: 158-159 Month 2: 249-250 Month 3: 340-341	88	8-fill if the individual is enrolled in fewer than four managed care plans.			
PLAN-ID-4	12	X	Month 1: 160-171 Month 2: 251-262 Month 3: 342-353	888888888888	8-fill if the individual is enrolled in fewer than four managed care plans.			
CHIP-CODE	1	X	Month 1: 172-172 Month 2: 263-263 Month 3: 354-354	1	1 = No Separate CHIP 2 = Medicaid Expansion CHIP 3 = Separate CHIP			

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DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
INCOME-CODE	2	X	Month 1: 173-174 Month 2: 264-265 Month 3: 355-356	4	INCOME-CODE currently is not a mandatory reporting element. Blank = State has not opted to include this field 00 = Individual was not Medicaid or CHIP eligible for this month 01 = Individual's family income is 0-100% of FPL for this month 02 = Individual's family income is 101-200% of FPL for this month 03 = Individual's family income is 201-250% of FPL for this month 04 = Individual's family income is 251-300% of FPL for this month 05 = Individual's family income is over 300% of FPL for this month 09 = Individual's family income is unknown for this month 88 = Individual was eligible for Medicaid but not enrolled in a CHIP program for the month			
WAIVER-TYPE-1	1	X	Month 1: 175-175 Month 2: 266-266 Month 3: 357-357	A	The value for WAIVER-TYPE-1 should match a value found on the state-specific waiver crosswalk. States should use the following hierarchy when reporting individuals who were enrolled in more than one waiver during the month: 1115 Pharmacy Plus [6]; 1115 Hurricane [A]; 1115 Family Planning [F]; 1915(c) [3]; 1915(b)(c) [4]; 1915(b) [2]; 1115 Research & Demo [1]; 1115 HIFA [5].			
WAIVER-ID-1	2	X	Month 1: 176-177 Month 2: 267-268 Month 3: 358-359	C1	This is a unique ID assigned by the state. The value for WAIVER-ID-1 should match a value found on the state-specific waiver crosswalk.			
WAIVER-TYPE-2	1	X	Month 1: 178-178 Month 2: 269-269 Month 3: 360-360	8	8-fill if the individual is enrolled in only one waiver.			

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DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
WAIVER-ID-2	2	X	Month 1: 179-180 Month 2: 270-271 Month 3: 361-362	88	8-fill if the individual is enrolled in only one waiver.			
WAIVER-TYPE-3	1	X	Month 1: 181-181 Month 2: 272-272 Month 3: 363-363	8	8-fill if the individual is enrolled in fewer than three waivers.			
WAIVER-ID-3	2	X	Month 1: 182-183 Month 2: 273-274 Month 3: 364-365	88	8-fill if the individual is enrolled in fewer than three waivers.			
DUAL-ELIGIBLE-CODE	2	9	Month 1: 184-185 Month 2: 275-276 Month 3: 366-367	01	This field is 0-filled for non-duals, but should be populated with a "10" if the separate CHIP enrollee has dual eligibility.			
FILLER	8	X	Month 1: 186-193 Month 2: 277-284 Month 3: 368-375		This is an obsolete field that should be left blank.			

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APPENDIX B

MSIS INPATIENT (IP) DATA FILE

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This file includes claims for inpatient hospital services.

DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
MSIS-IDENTIFICATION-NUMBER	20	X	01-20	123456789	The MSIS-IDENTIFICATION-NUMBER is the unique personal identification number assigned by the state. The MSIS-IDENTIFICATION-NUMBER in the claims files must match the MSIS-IDENTIFICATION-NUMBER or SOCIAL-SECURITY-NUMBER in the EL files depending on whether the state is an “SSN state” or “non-SSN state”. States that use the enrollee's Social Security Number as the value for the MSIS-IDENTIFICATION-NUMBER are classified as "SSN states". For SSN states, the MSIS-IDENTIFICATION-NUMBER on a claim should match the SOCIAL-SECURITY-NUMBER in the EL file. If the state is an SSN state but no SSN is available, use the temporary MSIS-IDENTIFICATION-NUMBER on claims. For non-SSN states, the MSIS-IDENTIFICATION-NUMBER on a claim should be the same as the MSIS-IDENTIFICATION-NUMBER in the EL file. See EL variable notes for MSIS-IDENTIFICATION-NUMBER assignment instructions. For more detailed guidance, refer to pages 18-19 of the MSIS File Specifications and Data Dictionary, Release 3.1.			
ADJUSTMENT-INDICATOR	1	9	21-21	2	0 = Original Claim/Encounter 1 = Void of a prior submission 2 = Re-submittal 3 = Credit adjustment 4 = Debit adjustment 5 = Gross adjustment Claims with ADJUSTMENT-INDICATOR = 0, 2, or 4 are expected to have positive values in signed elements. Claims with ADJUSTMENT-INDICATOR = 1 or 3 are expected to have negative values in signed elements.			
TYPE-OF-SERVICE	2	9	22-23	07	Note: the IP file should include claims with only the following Types of Service: 01 (Inpatient Hospital), 24 (Sterilizations), 25 (Abortions), or 39 (Religious Non-medical Healthcare Institution). All claims for inpatient psychiatric care provided in a separately administered psychiatric wing or psychiatric hospital are included in the LT file. Refer to Appendix F of this document and Attachment 4 of the MSIS File Specifications and Data Dictionary for specific descriptions.			

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[b] Unless otherwise noted, 9-fill all missing data elements.

This file includes claims for inpatient hospital services.

DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
TYPE-OF-CLAIM	1	X	24-24	1	A = Separate CHIP Fee-For-Service Claim B = Separate CHIP Capitation Claim C = Separate CHIP Encounter Claim D = Separate CHIP Service Tracking Claim (a.k.a. "Gross Adjustment") E = Separate CHIP Supplemental Payment Note that error conditions 3 and 4 on page 130 of the MSIS Data Dictionary should read "Value = 4 or D," not "Value = 4 or E."			
DATE-OF-PAYMENT-ADJUDICATION	8	9	25-32	19980531	This is the date on which the payment status of the claim was finally adjudicated by the state. For encounter records this is the day the encounter was processed. For adjustment records, use the date of final adjudication, when possible.			
MEDICAID-AMOUNT-PAID	8	S9	33-40	+00000950	This is the amount paid by Medicaid/separate CHIP on this claim or adjustment. For encounters (Type of Claim = C), the Medicaid Amount Paid should be equal to zero. If Medicaid/separate CHIP had no liability for the bill, 0-fill this field. If the encounter contains the amount paid to a provider by a plan, assign the payment to the AMOUNT-CHARGED. For fee-for-service claims where the Medicaid Amount Paid is only available at the header level, include all payment information on the header claim. Then, submit the line item claims with $0 in all payment fields.			
BEGINNING-DATE-OF-SERVICE	8	9	41-48	19980531	For single date/service, this is the date when the service was received; for multiple dates/services, this is the date when the service began.			
ENDING-DATE-OF-SERVICE	8	9	49-56	19980531	For single date/service, this is the date when the service was received; for multiple dates/services, this is the date when the service ended.			

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DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
PROVIDER-ID-NUMBER-BILLING	12	X	57-68	01CA79300	This is a unique ID assigned by the state to a provider. This should represent the entity billing for the service. For encounter records, this would be the entity billing (or reporting) to the managed care plan. If a legacy state-specific proprietary identifier is not assigned by the state then report the billing provider's NPI.			
AMOUNT-CHARGED	8	S9	69-76	+00000950	If TYPE-OF-CLAIM = C (encounter record), enter the actual amount paid to the provider by the managed care plan. If there was no amount paid then 0-fill the field.			
OTHER-THIRD-PARTY-PAYMENT	6	S9	77-82	+000200	This is the total amount paid by all sources other than Medicaid/separate CHIP, Medicare, and the enrollee's personal funds.			
PROGRAM-TYPE	1	9	83-83	1	This is the code indicating the special Medicaid program under which the service was provided. Valid values for this data element are: 1 = EPSDT 2 = Family Planning 3 = Rural Health Clinic 4 = FQHC 5 = Indian Health Services 6 = HCBS for Aged and Disabled 7 = HCBS Services 9 = Unknown			
PLAN-ID-NUMBER	12	X	84-95	HJ124	This is an identifier that uniquely identifies a managed care plan that has also been reported in the state's managed care plan crosswalk. The claim PLAN-ID-NUMBER should be the same as the EL PLAN-ID-1 through PLAN-ID-4.			

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MEDICAID-COVERED-INPATIENT-DAYS	5	S9	96-100	+00030	This is the number of inpatient hospital days covered by Medicaid/separate CHIP for this claim. This data element is applicable when the claim IP record includes at least one accommodation code (values 100-219) in the UB-REV-CODE fields.			
MEDICARE-DEDUCTIBLE-PAYMENT	5	S9	101-105	+00200	This is the amount paid by Medicaid for this claim toward the recipient's Medicare deductible. This field is relevant only for crossover claims (when Medicare is the third-party payee); if the claim is not a crossover claim, 8-fill the field. The sum of MEDICARE-DEDUCTIBLE-PAYMENT and MEDICARE-COINSURANCE-PAYMENT should equal the MEDICAID-AMOUNT-PAID. Crossover claims with Medicare deductibles can only occur on IP for for TOS = 01, 24, 25, or 39. Code the Medicare deductible payment in this field if it can be separately identified from the Medicare coinsurance payment. If the coinsurance and deductible payments cannot be separated, fill this field with the combined payment amount and code +99998 in MEDICARE-COINSURANCE-PAYMENT. For crossover claims with no deductible payment, 0-fill the field. For crossover claims with missing or invalid amounts, 9-fill. If the TYPE-OF-CLAIM = C (encounter), 8-fill.			

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MEDICARE-COINSURANCE-PAYMENT	5	S9	106-110	+99998	This is the amount paid by Medicaid/separate CHIP for this claim toward the recipient's Medicare coinsurance. This field is relevant only for crossover claims (Medicare is third-party payee). The sum of MEDICARE-DEDUCTIBLE-PAYMENT and MEDICARE-COINSURANCE-PAYMENT should equal the MEDICAID-AMOUNT-PAID. Crossover claims with Medicare deductibles can only occur on IP for for TOS = 01, 24, 25, or 39. If the claims are not crossover, 8-fill this field. If the Medicare coinsurance payment can be identified separately from Medicare deductible payments, code that amount in this field. If coinsurance and deductible payments cannot be separated, fill this field with +99998 and code combined payment amount in MEDICARE-DEDUCTIBLE-PAYMENT. For crossover claims with no coinsurance payment, 0-fill the field; for crossover claims with missing or invalid amounts, 9-fill the field. If the TYPE-OF-CLAIM = C (encounter), 8-fill.			
DIAGNOSIS-CODE-PRINCIPAL	8	X	111-118	12345	This is the ICD-9-CM code for the principal diagnosis for this claim. This should be a 5-character all numeric or alphanumeric value. Enter invalid codes exactly as they appear in the state's system. Do not 8-fill or 9-fill.			
DIAGNOSIS-CODE-2	8	X	119-126	54321	This is the second ICD-9-CM found on the claim. Enter invalid codes exactly as they appear in the state system. Do not 8-fill or 9-fill. If more than nine diagnosis codes appear, enter the codes for the first nine. If there are fewer than nine, space-fill unused ones.			
DIAGNOSIS-CODE-3	8	X	127-134	V1234	This is the third ICD-9-CM found on the claim. Enter invalid codes exactly as they appear in the state system. Do not 8-fill or 9-fill. If more than nine diagnosis codes appear, enter the codes for the first nine. If there are fewer than nine, space-fill unused ones.			

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DIAGNOSIS-CODE-4	8	X	135-142	V321	This is the fourth ICD-9-CM found on the claim. Enter invalid codes exactly as they appear in the state system. Do not 8-fill or 9-fill. If more than nine diagnosis codes appear, enter the codes for the first nine. If there are fewer than nine, space-fill unused ones.			
DIAGNOSIS-CODE-5	8	X	143-150	123	This is the fifth ICD-9-CM found on the claim. Enter invalid codes exactly as they appear in the state system. Do not 8-fill or 9-fill. If more than nine diagnosis codes appear, enter the codes for the first nine. If there are fewer than nine, space-fill unused ones.			
DIAGNOSIS-CODE-6	8	X	151-158	321	This is the sixth ICD-9-CM found on the claim. Enter invalid codes exactly as they appear in the state system. Do not 8-fill or 9-fill. If more than nine diagnosis codes appear, enter the codes for the first nine. If there are fewer than nine, space-fill unused ones.			
DIAGNOSIS-CODE-7	8	X	159-166	4321	This is the seventh ICD-9-CM found on the claim. Enter invalid codes exactly as they appear in the state system. Do not 8-fill or 9-fill. If more than nine diagnosis codes appear, enter the codes for the first nine. If there are fewer than nine, space-fill unused ones.			
DIAGNOSIS-CODE-8	8	X	167-174	1234	This is the eighth ICD-9-CM found on the claim. Enter invalid codes exactly as they appear in state system. Do not 8-fill or 9-fill. If more than nine diagnosis codes appear, enter the codes for the first nine. If there are fewer than nine, space-fill unused ones.			
DIAGNOSIS-CODE-9	8	X	175-182	V4321	This is the ninth ICD-9-CM found on the claim. Enter invalid codes exactly as they appear in state system. Do not 8-fill or 9-fill. If more than nine diagnosis codes appear, enter the codes for the first nine. If there are fewer than nine, space-fill unused ones.			

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PROC-CODE-PRINCIPAL	8	X	183-190	123	This is the code used by the state to identify the principal procedure performed during the hospital stay referenced by this claim; a principal procedure is performed for definitive treatment rather than for diagnostic or exploratory purposes; it is closely related to either the principal diagnosis or to complications that arise during other treatments.			
PROC-CODE-FLAG-PRINCIPAL	2	9	191-192	02	01 = CPT-4 02 = ICD-9-CM 03 = CRVS 74 (Obsolete) 04 = CRVS 69 (Obsolete) 05 = CRVS 64 (Obsolete) 06 = HCPCS (Both National and Regional HCPCS) 07 = ICD-10-CM (For future use) 10 - 87 = Other Systems 88 = Not Applicable 99 = Unknown			
PROC-CODE-MOD-PRINCIPAL	2	X	193-194	U1	This is the procedure code modifier used with the Principal Procedure Code. For example, some states use modifiers to indicate assistance in surgery or anesthesia services; a list of valid codes must be supplied by the state prior to submission of any file data. If no Principal Procedure was performed, 8-fill; if a modifier is not applicable, fill with spaces.			
PROC-CODE-2	8	X	195-202	1234	This is the code used by the state to identify a procedure performed in addition to the principal procedure during the hospital stay referenced by this claim.			
PROC-CODE-FLAG-2	2	9	203-204	02	This is the flag that identifies the coding system used for the associated procedure code.			

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PROC-CODE-MOD-2	2	X	205-206	U2	If there was only one procedure on the claim or the corresponding procedure code does not have a modifier, 8-fill. If a modifier is not applicable, fill with spaces.			
PROC-CODE-3	8	X	207-214	4321	8-fill if there were fewer than three procedures on the claim.			
PROC-CODE-FLAG-3	2	9	215-216	02	8-fill if there were fewer than three procedures on the claim.			
PROC-CODE MOD-3	2	X	217-218	U3	If there was fewer than three procedures on the claim or the corresponding procedure code does not have a modifier, 8-fill. If a modifier is not applicable, fill with spaces.			
PROC-CODE-4	8	X	219-226	123	8-fill if there were fewer than four procedures on the claim.			
PROC-CODE-FLAG-4	2	9	227-228	02	8-fill if there were fewer than four procedures on the claim.			

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PROC-CODE-MOD-4	2	X	229-230	U4	If there was fewer than four procedures on the claim or the corresponding procedure code does not have a modifier, 8-fill. If a modifier is not applicable, fill with spaces.			
PROC-CODE-5	8	X	231-238	321	8-fill if there were fewer than five procedures on the claim.			
PROC-CODE-FLAG-5	2	9	239-240	02	8-fill if there were fewer than five procedures on the claim.			
PROC-CODE-MOD-5	2	X	241-242	U5	If there was fewer than five procedures on the claim or the corresponding procedure code does not have a modifier, 8-fill. If a modifier is not applicable, fill with spaces.			
PROC-CODE-6	8	X	243-250	3210	8-fill if there were fewer than six procedures on the claim.			
PROC-CODE-FLAG-6	2	9	251-252	02	8-fill if there were fewer than six procedures on the claim.			

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PROC-CODE-MOD-6	2	X	253-254	U6	If there was fewer than six procedures on the claim or the corresponding procedure code does not have a modifier, 8-fill. If a modifier is not applicable, fill with spaces.			
ADMISSION-DATE	8	9	255-262	19980531	This field is the date on which the recipient was admitted to a hospital.			
PATIENT-STATUS	2	9	263-264	05	See Appendix G of this document for data element values. This is the code indicating the patient's status as of the ENDING-DATE-OF-SERVICE. NUBC Patient Status values are commonly captured on institutional or UB-04 claims. The most common value for this data element on the IP file should be 01 (Discharged to Home).			
DIAGNOSIS-RELATED-GROUP	4	9	265-268	0370	For this field, enter the DRG used by the State. If DRGs are not used, 8-fill the field. If the value is unknown, 9-fill the field.			
DIAGNOSIS-RELATED-GROUP-INDICATOR	4	X	269-272	HG15	This is an indicator identifying the grouping algorithm used to assign DRG values. Values are generated by combining state/group generating DRGs (US postal code for state, "HG" for CMS Grouper, or "XX" for any other system) with the number that represents the DRG used.			
PROC-DATE-PRINCIPAL	8	9	273-280	19980531	This field is the date (CCYYMMDD) on which the principal procedure was performed.			

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UB-REV-CODE-1	4	9	281-284	0202	This is a code that identifies a "specific accommodation, ancillary service, or billing calculation" (as defined by UB-92 or UB-04 Billing Manual, form locator 42). This data element is only relevant for providers using this form.			
UB-REV-UNITS-1	7	S9	285-291	+0000007	This field displays the units associated with UB-92 Revenue Code fields (UB-REV-CODE-1 through UB-REV-CODE-23). This should be "A quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood , or renal dialysis treatments, etc." (as defined by UB-92 Billing Manual, form locator 46).			
UB-REV-CHARGE-1	8	S9	292-299	+00000450	This is the total charge for the related UB-92 Revenue Code (UB-REV-CODE-1 through UB-REV-CODE-23) for the billing period. The total includes both covered and noncovered charges (as defined by UB-92 Billing Manual, form locator 47). If the amount is missing or invalid, then 9-fill. Enter the charge for each UB-92 Revenue Code listed on the claim (up to 23 occurrences). If more than 23 codes are used, enter the first 23 that appear. If fewer than 23 codes are used, 8-fill the remaining codes. The sum of the charges must be less than or equal to the AMOUNT-CHARGED. If TYPE-OF-CLAIM = 3, then enter the AMOUNT-CHARGED, if available. If not, 0-fill this element.			
UB-REV-CODE-2	4	9	300-303	0259	8-fill if there were fewer than two revenue codes on the claim.			
UB-REV-UNITS-2	7	S9	304-310	+0000123	8-fill if there were fewer than two revenue codes on the claim.			

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UB-REV-CHARGE-2	8	S9	311-318	+00012345	8-fill if there were fewer than two revenue codes on the claim.			
UB-REV-CODE-3	4	9	319-322	0269	8-fill if there were fewer than three revenue codes on the claim.			
UB-REV-UNITS-3	7	S9	323-329	+0000321	8-fill if there were fewer than three revenue codes on the claim.			
UB-REV-CHARGE-3	8	S9	330-337	+00000987	8-fill if there were fewer than three revenue codes on the claim.			
UB-REV-CODE-4	4	9	338-341	0271	8-fill if there were fewer than four revenue codes on the claim.			
UB-REV-UNITS-4	7	S9	342-348	+0000123	8-fill if there were fewer than four revenue codes on the claim.			

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UB-REV-CHARGE-4	8	S9	349-356	+00000090	8-fill if there were fewer than four revenue codes on the claim.			
UB-REV-CODE-5	4	9	357-360	0272	8-fill if there were fewer than five revenue codes on the claim.			
UB-REV-UNITS-5	7	S9	361-367	+0000050	8-fill if there were fewer than five revenue codes on the claim.			
UB-REV-CHARGE-5	8	S9	368-375	+00000321	8-fill if there were fewer than five revenue codes on the claim.			
UB-REV-CODE-6	4	9	376-379	0273	8-fill if there were fewer than six revenue codes on the claim.			
UB-REV-UNITS-6	7	S9	380-386	+0000060	8-fill if there were fewer than six revenue codes on the claim.			

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UB-REV-CHARGE-6	8	S9	387-394	+00000123	8-fill if there were fewer than six revenue codes on the claim.			
UB-REV-CODE-7	4	9	395-398	0274	8-fill if there were fewer than seven revenue codes on the claim.			
UB-REV-UNITS-7	7	S9	399-405	+0000987	8-fill if there were fewer than seven revenue codes on the claim.			
UB-REV-CHARGE-7	8	S9	406-413	+00000456	8-fill if there were fewer than seven revenue codes on the claim.			
UB-REV-CODE-8	4	9	414-417	0259	8-fill if there were fewer than eight revenue codes on the claim.			
UB-REV-UNITS-8	7	S9	418-424	+0000123	8-fill if there were fewer than eight revenue codes on the claim.			

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UB-REV-CHARGE-8	8	S9	425-432	+000012345	8-fill if there were fewer than eight revenue codes on the claim.			
UB-REV-CODE-9	4	9	433-436	0269	8-fill if there were fewer than nine revenue codes on the claim.			
UB-REV-UNITS-9	7	S9	437-443	+0000321	8-fill if there were fewer than nine revenue codes on the claim.			
UB-REV-CHARGE-9	8	S9	444-451	+00000987	8-fill if there were fewer than nine revenue codes on the claim.			
UB-REV-CODE-10	4	9	452-455	0271	8-fill if there were fewer than ten revenue codes on the claim.			
UB-REV-UNITS-10	7	S9	456-462	+0000123	8-fill if there were fewer than ten revenue codes on the claim.			

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UB-REV-CHARGE-10	8	S9	463-470	+00000090	8-fill if there were fewer than ten revenue codes on the claim.			
UB-REV-CODE-11	4	9	471-474	0272	8-fill if there were fewer than eleven revenue codes on the claim.			
UB-REV-UNITS-11	7	S9	475-481	+0000050	8-fill if there were fewer than eleven revenue codes on the claim.			
UB-REV-CHARGE-11	8	S9	482-489	+00000321	8-fill if there were fewer than eleven revenue codes on the claim.			
UB-REV-CODE-12	4	9	490-493	0273	8-fill if there were fewer than twelve revenue codes on the claim.			
UB-REV-UNITS-12	7	S9	494-500	+0000060	8-fill if there were fewer than twelve revenue codes on the claim.			

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UB-REV-CHARGE-12	8	S9	501-508	+00000123	8-fill if there were fewer than twelve revenue codes on the claim.			
UB-REV-CODE-13	4	9	509-512	0274	8-fill if there were fewer than thirteen revenue codes on the claim.			
UB-REV-UNITS-13	7	S9	513-519	+0000987	8-fill if there were fewer than thirteen revenue codes on the claim.			
UB-REV-CHARGE-13	8	S9	520-527	+00000456	8-fill if there were fewer than thirteen revenue codes on the claim.			
UB-REV-CODE-14	4	9	528-531	0259	8-fill if there were fewer than fourteen revenue codes on the claim.			
UB-REV-UNITS-14	7	S9	532-538	+0000123	8-fill if there were fewer than fourteen revenue codes on the claim.			

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UB-REV-CHARGE-14	8	S9	539-546	+000012345	8-fill if there were fewer than fourteen revenue codes on the claim.			
UB-REV-CODE-15	4	9	547-550	0269	8-fill if there were fewer than fifteen revenue codes on the claim.			
UB-REV-UNITS-15	7	S9	551-557	+0000321	8-fill if there were fewer than fifteen revenue codes on the claim.			
UB-REV-CHARGE-15	8	S9	558-565	+00000987	8-fill if there were fewer than fifteen revenue codes on the claim.			
UB-REV-CODE-16	4	9	566-569	0271	8-fill if there were fewer than sixteen revenue codes on the claim.			
UB-REV-UNITS-16	7	S9	570-576	+0000123	8-fill if there were fewer than sixteen revenue codes on the claim.			

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UB-REV-CHARGE-16	8	S9	577-584	+00000090	8-fill if there were fewer than sixteen revenue codes on the claim.			
UB-REV-CODE-17	4	9	585-588	0272	8-fill if there were fewer than seventeen revenue codes on the claim.			
UB-REV-UNITS-17	7	S9	589-595	+0000050	8-fill if there were fewer than seventeen revenue codes on the claim.			
UB-REV-CHARGE-17	8	S9	596-603	+00000321	8-fill if there were fewer than seventeen revenue codes on the claim.			
UB-REV-CODE-18	4	9	604-607	0273	8-fill if there were fewer than eighteen revenue codes on the claim.			
UB-REV-UNITS-18	7	S9	608-614	+0000060	8-fill if there were fewer than eighteen revenue codes on the claim.			

[a] COBOL format values: X = Alphanumeric, left justified, padded to field length with spaces; 9 = Numeric, right justified and filled left with zeros; S9 = Signed, positive or negative embedded within the last significant digit

[b] Unless otherwise noted, 9-fill all missing data elements.

This file includes claims for inpatient hospital services.

DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
UB-REV-CHARGE-18	8	S9	615-622	+00000123	8-fill if there were fewer than eighteen revenue codes on the claim.			
UB-REV-CODE-19	4	9	623-626	0274	8-fill if there were fewer than nineteen revenue codes on the claim.			
UB-REV-UNITS-19	7	S9	627-633	+0000987	8-fill if there were fewer than nineteen revenue codes on the claim.			
UB-REV-CHARGE-19	8	S9	634-641	+00000456	8-fill if there were fewer than nineteen revenue codes on the claim.			
UB-REV-CODE-20	4	9	642-645	0369	8-fill if there were fewer than twenty revenue codes on the claim.			
UB-REV-UNITS-20	7	S9	646-652	+0000001	8-fill if there were fewer than twenty revenue codes on the claim.			

[a] COBOL format values: X = Alphanumeric, left justified, padded to field length with spaces; 9 = Numeric, right justified and filled left with zeros; S9 = Signed, positive or negative embedded within the last significant digit

[b] Unless otherwise noted, 9-fill all missing data elements.

This file includes claims for inpatient hospital services.

DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
UB-REV-CHARGE-20	8	S9	653-660	+00054321	8-fill if there were fewer than twenty revenue codes on the claim.			
UB-REV-CODE-21	4	9	661-664	0710	8-fill if there were fewer than twenty-one revenue codes on the claim.			
UB-REV-UNITS-21	7	S9	665-671	+0000004	8-fill if there were fewer than twenty-one revenue codes on the claim.			
UB-REV-CHARGE-21	8	S9	672-679	+00000123	8-fill if there were fewer than twenty-one revenue codes on the claim.			
UB-REV-CODE-22	4	9	680-683	0369	8-fill if there were fewer than twenty-two revenue codes on the claim.			
UB-REV-UNITS-22	7	S9	684-690	+0000001	8-fill if there were fewer than twenty-two revenue codes on the claim.			

[a] COBOL format values: X = Alphanumeric, left justified, padded to field length with spaces; 9 = Numeric, right justified and filled left with zeros; S9 = Signed, positive or negative embedded within the last significant digit

[b] Unless otherwise noted, 9-fill all missing data elements.

This file includes claims for inpatient hospital services.

DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
UB-REV-CHARGE-22	8	S9	691-698	+00054321	8-fill if there were fewer than twenty-two revenue codes on the claim.			
UB-REV-CODE-23	4	9	699-702	0710	8-fill if there were fewer than twenty-three revenue codes on the claim.			
UB-REV-UNITS-23	7	S9	703-709	+0000004	8-fill if there were fewer than twenty-three revenue codes on the claim.			
UB-REV-CHARGE-23	8	S9	710-717	+00000123	8-fill if there were fewer than twenty-three revenue codes on the claim.			
NATIONAL-PROVIDER-ID	12	X	718-729	1234567890	This field displays the NPI of the institution billing/ caring for the beneficiary. When data are unavailable, 9-fill. The NPI should always be a 10-digit value. If legacy state-specific proprietary identifiers are available for providers, then report the legacy IDs in the PROVIDER-ID-NUMBER-BILLING field and the NPI in this field.			
PROVIDER-TAXONOMY	12	X	730-741	01X793000Q00	This is the taxonomy code for the institution billing/ caring for the beneficiary. States should use the Healthcare Provider Taxonomy Codes maintained by the National Uniform Claim Committee (NUCC) for standardized classification of health care providers.			

[a] COBOL format values: X = Alphanumeric, left justified, padded to field length with spaces; 9 = Numeric, right justified and filled left with zeros; S9 = Signed, positive or negative embedded within the last significant digit

[b] Unless otherwise noted, 9-fill all missing data elements.

This file includes claims for inpatient hospital services.

DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
INTERNAL-CONTROL-NUMBER-ORIG	21	X	742-762	ABC000111222 or 333444555666	This is a unique number (up to 21 alphanumeric characters) assigned by the state's payment system that identifies an original claim.			
INTERNAL-CONTROL-NUMBER-ADJ	21	X	763-783	ABC111222333 or 444555666	This is a unique claim number (up to 21 alpha/ numeric characters) assigned by the state's payment system that identifies the adjustment of another claim.			
FILLER	57	X	784-840		This is an obsolete field that should be left blank.			

[a] COBOL format values: X = Alphanumeric, left justified, padded to field length with spaces; 9 = Numeric, right justified and filled left with zeros; S9 = Signed, positive or negative embedded within the last significant digit

[b] Unless otherwise noted, 9-fill all missing data elements.

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APPENDIX C

MSIS LONG-TERM CARE (LT) DATA FILE

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This file includes ILTC services received in nursing facilities, ICF/MR, psychiatric hospitals, and independent psychiatric wings of acute care hospitals.

DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
MSIS-IDENTIFICATION-NUMBER	20	X	01-20	123456789	The MSIS-IDENTIFICATION-NUMBER is the unique personal identification number assigned by the state. The MSIS-IDENTIFICATION-NUMBER in the claims files must match the MSIS-IDENTIFICATION-NUMBER or SOCIAL-SECURITY-NUMBER in the EL files depending on whether the state is an “SSN state” or “non-SSN state”. States that use the enrollee's Social Security Number as the value for the MSIS-IDENTIFICATION-NUMBER are classified as "SSN states". For SSN states, the MSIS-IDENTIFICATION-NUMBER on a claim should match the SOCIAL-SECURITY-NUMBER in the EL file. If the state is an SSN state but no SSN is available, use the temporary MSIS-IDENTIFICATION-NUMBER on claims. For non-SSN states, the MSIS-IDENTIFICATION-NUMBER on a claim should be the same as the MSIS-IDENTIFICATION-NUMBER in the EL file. See EL variable notes for MSIS-IDENTIFICATION-NUMBER assignment instructions. For more detailed guidance, refer to pages 18-19 of the MSIS File Specifications and Data Dictionary, Release 3.1.			
ADJUSTMENT-INDICATOR	1	9	21-21	2	0 = Original Claim/Encounter 1 = Void of a prior submission 2 = Re-submittal 3 = Credit adjustment 4 = Debit adjustment 5 = Gross adjustment Claims with ADJUSTMENT-INDICATOR=0,2,4 are expected to have positive values in signed elements. Claims with ADJUSTMENT-INDICATOR=1,3 are expected to have negative values in signed elements.			

[a] COBOL format values: X = Alphanumeric, left justified, padded to field length with spaces; 9 = Numeric, right justified and filled left with zeros; S9 = Signed, positive or negative embedded within the last significant digit

[b] Unless otherwise noted, 9-fill all missing data elements.

This file includes ILTC services received in nursing facilities, ICF/MR, psychiatric hospitals, and independent psychiatric wings of acute care hospitals.

DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
TYPE-OF-SERVICE	2	9	22-23	07	Note that the LT file should include claims with only the following Types of Service: 02 (Mental Hospital Services for the Aged), 04 (Inpatient Psychiatric Facility Services for Individuals <= 21 years), 05 (ICF Services for the Mentally Retarded), 07 (All Other NFs). All claims for inpatient psychiatric care provided in a separately administered psychiatric wing or psychiatric hospital are included in the LT file. Refer to Appendix F of this document and Attachment 4 of the MSIS File Specifications and Data Dictionary for specific descriptions.			
TYPE-OF-CLAIM	1	X	24-24	1	A = Separate CHIP Fee-For-Service Claim B = Separate CHIP Capitation Claim C = Separate CHIP Encounter Claim D = Separate CHIP Service Tracking Claim (a.k.a. "Gross Adjustment") E = Separate CHIP Supplemental Payment Note that error conditions 3 and 4 on page 130 of the MSIS Data Dictionary should read "Value = 4 or D," not "Value = 4 or E."			
DATE-OF-PAYMENT-ADJUDICATION	8	9	25-32	19980531	This is the date on which the payment status of the claim was finally adjudicated by the state. For encounter records this is the day the encounter was processed. For adjustment records, use the date of final adjudication, when possible.			
MEDICAID-AMOUNT-PAID	8	S9	33-40	+00000950	This is the amount paid by Medicaid/separate CHIP on this claim or adjustment. For encounters (Type of Claim = C), the Medicaid Amount Paid should be equal to zero. If Medicaid/separate CHIP had no liability for the bill, 0-fill this field. If the encounter contains the amount paid to a provider by a plan, assign the payment to the AMOUNT-CHARGED. For fee-for-service claims where the Medicaid Amount Paid is only available at the header level, include all payment information on the header claim. Then, submit the line item claims with $0 in all payment fields.			

[a] COBOL format values: X = Alphanumeric, left justified, padded to field length with spaces; 9 = Numeric, right justified and filled left with zeros; S9 = Signed, positive or negative embedded within the last significant digit

[b] Unless otherwise noted, 9-fill all missing data elements.

This file includes ILTC services received in nursing facilities, ICF/MR, psychiatric hospitals, and independent psychiatric wings of acute care hospitals.

DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
BEGINNING-DATE-OF-SERVICE	8	9	41-48	19980531	For single date/service, this is the date when the service was received; for multiple dates/services, this is the date when the service began.			
ENDING-DATE-OF-SERVICE	8	9	49-56	19980531	For single date/service, this is the date when the service was received; for multiple dates/services, this is the date when the service ended.			
PROVIDER-ID-NUMBER-BILLING	12	X	57-68	01CA79300	This is a unique ID assigned by the state to a provider. This should represent the entity billing for the service. For encounter records, this would be the entity billing (or reporting) to the managed care plan. If a legacy state-specific proprietary identifier is not assigned by the state then report the billing provider's NPI.			
AMOUNT-CHARGED	8	S9	69-76	+00000950	If TYPE-OF-CLAIM = C (encounter record), enter the actual amount paid to the provider by the MC plan. If there was no amount paid then 0-fill the field.			
OTHER-THIRD-PARTY-PAYMENT	6	S9	77-82	+000200	This is the total amount paid by all sources other than Medicaid/separate CHIP, Medicare, and the enrollee's personal funds.			

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[b] Unless otherwise noted, 9-fill all missing data elements.

This file includes ILTC services received in nursing facilities, ICF/MR, psychiatric hospitals, and independent psychiatric wings of acute care hospitals.

DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
PROGRAM-TYPE	1	9	83-83	1	This is the code indicating the special Medicaid program under which the service was provided. Valid values for this data element are: 1 = EPSDT 2 = Family Planning 3 = Rural Health Clinic 4 = FQHC 5 = Indian Health Services 6 = HCBS for Aged and Disabled 7 = HCBS Services 9 = Unknown			
PLAN-ID-NUMBER	12	X	84-95	HJ124	This is an identifier that uniquely identifies a managed care plan that has also been reported in the state's managed care plan crosswalk. The claim PLAN-ID-NUMBER should be the same as the EL PLAN-ID-1 through PLAN-ID-4.			
MEDICAID-COVERED-INPATIENT-DAYS	5	S9	96-100	+00030	This is the number of inpatient psychiatric days covered by Medicaid/separate CHIP for this claim.			

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[b] Unless otherwise noted, 9-fill all missing data elements.

This file includes ILTC services received in nursing facilities, ICF/MR, psychiatric hospitals, and independent psychiatric wings of acute care hospitals.

DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
MEDICARE-DEDUCTIBLE-PAYMENT	5	S9	101-105	+00200	This is the amount paid by Medicaid for this claim toward the recipient's Medicare deductible. This field is relevant only for crossover claims (when Medicare is the third-party payee); if a claim is not a crossover claim, 8-fill the field. The sum of MEDICARE-DEDUCTIBLE-PAYMENT and MEDICARE-COINSURANCE-PAYMENT should equal the MEDICAID-AMOUNT-PAID. Crossover claims with Medicare deductibles can only occur on LT claims with TYPE-OF-SERVICE = 02, 04, or 07. Code the Medicare deductible payment in this field if it can be separately identified from the Medicare coinsurance payment. If the coinsurance and deductible payments cannot be separated, fill this field with the combined payment amount and code +99998 in MEDICARE-COINSURANCE-PAYMENT. For crossover claims with no deductible payment, 0-fill the field. For crossover claims with missing or invalid amounts, 9-fill. If the TYPE-OF-CLAIM = C (encounter), 8-fill.			

[a] COBOL format values: X = Alphanumeric, left justified, padded to field length with spaces; 9 = Numeric, right justified and filled left with zeros; S9 = Signed, positive or negative embedded within the last significant digit

[b] Unless otherwise noted, 9-fill all missing data elements.

This file includes ILTC services received in nursing facilities, ICF/MR, psychiatric hospitals, and independent psychiatric wings of acute care hospitals.

DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
MEDICARE-COINSURANCE-PAYMENT	5	S9	106-110	+99998	This is the amount paid by Medicaid/separate CHIP for this claim toward the recipient's Medicare coinsurance. This field is relevant only for crossover claims (when Medicare is the third-party payee); if a claim is not a crossover claim, 8-fill the field. The sum of MEDICARE-DEDUCTIBLE-PAYMENT and MEDICARE-COINSURANCE-PAYMENT should equal the MEDICAID-AMOUNT-PAID. Crossover claims with Medicare coinsurance can only occur on LT for TOS = 02, 04, or 07. If the Medicare coinsurance payment can be identified separately from Medicare deductible payments, code that amount in this field. If coinsurance and deductible payments cannot be separated, fill this field with +99998 and code combined payment amount in MEDICARE-DEDUCTIBLE-PAYMENT. For crossover claims with no coinsurance payment, 0-fill the field; for crossover claims with missing or invalid amounts, 9-fill the field. If the TYPE-OF-CLAIM = C (encounter), 8-fill.			
DIAGNOSIS-CODE-1	8	X	111-118	12345	This is the ICD-9-CM code for the first diagnosis for this claim.			
DIAGNOSIS-CODE-2	8	X	119-126	54321	This is the second ICD-9-CM found on the claim. Enter invalid codes exactly as they appear in state system. Do not 8-fill or 9-fill. If more than five diagnosis codes appear, enter the codes for the first five. If there are fewer than five, space-fill unused ones.			

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This file includes ILTC services received in nursing facilities, ICF/MR, psychiatric hospitals, and independent psychiatric wings of acute care hospitals.

DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
DIAGNOSIS-CODE-3	8	X	127-134	V1234	This is the third ICD-9-CM found on the claim. Enter invalid codes exactly as they appear in state system. Do not 8-fill or 9-fill. If more than five diagnosis codes appear, enter the codes for the first five. If there are fewer than five, space-fill unused ones.			
DIAGNOSIS-CODE-4	8	X	135-142	V321	This is the fourth ICD-9-CM found on the claim. Enter invalid codes exactly as they appear in state system. Do not 8-fill or 9-fill. If more than five diagnosis codes appear, enter the codes for the first five. If there are fewer than five, space-fill unused ones.			
DIAGNOSIS-CODE-5	8	X	143-150	123	This is the fifth ICD-9-CM found on the claim. Enter invalid codes exactly as they appear in state system. Do not 8-fill or 9-fill. If more than five diagnosis codes appear, enter the codes for the first five. If there are fewer than five, space-fill unused ones.			
ADMISSION-DATE	8	9	151-158	19980531	This is the date on which the recipient was admitted to a long-term care facility.			
PATIENT-STATUS	2	9	159-160	05	See Appendix G of this document for data element values. This is the code indicating the patient's status as of the ENDING-DATE-OF-SERVICE. NUBC Patient Status values are commonly captured on institutional or UB-04 claims. The most common value for this data element on the LT file should be 30 (Still a Patient).			
ICF-MR-DAYS	5	S9	161-165	+00014	This is the number of days of intermediate care for the mentally retarded that were paid for, in whole or in part, by Medicaid/separate CHIP. ICF-MR-DAYS is applicable only for TYPE-OF-SERVICE = 05. For all claims for psychiatric services or nursing facility care services (TYPE-OF-SERVICE = 02, 04 or 07), 8-fill this element.			

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[b] Unless otherwise noted, 9-fill all missing data elements.

This file includes ILTC services received in nursing facilities, ICF/MR, psychiatric hospitals, and independent psychiatric wings of acute care hospitals.

DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
LEAVE-DAYS	5	S9	166-170	+00004	This is the number of days, during the period covered by Medicaid/separate CHIP, on which the patient did not reside in the long term care facility. If TYPE-OF-SERVICE = 02 or 04, 8-fill this element.			
NURSING-FACILITY-DAYS	5	S9	171-175	+00014	This is the number of days of nursing care included in this claim that were paid for, in whole or in part, by Medicaid/separate CHIP. It includes days during which nursing facility received partial payment for holding a bed during patient leave days. This data element is applicable for TYPE-OF-SERVICE = 07. For all claims for psychiatric services or intermediate care services for the mentally retarded (TYPE-OF-SERVICE = 02, 04, or 05), 8-fill this element.			
PATIENT-LIABILITY	6	S9	176-181	+000200	This is the total amount paid by the patient for services where the patient is required to use personal funds to cover part of his or her care before Medicaid funds can be utilized.			
NATIONAL-PROVIDER-ID	12	X	182-193	1234567890	This field displays the NATIONAL-PROVIDER-ID (NPI) of the institution billing/caring for the beneficiary. When data are unavailable, 9-fill. The NPI should always be a 10-digit value. If legacy state-specific proprietary identifiers are available for providers, then report the legacy IDs in the PROVIDER-ID-NUMBER-BILLING field and the NPI in this field.			
PROVIDER-TAXONOMY	12	X	194-205	01X793000Q00	This is the taxonomy code for the institution billing/ caring for the beneficiary. States should use the Healthcare Provider Taxonomy Codes maintained by the National Uniform Claim Committee (NUCC) for standardized classification of health care providers.			

[a] COBOL format values: X = Alphanumeric, left justified, padded to field length with spaces; 9 = Numeric, right justified and filled left with zeros; S9 = Signed, positive or negative embedded within the last significant digit

[b] Unless otherwise noted, 9-fill all missing data elements.

This file includes ILTC services received in nursing facilities, ICF/MR, psychiatric hospitals, and independent psychiatric wings of acute care hospitals.

DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
INTERNAL-CONTROL-NUMBER-ORIG	21	X	206-226	ABC000111222 or 333444555666	This is a unique number (up to 21 alphanumeric characters) assigned by the state's payment system that identifies an original claim.			
INTERNAL-CONTROL-NUMBER-ADJ	21	X	227-247	ABC111222333 or 444555666	This is a unique claim number (up to 21 alpha/ numeric characters) assigned by the state's payment system that identifies the adjustment of another claim.			
FILLER	53	X	278-300		This is an obsolete field that should be left blank.			

[a] COBOL format values: X = Alphanumeric, left justified, padded to field length with spaces; 9 = Numeric, right justified and filled left with zeros; S9 = Signed, positive or negative embedded within the last significant digit

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APPENDIX D

MSIS OTHER (OT) DATA FILE

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This file includes managed care capitation payments and any other provider claims that are not reported in the IP, LT, or RX files.

DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
MSIS-IDENTIFICATION-NUMBER	20	X	01-20	123456789	The MSIS-IDENTIFICATION-NUMBER is the unique personal identification number assigned by the state. The MSIS-IDENTIFICATION-NUMBER in the claims files must match the MSIS-IDENTIFICATION-NUMBER or SOCIAL-SECURITY-NUMBER in the EL files depending on whether the state is an “SSN state” or “non-SSN state”. States that use the enrollee's Social Security Number as the value for the MSIS-IDENTIFICATION-NUMBER are classified as "SSN states". For SSN states, the MSIS-IDENTIFICATION-NUMBER on a claim should match the SOCIAL-SECURITY-NUMBER in the EL file. If the state is an SSN state but no SSN is available, use the temporary MSIS-IDENTIFICATION-NUMBER on claims. For non-SSN states, the MSIS-IDENTIFICATION-NUMBER on a claim should be the same as the MSIS-IDENTIFICATION-NUMBER in the EL file. See EL variable notes for MSIS-IDENTIFICATION-NUMBER assignment instructions. For more detailed guidance, refer to pages 18-19 of the MSIS File Specifications and Data Dictionary, Release 3.1.			
ADJUSTMENT-INDICATOR	1	9	21-21	2	0 = Original Claim/Encounter 1 = Void of a prior submission 2 = Re-submittal 3 = Credit adjustment 4 = Debit adjustment 5 = Gross adjustment Claims with ADJUSTMENT-INDICATOR = 0, 2, or 4 are expected to have positive values in signed elements. Claims with ADJUSTMENT-INDICATOR = 1 or 3 are expected to have negative values in signed elements.			
TYPE-OF-SERVICE	2	9	22-23	07	Note that the OT file should include claims with only the following Types of Service: 08, 09, 10, 11, 12, 13, 15, 19, 20, 21, 22, 24, 25, 26, 30, 31, 33, 34, 35, 36, 37, or 38. Refer to Appendix F of this document and Attachment 4 of the MSIS File Specifications and Data Dictionary for specific descriptions.			

[a] COBOL format values: X = Alphanumeric, left justified, padded to field length with spaces; 9 = Numeric, right justified and filled left with zeros; S9 = Signed, positive or negative embedded within the last significant digit

[b] Unless otherwise noted, 9-fill all missing data elements.

This file includes managed care capitation payments and any other provider claims that are not reported in the IP, LT, or RX files.

DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
TYPE-OF-CLAIM	1	X	24-24	1	A = Separate CHIP Fee-For-Service Claim B = Separate CHIP Capitation Claim C = Separate CHIP Encounter Claim D = Separate CHIP Service Tracking Claim (a.k.a. "Gross Adjustment") E = Separate CHIP Supplemental Payment Note that error conditions 3 and 4 on page 130 of the MSIS Data Dictionary should read "Value = 4 or D," not "Value = 4 or E."			
DATE-OF-PAYMENT-ADJUDICATION	8	9	25-32	19980531	This is the date on which the payment status of the claim was finally adjudicated by the state. For encounter records this is the day the encounter was processed. For adjustment records, use the date of final adjudication, when possible.			
MEDICAID-AMOUNT-PAID	8	S9	33-40	+00000950	This is the amount paid by Medicaid/separate CHIP on this claim or adjustment. For encounters (Type of Claim = C), the Medicaid Amount Paid should be equal to zero. If Medicaid/separate CHIP had no liability for the bill, 0-fill this field. If the encounter contains the amount paid to a provider by a plan, assign the payment to the AMOUNT-CHARGED. For fee-for-service claims where the Medicaid Amount Paid is only available at the header level, include all payment information on the header claim. Then, submit the line item claims with $0 in all payment fields.			
BEGINNING-DATE-OF-SERVICE	8	9	41-48	19980531	For single date/service, this is the date of the service received; for multiple dates/services, this is the date when the service began; for capitation premiums, this is the date on which the related period of coverage began.			
ENDING-DATE-OF-SERVICE	8	9	49-56	19980531	For single date/service, this is the date of the service received; for multiple dates/services, this is the date when the service ended; for capitation premiums, this is the date on which the related period of coverage ended.			

[a] COBOL format values: X = Alphanumeric, left justified, padded to field length with spaces; 9 = Numeric, right justified and filled left with zeros; S9 = Signed, positive or negative embedded within the last significant digit

[b] Unless otherwise noted, 9-fill all missing data elements.

This file includes managed care capitation payments and any other provider claims that are not reported in the IP, LT, or RX files.

DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
PROVIDER-ID-NUMBER-BILLING	12	X	57-68	01CA79300	This is a unique ID assigned by the state to a provider or capitation plan. This should represent the entity billing for the service. For encounter records, this would be the entity billing (or reporting) to the managed care plan. If a legacy state-specific proprietary identifier is not assigned by the state then report the billing provider's NPI.			
AMOUNT-CHARGED	8	S9	69-76	+00000950	If TYPE-OF-CLAIM = C (encounter record), enter the actual amount paid to the provider by the managed care plan. If there was no amount paid then 0-fill the field.			
OTHER-THIRD-PARTY-PAYMENT	6	S9	77-82	+000200	This is the total amount paid by all sources other than Medicaid/separate CHIP, Medicare, and the recipient's personal funds.			
PROGRAM-TYPE	1	9	83-83	1	This is a code indicating the special Medicaid program under which the service was provided. Valid values for this data element are: 1 = EPSDT 2 = Family Planning 3 = Rural Health Clinic 4 = FQHC 5 = Indian Health Services 6 = HCBS for Aged and Disabled 7 = HCBS Services 9 = Unknown			
PLAN-ID-NUMBER	12	X	84-95	HJ124	This is an identifier that uniquely identifies a managed care plan that has also been reported in the state's managed care plan crosswalk. The claim PLAN-ID-NUMBER should be the same as the EL PLAN-ID-1 through PLAN-ID-4.			

[a] COBOL format values: X = Alphanumeric, left justified, padded to field length with spaces; 9 = Numeric, right justified and filled left with zeros; S9 = Signed, positive or negative embedded within the last significant digit

[b] Unless otherwise noted, 9-fill all missing data elements.

This file includes managed care capitation payments and any other provider claims that are not reported in the IP, LT, or RX files.

DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
QUANTITY-OF-SERVICE	5	S9	96-100	+00004	This is the number of units of service received by the recipient as shown on the claim record; this field is only applicable when the service being billed can be quantified in discrete units, e.g., number of visits. This element is not applicable for institutional services, dental, lab, x-ray, premium payments, or miscellaneous services. For these services, 8-fill this data element.			
MEDICARE-DEDUCTIBLE-PAYMENT	5	S9	101-105	+00200	This is the amount paid by Medicaid for this claim toward the recipient's Medicare deductible. This field is relevant only for crossover claims (when Medicare is the third-party payee); if a claim is not a crossover claim, 8-fill the field. The sum of MEDICARE-DEDUCTIBLE-PAYMENT and MEDICARE-COINSURANCE-PAYMENT should equal the MEDICAID-AMOUNT-PAID. Crossover claims with Medicare deductibles can only occur on OT claims with TYPE-OF-SERVICE = 08, 10 through 13, 15, 19, 24, 25, 26, 30, 31, or 33 through 36. Code the Medicare deductible payment in this field if it can be separately identified from the Medicare coinsurance payment. If the coinsurance and deductible payments cannot be separated, fill this field with the combined payment amount and code +99998 in MEDICARE-COINSURANCE-PAYMENT. For crossover claims with no deductible payment, 0-fill the field. For crossover claims with missing or invalid amounts, 9-fill. If the TYPE-OF-CLAIM = 3 (encounter), 8-fill.			

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This file includes managed care capitation payments and any other provider claims that are not reported in the IP, LT, or RX files.

DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
MEDICARE-COINSURANCE-PAYMENT	5	S9	106-110	+99998	This is the amount paid by Medicaid/separate CHIP for this claim toward the recipient's Medicare coinsurance. This field is relevant only for crossover claims (when Medicare is the third-party payee); if a claim is not a crossover claim, 8-fill the field. The sum of MEDICARE-DEDUCTIBLE-PAYMENT and MEDICARE-COINSURANCE-PAYMENT should equal the MEDICAID-AMOUNT-PAID. Crossover claims with Medicare coinsurance can only occur on OT for TOS = 08, 10 through 13, 15, 19, 24, 25, 26, 30, 31, or 33 through 36. If the Medicare coinsurance payment can be identified separately from Medicare deductible payments, code that amount in this field. If coinsurance and deductible payments cannot be separated, fill this field with +99998 and code combined payment amount in MEDICARE-DEDUCTIBLE-PAYMENT. For crossover claims with no coinsurance payment, 0-fill the field; for crossover claims with missing or invalid amounts, 9-fill the field. If the TYPE-OF-CLAIM = C (encounter), 8-fill.			
DIAGNOSIS-CODE-1	8	X	111-118	21010	This is the ICD-9-CM code for the first diagnosis for this claim.			
DIAGNOSIS-CODE-2	8	X	119-126	V123	This is the second ICD-9-CM found on the claim. Enter invalid codes exactly as they appear in state system. Do not 8-fill or 9-fill. If there is only one diagnosis, space-fill the second diagnosis.			

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[b] Unless otherwise noted, 9-fill all missing data elements.

This file includes managed care capitation payments and any other provider claims that are not reported in the IP, LT, or RX files.

DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
PLACE-OF-SERVICE	2	9	127-128	11	This is a code indicating where the service was performed; CMS 1500 values are used for this data element. Refer to Appendix H of this document and Attachment 4 of the MSIS File Specifications and Data Dictionary for specific descriptions.			
SPECIALTY-CODE	4	X	129-132	1234	This is a code that describes the area of specialty for the individual providing the service; applies only to physicians, osteopaths, dentists, and other licensed practitioners. The code is state specific. Space-fill if no specialty code is available.			
SERVICE-CODE	8	X	133-140	99201	This is a code used by the state to indicate the service provided during the period covered by the claim.			
SERVICE-CODE-FLAG	2	9	141-142	01	01 = CPT-4 02 = ICD-9-CM 03 = CRVS 74 (Obsolete) 04 = CRVS 69 (Obsolete) 05 = CRVS 64 (Obsolete) 06 = HCPCS (Both National and Regional HCPCS) 07 = ICD-10-CM (For future use) 10 - 87 = Other Systems 88 = Not Applicable 99 = Unknown			
SERVICE-CODE-MOD	2	X	143-144	26	A service code modifier can be used to enhance the SERVICE-CODE (e.g., anesthesia or surgical assistance services billed separately from actual procedure); if modifiers other than standard HCPCS or CPT values are used, the state must supply a list of valid codes and their definitions prior to submission of any data files.			

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[b] Unless otherwise noted, 9-fill all missing data elements.

This file includes managed care capitation payments and any other provider claims that are not reported in the IP, LT, or RX files.

DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
UB-92-REVENUE-CODE	4	9	145-148	0305	This is the UB-92 revenue code reported on the UB-92 line item that is represented on this claim/ encounter record; only valid codes as defined by the National Uniform Billing Committee should be used.			
PROVIDER-ID-NUMBER-SERVICING	12	X	149-160	01CA79300	This is a unique number to identify the provider who treated the enrollee (as opposed to the provider “billing” for the service, see PROVIDER-ID-NUMBER-BILLING). If the servicing and the billing provider are the same, then use the same number in both fields. For capitation payments, 8-fill this field.			
NATIONAL-PROVIDER-ID	12	X	161-172	1234567890	This is a unique number used to identify the provider who treated the recipient. The NATIONAL-PROVIDER-ID should always be a 10-digit value. If legacy state-specific proprietary identifiers are available for providers, then report the legacy IDs in the PROVIDER-ID-NUMBER-SERVICING and PROVIDER-ID-NUMBER-BILLING fields and the NPI in this field. For capitation payments, 8-fill this field.			
PROVIDER-TAXONOMY	12	X	173-184	01CA79300000	This is the taxonomy code for the provider who treated the recipient (as opposed to the provider “billing” for the service). This should be 8-filled for capitation payments. States should use the Healthcare Provider Taxonomy Codes maintained by the National Uniform Claim Committee (NUCC) for standardized classification of health care providers.			
INTERNAL-CONTROL-NUMBER-ORIG	21	X	185-205	ABC000111222 or 333444555666	This is a unique number (up to 21 alphanumeric characters) assigned by the state’s payment system that identifies an original claim.			

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[b] Unless otherwise noted, 9-fill all missing data elements.

This file includes managed care capitation payments and any other provider claims that are not reported in the IP, LT, or RX files.

DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
LINE-NUMBER-ORIG	3	9	206-208	001	This is a unique number to identify the transaction line number that is being reported on the original claim.			
INTERNAL-CONTROL-NUMBER-ADJ	21	X	209-229	ABC111222333 or 444555666	This is a unique claim number (up to 21 alpha/ numeric characters) assigned by the state's payment system that identifies the adjustment of another claim.			
LINE-NUMBER-ADJ	3	9	230-232	001	This is used to report the transaction line number assigned to an adjustment claim line.			
FILLER	48	X	233-280		This is an obsolete field that should be left blank.			

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[b] Unless otherwise noted, 9-fill all missing data elements.

APPENDIX E

MSIS PRESCRIPTION DRUG (RX) DATA FILE

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This file includes claims for prescription drugs and durable medical equipment provided by pharmacies and pharmacists.

DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
MSIS-IDENTIFICATION-NUMBER	20	X	01-20	123456789	The MSIS-IDENTIFICATION-NUMBER is the unique personal identification number assigned by the state. The MSIS-IDENTIFICATION-NUMBER in the claims files must match the MSIS-IDENTIFICATION-NUMBER or SOCIAL-SECURITY-NUMBER in the EL files depending on whether the state is an “SSN state” or “non-SSN state”. States that use the enrollee's Social Security Number as the value for the MSIS-IDENTIFICATION-NUMBER are classified as "SSN states". For SSN states, the MSIS-IDENTIFICATION-NUMBER on a claim should match the SOCIAL-SECURITY-NUMBER in the EL file. If the state is an SSN state but no SSN is available, use the temporary MSIS-IDENTIFICATION-NUMBER on claims. For non-SSN states, the MSIS-IDENTIFICATION-NUMBER on a claim should be the same as the MSIS-IDENTIFICATION-NUMBER in the EL file. See EL variable notes for MSIS-IDENTIFICATION-NUMBER assignment instructions. For more detailed guidance, refer to pages 18-19 of the MSIS File Specifications and Data Dictionary, Release 3.1.			
ADJUSTMENT-INDICATOR	1	9	21-21	2	0 = Original Claim/Encounter 1 = Void of a prior submission 2 = Re-submittal 3 = Credit adjustment 4 = Debit adjustment 5 = Gross adjustment Claims with ADJUSTMENT-INDICATOR = 0, 2, or 4 are expected to have positive values in signed elements. Claims with ADJUSTMENT-INDICATOR = 1 or 3 are expected to have negative values in signed elements.			
TYPE-OF-SERVICE	2	9	22-23	07	Refer to Appendix F of this document and Attachment 4 of the MSIS File Specifications and Data Dictionary for specific descriptions.			

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[b] Unless otherwise noted, 9-fill all missing data elements.

This file includes claims for prescription drugs and durable medical equipment provided by pharmacies and pharmacists.

DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
TYPE-OF-CLAIM	1	X	24-24	1	A = Separate CHIP Fee-For-Service Claim B = Separate CHIP Capitation Claim C = Separate CHIP Encounter Claim D = Separate CHIP Service Tracking Claim (a.k.a. "Gross Adjustment") E = Separate CHIP Supplemental Payment Note that error conditions 3 and 4 on page 130 of the MSIS Data Dictionary should read "Value = 4 or D," not "Value = 4 or E."			
DATE-OF-PAYMENT-ADJUDICATION	8	9	25-32	19980531	This is the date on which the payment status of the claim was finally adjudicated by the state. For encounter records, this is the day the encounter was processed. For adjustment records, use the date of final adjudication when possible.			
MEDICAID-AMOUNT-PAID	8	S9	33-40	+00000950	For encounters (Type of Claim = C) the Medicaid Amount Paid should be zero. If Medicaid has no liability for the bill, 0-fill this field. If the encounter contains the amount paid to a provider by a plan, assign the payment to the AMOUNT-CHARGED. For fee-for-service claims where the Medicaid Amount Paid is only available at the header level, include all payment information on the header claim.			
DATE-PRESCRIBED	8	9	41-48	19980531	This is the date on which the drug, device or supply was prescribed by the physician or other practitioner.			
FILLER	8	9	49-56		This is an obsolete field that should be left blank.			

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This file includes claims for prescription drugs and durable medical equipment provided by pharmacies and pharmacists.

DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
PROVIDER-ID-NUMBER-BILLING	12	X	57-68	01CA79300	This is a unique ID assigned by the state to a provider. This should represent the entity billing for the service. For encounter records, this would be the entity billing (or reporting) to the managed care plan. If a legacy state-specific proprietary identifier is not assigned by the state then report the billing provider's NPI.			
AMOUNT-CHARGED	8	S9	69-76	+00000950	If TYPE-OF-CLAIM = C (encounter record), enter the actual amount paid to the provider by the managed care plan. If there was no amount paid then 0-fill the field.			
OTHER-THIRD-PARTY-PAYMENT	6	S9	77-82	+000200	This is the total amount paid by all sources other than Medicaid/separate CHIP, Medicare, and the enrollee's personal funds.			
PROGRAM-TYPE	1	9	83-83	1	This is the code indicating the special Medicaid program under which the service was provided. Valid values for this data element are: 1 = EPSDT 2 = Family Planning 3 = Rural Health Clinic 4 = FQHC 5 = Indian Health Services 6 = HCBS for Aged and Disabled 7 = HCBS Services 9 = Unknown			
PLAN-ID-NUMBER	12	X	84-95	HJ124	This is an identifier that uniquely identifies a managed care plan that has also been reported in the state's managed care plan crosswalk. The claim PLAN-ID-NUMBER should be the same as the EL PLAN-ID-1 through PLAN-ID-4.			

[a] COBOL format values: X = Alphanumeric, left justified, padded to field length with spaces; 9 = Numeric, right justified and filled left with zeros; S9 = Signed, positive or negative embedded within the last significant digit

[b] Unless otherwise noted, 9-fill all missing data elements.

This file includes claims for prescription drugs and durable medical equipment provided by pharmacies and pharmacists.

DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
QUANTITY-OF-SERVICE	5	S9	96-100	+00004	This is the number of units of service received by the recipient as shown on the claim record; this field is only applicable when the service being billed can be quantified in discrete units, e.g., a number of units of a prescription/refill that were filled.			
DAYS-SUPPLY	3	9	101-103	031	This is the number of days supply dispensed. Values should be in the range 1-364. If the value is unknown, then 9-fill the data element.			
NATIONAL-DRUG-CODE	12	X	104-115	00039001460	This is a code indicating the drug, device, or medical supply covered by this claim, in National Drug Code (NDC) format. If Durable Medical Equipment or supply is prescribed by a physician and provided by a pharmacy then HCPCS or state specific codes can be put in the NDC field. For compound drugs, report "COMPOUND" as the NATIONAL-DRUG-CODE.			
PRESCRIPTION-FILL-DATE	8	9	116-123	19980531	This is the date the drug, device, or supply was dispensed by the provider.			
NEW-REFILL-INDICATOR	2	9	124-125	03	This is an indicator showing whether the prescription being filled was a new prescription or a refill; if it is a refill, the indicator will indicate the number of refills: 00 = New prescription 01-98 = Number of refill 99 = Unknown			

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[b] Unless otherwise noted, 9-fill all missing data elements.

This file includes claims for prescription drugs and durable medical equipment provided by pharmacies and pharmacists.

DATA ELEMENTS	LENGTH	COBOL FORMAT[a]	START-END POSITION OF ELEMENT	EXAMPLE	VARIABLE NOTES[b]	CURRENTLY REPORTED FOR SEPARATE CHIP (YES/NO)?	STATE SPECIFICATION	PROGRAMMER CODING NOTES
PRESCRIBING-PHYSICIAN-ID-NUMBER	12	X	126-137	01CA79300	This is a unique identification number assigned to a provider that identifies the physician or other provider prescribing the drug, device, or supply. For physicians, this must be the individual's ID number, not a group identification number. If an ID is not available, but the physician's Drug Enforcement Agency (DEA) is on the state's file, then the state should use the DEA ID.			
NATIONAL-PROVIDER-ID	12	X	138-149	1234567890	This is a unique identifier used to identify the provider billing for the service. The NATIONAL-PROVIDER-ID should always be a 10-digit value. If legacy state-specific proprietary identifiers are available for providers, then report the legacy IDs in the PROVIDER-ID-NUMBER-BILLING field and the NPI in this field.			
PROVIDER-TAXONOMY	12	X	150-161	01CA79300000	This is the taxonomy code for the billing provider. States should use the Healthcare Provider Taxonomy Codes maintained by the National Uniform Claim Committee (NUCC) for standardized classification of health care providers.			
INTERNAL-CONTROL-NUMBER-ORIG	21	X	162-182	ABC000111222 or 333444555666	This is a unique number (up to 21 alphanumeric characters) assigned by the state's payment system that identifies an original claim.			
INTERNAL-CONTROL-NUMBER-ADJ	21	X	183-203	ABC111222333 or 444555666	This is a unique claim number (up to 21 alpha/ numeric characters) assigned by the state's payment system that identifies the adjustment of another claim.			
FILLER	47	X	204-250		This is an obsolete field that should be left blank.			

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APPENDIX F

TYPE-OF-SERVICE (TOS) VALUES

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Type-of-Service (TOS) Values

01 = Inpatient hospital
02 = Mental hospital services for the aged
04 = Inpatient psychiatric facility services for individuals age 21 years and under
05 = ICF services for the mentally retarded
07 = NFs, all other
08 = Physicians
09 = Dental
10 = Other practitioners
11 = Outpatient hospital
12 = Clinic
13 = Home health
15 = Lab and x-ray
16 = Prescribed drugs
19 = Other services
20 = Capitated payments to HMO, HIO, or PACE plan
21 = Capitated payments to prepaid health plans (PHPs)
22 = Capitated payments for primary care case management (PCCM)
24 = Sterilizations
25 = Abortions
26 = Transportation services
30 = Personal care services
31 = Targeted case management
33 = Rehabilitation services
34 = Physical therapy, occupational therapy, speech therapy, and hearing and language therapy
35 = Hospice benefits
36 = Nurse midwife services
37 = Nurse practitioner services
38 = Private-duty nursing
39 = Religious non-medical health care institutions

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APPENDIX G

PATIENT-STATUS VALUES

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Patient-Status Values

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

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

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APPENDIX H

PLACE-OF-SERVICE (POS) VALUES

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Place-of-Service (POS) Values

00-02 = Unassigned
03 = School
04 = Homeless shelter
05 = Indian Health Service free-standing facility
06 = Indian Health Service provider-based facility
07 = Tribal 638 free-standing facility
08 = Tribal 638 provider-based facility
09-10 = Unassigned
11 = Office
12 = Home
13 = Assisted-living facility
14 = Group home
15 = Mobile unit
16-19 = Unassigned
20 = Urgent care facility
21 = Inpatient hospital
22 = Outpatient hospital
23 = Emergency room—hospital
24 = Ambulatory surgery center
25 = Birthing center
26 = Military treatment facility
27-30 = Unassigned
31 = Skilled nursing facility (obsolete)
32 = Nursing facility
33 = Custodial care facility
34 = Hospice
35-40 = Unassigned
41 = Ambulance (land)
42 = Ambulance (air or water)
43-48 = Unassigned
49 = Independent clinic
50 = Federally qualified health center
51 = Inpatient psychiatric facility
52 = Psychiatric facility partial hospitalization
53 = Community mental health center
54 = ICF for the mentally retarded
55 = Residential substance abuse treatment facility
56 = Psychiatric residential treatment center
57 = Nonresidential substance abuse treatment facility
58-59 = Unassigned
60 = Mass immunization center
61 = Comprehensive inpatient rehab facility
62 = Comprehensive outpatient rehab facility
63-64 = Unassigned
65 = End-stage renal disease treatment facility
66-70 = Unassigned
71 = State or local public health clinic
72 = Rural health clinic
73-80 = Unassigned
81 = Independent laboratory
82-87 = Unassigned
88 = Not applicable
89-98 = Unassigned
99 = Other unlisted facility

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