Chronic Conditions Warehouse

CODEBOOK:

T-MSIS Analytic Files (TAF) Claims Research Identifiable Files (RIFs)

OCTOBER 2022 | VERSION 1.5

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Revision Log

Date	Changed by	Revisions	Version
October 2022	K. Schneider	Added new field on each header claim record: FED_SRVC_CTGRY_CD; added DGNS_1_CCSR_CTGRY_CD and BLG_PRVDR_NPPES_TXNMY_CD to IP, LT, and OT header claims; added LINE_PRCDR_CCS_CTGRY_CD and SRVC_PRVDR_NPPES_TXNMY_CD to the OT line file. Updated value details for LINE_PRCDR_MDFR_CD_1- LINE_PRCDR_MDFR_CD_4; added new valid values for DGNS_POA_IND_1-DGNS_POA_IND_12, TOS_CD, XIX_SRVC_CTGRY_CD, and XXI_SRVC_CTGRY_CD	1.5
November 2021	K. Schneider	Added new valid values for TOS_CD and XIX_SRVC_CTGRY_CD.	1.4
September 2021	K. Schneider	Added new valid values for XIX_SRVC_CTGRY_CD and XXI_SRVC_CTGRY_CD.	1.3
September 2021	K. Schneider A. Meyer	Added new field — PRSN_CLM_IND, adjusted definition, and values for SUBMTG_STATE_CD and CLM_TYPE_CD. Added new valid values for XIX_SRVC_CTGRY_CD XXI and SRVC_CTGRY_CD; added new valid values related to COVID-19: PGM_TYPE_CD, BNFT_TYPE_CD, and TOS_CD.	1.2
August 2020	K. Schneider	Updated for the 2017–2018 data release. Added valid values to IP_SUD_TXNMY_IND, NDC_UOM_CD, SUD_TXNMY_IND, TOS_CD, WVR_TYPE_CD, and XXI_SRVC_CTGRY_CD	1.1
November 2019	K. Schneider K. Russell	Initial release of codebook for T-MSIS Analytic Files (TAF) Claims files	1.0

Tips on Navigating the Codebook

The Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF) claims files include all "final action" Medicaid and Children's Health Insurance Program (CHIP) service records for a given year (i.e., all T-MSIS claims Centers for Medicare & Medicaid Services (CMS) determined to be final, as of the TAF creation date). The claims included in these files are active, final-action, non-voided, and non-denied claims[1] (except for Illinois).[2] The TAF claims files are available for four care settings:

1. Inpatient (IP)
2. Long-term care (LT)
3. Other services (OT)
4. Pharmacy (RX)

For more information about the TAF claims files, please reference the *CCW T-MSIS Analytic Files (TAF) User Guide*, available at https://www2.ccwdata.org/web/guest/user-documentation.

This document is a detailed codebook that describes each variable in the TAF claims research files. Because the files have such a large number of variables, we have included several ways for analysts to quickly find the information they need.

- A complete listing of all variables in the files, in alphabetical order based on their SAS variable names.
- Individual entries for each variable that contain a short description of the variable, the possible values for the variable, and, in many cases, notes that discuss how the variable was constructed and should be used.

We have included hyperlinks throughout the codebook to make it easier for analysts to navigate between the table of contents and the detailed entries for the individual variables:

- Clicking on any variable name in the Table of Contents will take you to the detailed description for that variable.
- From the detailed description for any individual variable, clicking on the ^Back to TOC^ link after each variable description will take you back to the Table of Contents.

[1] "Non-denied" claims mean they were not denied at the header level; there may be denied lines in the line file – i.e. the claim was not completely denied, however some lines for these claims may be denied.
[2] For IL, all transactional claims/encounter records are included in the RIF. Additional information and guidance is available on the ResDAC website in the document "TAF Technical Guidance: How to Use Illinois Claims Data." https://www.resdac.org/

Table of Contents

This section of the codebook contains a list of all variables in alphabetical order based on the SAS variable name.

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Variable Details

This section of the codebook contains one entry for each variable in the TAF claims files. Each entry contains variable details to facilitate understanding and use of the variables.

ACTL_SRVC_QTY

LABEL: Actual Service Quantity

DESCRIPTION: The quantity of a drug, service, or product that is rendered/dispensed for a prescription, on a specific date of service, or billing time span.

SHORT NAME: ACTL_SRVC_QTY

LONG NAME: ACTL_SRVC_QTY

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Line
LT Line
OT Line

VALUES: Valid numeric value, three decimal places.

Null/missing = source value is missing or unknown

COMMENT: —

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ADJDCTN_DT

LABEL: Adjudication Date

DESCRIPTION: The date on which the state made the final adjudication on the payment status of the claim.

SHORT NAME: ADJDCTN_DT

LONG NAME: ADJDCTN_DT

TYPE: DATE

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): All Header, Claim and Line Files

VALUES: Date (numeric, system dependent)

COMMENT: —

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ADJUST_CD

LABEL: Claim Adjustment Code

DESCRIPTION: Code indicating the type of adjustment record.

SHORT NAME: ADJUST_CD

LONG NAME: ADJUST_CD

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S):
IP Header
LT Header
OT Header
RX Header

VALUES:
0 = Original Claim/Encounter
1 = Void/Reversal of a prior submission
2 = Re-submittal
3 = Credit Adjustment (negative supplemental)
4 = Replacement/Resubmission of a prior submission
5 = Gross Credit/Gross Credit Adjustment
6 = Gross Debit/Debit Credit Adjustment

COMMENT: —

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ADJUST_RSN_CD

LABEL: Adjustment Reason Code

DESCRIPTION: Claim adjustment reason codes communicate why a claim was paid differently than it was billed.

SHORT NAME: ADJUST_RSN_CD

LONG NAME: ADJUST_RSN_CD

TYPE: CHAR

LENGTH: 3

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: 001 = Deductible Amount

002 = Coinsurance Amount

003 = Co-payment Amount

004 = The procedure code is inconsistent with the modifier used or a required modifier is missing

005 = The procedure code/type of bill is inconsistent with the place of service

006 = The procedure/revenue code is inconsistent with the patient's age

007 = The procedure/revenue code is inconsistent with the patient's gender

008 = The procedure code is inconsistent with the provider type/specialty (taxonomy)

009 = The diagnosis is inconsistent with the patient's age

010 = The diagnosis is inconsistent with the patient's gender

011 = The diagnosis is inconsistent with the procedure

012 = The diagnosis is inconsistent with the provider type

013 = The date of death precedes the date of service

014 = The date of birth follows the date of service

015 = The authorization number is missing, invalid, or does not apply to the billed services or provider

016 = Claim/service lacks information or has submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

017 = Requested information was not provided or was insufficient/incomplete

018 = Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)

019 = This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier

020 = This injury/illness is covered by the liability carrier

021 = This injury/illness is the liability of the no-fault carrier

022 = This care may be covered by another payer per coordination of benefits

023 = The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)

024 = Charges are covered under a capitation agreement/managed care plan

025 = Payment denied. Your Stop loss deductible has not been met

026 = Expenses incurred prior to coverage

027 = Expenses incurred after coverage terminated

028 = Coverage not in effect at the time the service was provided. Notes: Redundant to codes 026and027.

029 = The time limit for filing has expired

030 = Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements

031 = Patient cannot be identified as our insured

032 = Our records indicate the patient is not an eligible dependent

033 = Insured has no dependent coverage

034 = Insured has no coverage for newborns

035 = Lifetime benefit maximum has been reached

036 = Balance does not exceed co-payment amount

037 = Balance does not exceed deductible

039 = Services denied at the time authorization/pre-certification was requested

040 = Charges do not meet qualifications for emergent/urgent care

041 = Discount agreed to in Preferred Provider contract

042 = Charges exceed our fee schedule or maximum allowable amount

043 = Gramm-Rudman reduction

044 = Prompt-pay discount

045 = Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)

046 = This (these) service(s) is (are) not covered. (No longer used: 10/16/2003, Use code 096).

047 = This (these) diagnosis(es) is (are) not covered, missing, or are invalid

048 = This (these) procedure(s) is (are) not covered. (No longer used: 10/16/2003, Use code 096).

049 = This is a non-covered service because it is a routine/preventive exam, or a diagnostic/screening procedure done in conjunction with a routine/preventive exam

050 = These are non-covered services because this is not deemed a 'medical necessity' by the payer

051 = These are non-covered services because this is a pre-existing condition

052 = The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed

053 = Services by an immediate relative or a member of the same household are not covered

054 = Multiple physicians/assistants are not covered in this case

055 = Procedure/treatment/drug is deemed experimental/investigational by the payer

056 = Procedure/treatment has not been deemed 'proven to be effective' by the payer

057 = Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply. (No longer used: 06/30/2007, Split into codes 150, 151, 152, 153 and 154).

058 = Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service

059 = Processed based on multiple or concurrent procedure rules. (For example, multiple surgery or diagnostic imaging, concurrent anesthesia.)

060 = Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services

061 = Adjusted for failure to obtain second surgical opinion

062 = Payment denied/reduced for absence of, or exceeded, pre-certification/authorization

063 = Correction to a prior claim

064 = Denial reversed per Medical Review

065 = Procedure code was incorrect. This payment reflects the correct code.

066 = Blood Deductible

067 = Lifetime reserve days. (Handled in QTY, QTY01=LA)

068 = DRG weight. (Handled in CLP12)

069 = Day outlier amount

070 = Cost outlier - Adjustment to compensate for additional costs

071 = Primary Payer amount. (No longer used: 06/30/2000, Use code 023).

072 = Coinsurance day. (Handled in QTY, QTY01=CD)

073 = Administrative days

074 = Indirect Medical Education Adjustment

075 = Direct Medical Education Adjustment

076 = Disproportionate Share Adjustment

077 = Covered days. (Handled in QTY, QTY01=CA)

078 = Non-Covered days/Room charge adjustment

079 = Cost Report days. (Handled in MIA15)

080 = Outlier days. (Handled in QTY, QTY01=OU)

081 = Discharges

082 = PIP days

083 = Total visits

084 = Capital Adjustment. (Handled in MIA)

085 = Patient Interest Adjustment (Use Only Group code PR). Notes: Only use when the payment of interest is the responsibility of the patient.

086 = Statutory Adjustment. Notes: Duplicative of code 045.

087 = Transfer amount

088 = Adjustment amount represents collection against receivable created in prior overpayment

089 = Professional fees removed from charges

090 = Ingredient cost adjustment. Usage: To be used for pharmaceuticals only.

091 = Dispensing fee adjustment

092 = Claim Paid in full

093 = No Claim level Adjustments. Notes: As of 004010, CAS at the claim level is optional.

094 = Processed in Excess of charges

095 = Plan procedures not followed

096 = Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).

097 = The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

098 = The hospital must file the Medicare claim for this inpatient non-physician service

099 = Medicare Secondary Payer Adjustment Amount

100 = Payment made to patient/insured/responsible party

101 = Predetermination: anticipated payment upon completion of services or claim adjudication

102 = Major Medical Adjustment

103 = Provider promotional discount (e.g., Senior citizen discount).

104 = Managed care withholding

105 = Tax withholding

106 = Patient payment option/election not in effect.

107 = The related or qualifying claim/service was not identified on this claim.

108 = Rent/purchase guidelines were not met

109 = Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor

110 = Billing date predates service date

112 = Service not furnished directly to the patient and/or not documented

117 = Transportation is only covered to the closest facility that can provide the necessary care

118 = ESRD network support adjustment

119 = Benefit maximum for this time period or occurrence has been reached

121 = Indemnification adjustment — compensation for outstanding member responsibility

123 = Payer refund due to overpayment

125 = Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

126 = Deductible — Major Medical. (No longer used: 04/01/2008, Use Group Code PR and code 1).

127 = Coinsurance — Major Medical. (No longer used: 04/01/2008, Use Group Code PR and code 2).

128 = Newborn's services are covered in the mother's Allowance

129 = Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

130 = Claim submission fee

131 = Claim specific negotiated discount

132 = Prearranged demonstration project adjustment

133 = The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).

135 = Interim bills cannot be processed

136 = Failure to follow prior payer's coverage rules. (Use only with Group Code OA)

137 = Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.

139 = Contracted funding agreement — Subscriber is employed by the provider of services. Use only with Group Code CO.

140 = Patient/Insured health identification number and name do not match

141 = Claim spans eligible and ineligible periods of coverage

142 = Monthly Medicaid patient liability amount

143 = Portion of payment deferred

144 = Incentive adjustment, e.g., preferred product/service

145 = Premium payment withholding. (No longer used: 04/01/2008, Use Group Code CO and code 45).

146 = Diagnosis was invalid for the date(s) of service reported

147 = Provider contracted/negotiated rate expired or not on file

148 = Information from another provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

149 = Lifetime benefit maximum has been reached for this service/benefit category

150 = Payer deems the information submitted does not support this level of service

151 = Payment adjusted because the payer deems the information submitted does not support this many/frequency of services

152 = Payer deems the information submitted does not support this length of service

153 = Payer deems the information submitted does not support this dosage

154 = Payer deems the information submitted does not support this day's supply

159 = Service/procedure was provided as a result of terrorism

163 = Attachment/other documentation referenced on the claim was not received

164 = Attachment/other documentation referenced on the claim was not received in a timely fashion

165 = Referral absent or exceeded

166 = These services were submitted after this payers responsibility for processing claims under this plan ended

167 = This (these) diagnosis(es) is (are) not covered

168 = Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan

169 = Alternate benefit has been provided

170 = Payment is denied when performed/billed by this type of provider

171 = Payment is denied when performed/billed by this type of provider in this type of facility.

172 = Payment is adjusted when performed/billed by a provider of this specialty

173 = Service/equipment was not prescribed by a physician

174 = Service was not prescribed prior to delivery

176 = Prescription is not current

177 = Patient has not met the required eligibility requirements

178 = Patient has not met the required spend down requirements

179 = Patient has not met the required waiting requirements.

180 = Patient has not met the required residency requirements

181 = Procedure code was invalid on the date of service

182 = Procedure modifier was invalid on the date of service

183 = The referring provider is not eligible to refer the service billed

184 = The prescribing/ordering provider is not eligible to prescribe/order the service billed

185 = The rendering provider is not eligible to perform the service billed

186 = Level of care change adjustment

187 = Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.)

189 = 'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service

190 = Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay

192 = Nonstandard adjustment code from paper remittance. Usage: This code is to be used by providers/payers providing Coordination of Benefits information to another payer in the 837 transaction only. This code is only used when the non-standard code cannot be reasonably mapped to an existing Claims Adjustment Reason Code, specifically Deductible, Coinsurance and Co-payment.

193 = Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

194 = Anesthesia performed by the operating physician, the assistant surgeon or the attending physician

196 = Claim/service denied based on prior payer's coverage determination. (No longer used: 02/01/2007, Use code 136)

197 = Precertification/authorization/notification/pre-treatment absent

198 = Precertification/notification/authorization/pre-treatment exceeded

199 = Revenue code and Procedure code do not match

200 = Expenses incurred during lapse in coverage

201 = Patient is responsible for amount of this claim/service through 'set aside arrangement' or other agreement. (Use only with Group Code PR) At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

202 = Non-covered personal comfort or convenience services

203 = Discontinued or reduced service

204 = This service/equipment/drug is not covered under the patient’s current benefit plan

206 = National Provider Identifier — missing

207 = National Provider identifier — Invalid format

208 = National Provider Identifier — Not matched

209 = Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with Group code OA)

210 = Payment adjusted because pre-certification/authorization not received in a timely fashion

211 = National Drug Codes (NDC) not eligible for rebate, are not covered.

215 = Based on subrogation of a third-party settlement

216 = Based on the findings of a review organization

217 = Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Property and Casualty only). (No longer used: 07/01/2014, Use code P5).

222 = Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.

223 = Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.

225 = Penalty or Interest Payment by Payer (Only used for plan-to-plan encounter reporting within the 837)

226 = Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

227 = Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

231 = Mutually exclusive procedures cannot be done in the same day/setting. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.

232 = Institutional Transfer Amount. Usage: Applies to institutional claims only and explains the DRG amount difference when the patient care crosses multiple institutions.

233 = Services/charges related to the treatment of a hospital-acquired condition or preventable medical error

234 = This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

236 = This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.

237 = Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

238 = Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)

239 = Claim spans eligible and ineligible periods of coverage. Rebill separate claims.

240 = The diagnosis is inconsistent with the patient's birth weight. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.

242 = Services not provided by network/primary care providers. Notes: This code replaces deactivated code 038

243 = Services not authorized by network/primary care providers. Notes: This code replaces deactivated code 038

246 = This non-payable code is for required reporting only.

247 = Deductible for Professional service rendered in an Institutional setting and billed on an Institutional claim. Notes: For Medicare Bundled Payment use only, under the Patient Protection and Affordable Care Act (PPACA).

248 = Coinsurance for Professional service rendered in an Institutional setting and billed on an Institutional claim. Notes: For Medicare Bundled Payment use only, under the Patient Protection and Affordable Care Act (PPACA).

250 = The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).

251 = The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).

252 = An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).

253 = Sequestration — reduction in federal payment

254 = Claim received by the dental plan, but benefits not available under this plan. Submit these services to the patient's medical plan for further consideration. Notes: Use CARC 290 if the claim was forwarded.

256 = Service not payable per managed care contract.

258 = Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.

259 = Additional payment for Dental/Vision service utilization.

260 = Processed under Medicaid ACA Enhanced Fee Schedule

265 = Adjustment for administrative cost. Usage: To be used for pharmaceuticals only.

266 = Adjustment for compound preparation cost. Usage: To be used for pharmaceuticals only.

267 = Claim/service spans multiple months. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

270 = Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's dental plan for further consideration. Notes: Use CARC 291 if the claim was forwarded.

272 = Coverage/program guidelines were not met

273 = Coverage/program guidelines were exceeded

275 = Prior payer's (or payers') patient responsibility (deductible, coinsurance, co-payment) not covered. (Use only with Group Code PR)

276 = Services denied by the prior payer(s) are not covered by this payer

279 = Services not provided by Preferred network providers. Usage: Use this code when there are member network limitations. For example, using contracted providers not in the member's 'narrow' network.

283 = Attending provider is not eligible to provide direction of care

284 = Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the billed services.

285 = Appeal procedures not followed

286 = Appeal time limits not met

288 = Referral absent

289 = Services considered under the dental and medical plans, benefits not available. Notes: Also refer to CARCs 254, 270, and 280.

A0 = Patient refund amount

A1 = Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

A2 = Contractual adjustment. (No longer used: 01/01/2008, Use code 45 with Group Code 'CO' or use another appropriate specific adjustment code).

A6 = Prior hospitalization or 30-day transfer requirement not met

A7 = Presumptive Payment Adjustment

A8 = Ungroupable DRG

B1 = Non-covered visits

B3 = Covered charges (No longer used: 10/16/2003)

B5 = Coverage/program guidelines were not met or were exceeded. (No longer used: 05/01/2016, This code has been replaced by 272 and 273).

B7 = This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.

B8 = Alternative services were available, and should have been utilized

B9 = Patient is enrolled in a Hospice

B10 = Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.

B11 = The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.

B12 = Services not documented in patient's medical records

B13 = Previously paid. Payment for this claim/service may have been provided in a previous payment

B14 = Only one visit or consultation per physician per day is covered

B15 = This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.

B16 = 'New Patient' qualifications were not met

B20 = Procedure/service was partially or fully furnished by another provider

B22 = This payment is adjusted based on the diagnosis

B23 = Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test

P14 = The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Notes: This code replaces deactivated code W3

COMMENT: Values will include leading zeros.

Values and websites referenced may change over time. Refer to this website for current information. http://www.x12.org/codes/claim-adjustment-reason-codes/

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ADMSN_DT

LABEL: Admission Date

DESCRIPTION: The date on which the recipient was admitted to a hospital.

SHORT NAME: ADMSM_DT

LONG NAME: ADMSM_DT

TYPE: DATE

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header

VALUES: Date (numeric, system dependent)

COMMENT: —

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ADMSN_HR

LABEL: Admission Hour

DESCRIPTION: The time (hour) of admission to the hospital

SHORT NAME: ADMSN_HR

LONG NAME: ADMSN_HR

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header

VALUES:
00 = 0:00–0:59
01 = 1:00–1:59
02 = 2:00–2:59
03 = 3:00–3:59
04 = 4:00–4:59
05 = 5:00–5:59
06 = 6:00–6:59
07 = 7:00–7:59
08 = 8:00–8:59
09 = 9:00–9:59
10 = 10:00–10:59
11 = 11:00–11:59
12 = 12:00–12:59
13 = 13:00–13:59
14 = 14:00–14:59
15 = 15:00–15:59
16 = 16:00–16:59
17 = 17:00–17:59
18 = 18:00–18:59
19 = 19:00–19:59
20 = 20:00–20:59
21 = 21:00–21:59
22 = 22:00–22:59
23 = 23:00–23:59
Null/missing = source value is missing or unknown

COMMENT: A 24-hour clock is used (e.g., 5:00 am is 05:00 and 5:00 pm is 17:00).

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ADMSN_TYPE_CD

LABEL: Admission Type Code

DESCRIPTION: The basic types of admission for Inpatient hospital stays and a code indicating the priority of this admission.

SHORT NAME: ADMSN_TYPE_CD

LONG NAME: ADMSN_TYPE_CD

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header

VALUES:

1 = Emergency: The patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency room.

2 = Urgent: The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient is admitted to the first available and suitable accommodation.

3 = Elective: The patient's condition permits adequate time to schedule the availability of a suitable accommodation.

4 = Newborn: The patient is a newborn delivered either inside the admitting hospital (UB04 FL 15 value 5 [A baby born inside the admitting hospital] or outside of the hospital (UB04 FL 15 value "6" [A baby born outside the admitting hospital]).

5 = Trauma: The patient visits a trauma center (A trauma center means a facility licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of surgeons and involving a trauma activation.)

Null/missing = source value is missing, unknown, or not on the valid value list or within the range of valid values

COMMENT: —

^ Back to TOC ^

ADMTG_DGNS_CD

LABEL: Admitting Diagnosis Code

DESCRIPTION: The ICD-9/10-CM Diagnosis Code provided at the time of admission by the physician.

SHORT NAME: ADMTG_DGNS_CD

LONG NAME: ADMTG_DGNS_CD

TYPE: CHAR

LENGTH: 7

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header

VALUES: ICD9: http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html

ICD10: https://www.cms.gov/Medicare/Coding/ICD10/2017-ICD-10-CM- and-GEMs.html

COMMENT: —

^ Back to TOC ^

ADMTG_DGNS_VRSN_CD

LABEL: Admitting Diagnosis Version Code (ICD-9 or ICD-10)

DESCRIPTION: The variable identifies the coding system used for the admitting diagnosis code

SHORT NAME: ADMTG_DGNS_VRSN_CD

LONG NAME: ADMTG_DGNS_VRSN_CD

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header

VALUES: 1 = ICD-9
2 = ICD-10
3 = Other
Null/missing = source value is missing, unknown, or not on the valid value list or within the range of valid values

COMMENT: —

^ Back to TOC ^

ADMTG_PRVDR_ID

LABEL: Admitting Provider Identification Number

DESCRIPTION: The state-assigned provider identifier for the doctor responsible for admitting a patient to a hospital or other inpatient health facility

SHORT NAME: ADMTG_PRVDR_ID

LONG NAME: ADMTG_PRVDR_ID

TYPE: CHAR

LENGTH: 30

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header

VALUES: Valid values are supplied by the state

COMMENT: —

^ Back to TOC ^

ADMTG_PRVDR_NPI

LABEL: Admitting Provider NPI

DESCRIPTION: The National Provider ID (NPI) of the doctor responsible for admitting a patient to a hospital or other inpatient health facility.

SHORT NAME: ADMTG_PRVDR_NPI

LONG NAME: ADMTG_PRVDR_NPI

TYPE: CHAR

LENGTH: 10

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header

VALUES: https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/

Null/missing = source value is missing or unknown

COMMENT: Values and websites referenced may change over time.

To search CMS's NPI registry, you may use the following link: https://npiregistry.cms.hhs.gov/

^ Back to TOC ^

ADMTG_PRVDR_SPCLTY_CD

LABEL: Admitting Provider Specialty Code

DESCRIPTION: This code describes the area of specialty for the admitting provider.

SHORT NAME: ADMTG_PRVDR_SPCLTY_CD

LONG NAME: ADMTG_PRVDR_SPCLTY_CD

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header

VALUES:
01 = General Practice
02 = General Surgery
03 = Allergy/Immunology
04 = Otolaryngology
05 = Anesthesiology
06 = Cardiology
07 = Dermatology
08 = Family Practice
09 = Interventional Pain Management
10 = Gastroenterology
11 = Internal Medicine
12 = Osteopathic Manipulative Therapy
13 = Neurology
14 = Neurosurgery
15 = Speech Language Pathologist
16 = Obstetrics/Gynecology
17 = Hospice and Palliative Care
18 = Ophthalmology
19 = Oral Surgery (dentists only)
20 = Orthopedic Surgery
21 = Cardiac Electrophysiology
22 = Pathology
23 = Sports Medicine
24 = Plastic and Reconstructive Surgery
25 = Physical Medicine and Rehabilitation
26 = Psychiatry
27 = Geriatric Psychiatry
28 = Colorectal Surgery (formerly proctology)
29 = Pulmonary Disease
30 = Diagnostic Radiology
31 = Cardiac Rehabilitation and Intensive Cardiac Rehabilitation

32 = Anesthesiologist Assistant
33 = Thoracic Surgery
34 = Urology
35 = Chiropractic
36 = Nuclear Medicine
37 = Pediatric Medicine
38 = Geriatric Medicine
39 = Nephrology
40 = Hand Surgery
41 = Optometry
42 = Certified Nurse Midwife
43 = Certified Registered Nurse Anesthetist (CRNA)
44 = Infectious Disease
45 = Mammography Center
46 = Endocrinology
47 = Independent Diagnostic Testing Facility (IDTF)
48 = Podiatry
49 = Ambulatory Surgical Center
50 = Nurse Practitioner
51 = Medical Supply Company with Orthotist
52 = Medical Supply Company with Prosthetist
53 = Medical Supply Company with Orthotist-Prosthetist
54 = Other Medical Supply Company
55 = Individual Certified Orthotist
56 = Individual Certified Prosthetist
57 = Individual Certified Orthotist-Prosthetist
58 = Medical Supply Company with Pharmacist
59 = Ambulance Service Provider
60 = Public Health or Welfare Agency
61 = Voluntary Health or Charitable Agency
62 = Psychologist, Clinical
63 = Portable X-Ray Supplier
64 = Audiologist
65 = Physical Therapist in Private Practice
66 = Rheumatology
67 = Occupational Therapist in Private Practice
68 = Psychologist, Clinical
69 = Clinical Laboratory
70 = Single or Multispecialty Clinic or Group Practice
71 = Registered Dietitian or Nutrition Professional
72 = Pain Management
73 = Mass Immunization Roster Biller
74 = Radiation Therapy Center
75 = Slide Preparation Facility
76 = Peripheral Vascular Disease
77 = Vascular Surgery
78 = Cardiac Surgery
79 = Addiction Medicine

80 = Licensed Clinical Social Worker
81 = Critical Care (Intensivists)
82 = Hematology
83 = Hematology/Oncology
84 = Preventive Medicine
85 = Maxillofacial Surgery
86 = Neuropsychiatry
87 = All Other Suppliers
88 = Unknown Supplier/Provider Specialty
89 = Certified Clinical Nurse Specialist
90 = Medical Oncology
91 = Surgical Oncology
92 = Radiation Oncology
93 = Emergency Medicine
94 = Interventional Radiology
95 = Advance Diagnostic Imaging
96 = Optician
97 = Physician Assistant
98 = Gynecological/Oncology
99 = Undefined physician type (provider is an MD)
A0 = Hospital-General
A1 = Skilled Nursing Facility
A2 = Intermediate Care Nursing Facility
A3 = Other Nursing Facility
A4 = Home Health Agency
A5 = Pharmacy
A6 = Medical Supply Company with Respiratory Therapist
A7 = Department Store
A8 = Grocery Store
A9 = Indian Health Service facility
B1 = Oxygen supplier
B2 = Pedorthic personnel
B3 = Medical supply company with pedorthic personnel
B4 = Rehabilitation Agency
B5 = Ocularist
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

ADMTG_PRVDR_TXNMY_CD

LABEL: Admitting Provider Taxonomy Code

DESCRIPTION: The taxonomy code for the admitting provider.

SHORT NAME: ADMTG_PRVDR_TXNMY_CD

LONG NAME: ADMTG_PRVDR_TXNMY_CD

TYPE: CHAR

LENGTH: 12

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header

VALUES: http://www.wpc-edi.com/reference/

Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

ADMTG_PRVDR_TYPE_CD

LABEL: Admitting Provider Type Code

DESCRIPTION: A code describing the type of admitting provider.

SHORT NAME: ADMTG_PRVDR_TYPE_CD

LONG NAME: ADMTG_PRVDR_TYPE_CD

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header

VALUES:
01 = Physician
02 = Speech Language Pathologist
03 = Oral Surgery (Dentist only)
04 = Cardiac Rehabilitation and Intensive Cardiac Rehabilitation
05 = Anesthesiology Assistant
06 = Chiropractic
07 = Optometry
08 = Certified Nurse Midwife
09 = Certified Registered Nurse Anesthetist (CRNA)
10 = Mammography Center
11 = Independent Diagnostic Testing Facility (IDTF)
12 = Podiatry
13 = Ambulatory Surgical Center
14 = Nurse Practitioner
15 = Medical Supply Company with Orthotist
16 = Medical Supply Company with Prosthetist
17 = Medical Supply Company with Orthotist-Prosthetist
18 = Other Medical Supply Company
19 = Individual Certified Orthotist
20 = Individual Certified Prosthetist
21 = Individual Certified Prosthetist-Orthotist
22 = Medical Supply Company with Pharmacist
23 = Ambulance Service Provider
24 = Public Health or Welfare Agency
25 = Voluntary Health or Charitable Agency
26 = Psychologist, Clinical
27 = Portable X-Ray Supplier
28 = Audiologist
29 = Physical Therapist in Private Practice
30 = Occupational Therapist in Private Practice
31 = Clinical Laboratory

32 = Clinic or Group Practice
33 = Registered Dietitian or Nutrition Professional
34 = Mass Immunizer Roster Biller
35 = Radiation Therapy Center
36 = Slide Preparation Facility
37 = Licensed Clinical Social Worker
38 = Certified Clinical Nurse Specialist
39 = Advance Diagnostic Imaging
40 = Optician
41 = Physician Assistant
42 = Hospital-General
43 = Skilled Nursing Facility
44 = Intermediate Care Nursing Facility
45 = Other Nursing Facility
46 = Home Health Agency
47 = Pharmacy
48 = Medical Supply Company with Respiratory Therapist
49 = Department Store
50 = Grocery Store
51 = Indian Health Service Facility
52 = Oxygen supplier
53 = Pedorthic personnel
54 = Medical supply company with pedorthic personnel
55 = Rehabilitation Agency
56 = Ocularist
57 = All Other
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

ALOWD_SRVC_QTY

LABEL: Maximum Allowed Service Quantity

DESCRIPTION: On facility claims, this field is to capture maximum allowable quantity by revenue code category, e.g., number of days in a particular type of accommodation, pints of blood, etc.

SHORT NAME: ALOWD_SRVC_QTY

LONG NAME: ALOWD_SRVC_QTY

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Line
LT Line
OT Line

VALUES: Valid numeric value, three decimal places; may be negative.
Null/missing = source value is missing or unknown

COMMENT: When HCPCS codes are required for services, the units are equal to the number of times the procedure/service being reported was performed.

^ Back to TOC ^

BENE_ID

LABEL: Encrypted CCW Beneficiary Identifier

DESCRIPTION: Encrypted CCW Beneficiary Identifier

The Chronic Conditions Data Warehouse (CCW) assigns a unique beneficiary identification number to each individual who receives Medicare and/or Medicaid, and uses that number to identify an individual's records in all CCW data files (e.g., Medicare claims, Medicare encounter, MAX claims, T-MSIS claims, and MDS assessment data).

This number does not change during a beneficiary's lifetime and each number is used only once.

The BENE_ID is specific to the CCW and is not applicable to any other identification system or data source.

SHORT NAME: BENE_ID

LONG NAME: BENE_ID

TYPE: CHAR

LENGTH: 15

SOURCE: CCW (derived)

FILE(S): All Header Claim, Line, and Occurrence Code Files

VALUES: 15-character alphanumeric string (Ex. 22222222GDDGjJs)
Null/missing = not enough identifying information to assign a BENE_ID

COMMENT: If the BENE_ID is null/missing, then use the combination of MSIS_ID and STATE_CD to identify distinct enrollees. Note that if using multiple years of data, MSIS_ID and STATE_CD may not represent the same person over time. Additional details regarding how to uniquely identify individuals within the researcher files is found in the user guide https://www2.ccwdata.org/web/guest/user-documentation

^ Back to TOC ^

BENE_LIABILITY_AMT

LABEL: Total Beneficiary Long-Term Care Liability Amount

DESCRIPTION: The total amount paid by the patient for services where they are required to use their personal funds to cover part of their care before Medicaid funds can be utilized.

SHORT NAME: BENE_LIABILITY_AMT

LONG NAME: BENE_LIABILITY_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): LT Header

VALUES: Dollar amount with two decimal places (e.g., 98.76)
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

BILL_TYPE_CD

LABEL: Bill Type Code

DESCRIPTION: A data element corresponding with UB-04 form locator FL4 that classifies the claim as to the type of facility (2nd digit), type of care (3rd digit) and the billing record's sequence in the episode of care (4th digit). (Note that the 1st digit is always zero.)

SHORT NAME: BILL_TYPE_CD

LONG NAME: BILL_TYPE_CD

TYPE: CHAR

LENGTH: 4

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header

VALUES: Examples: 011*x* and 012x= inpatient hospital (where "x" is any digit in the 4th position)

1st Digit = 0

2nd Digit — Type of Facility
- 1 = Hospital
- 2 = Skilled Nursing
- 3 = Home Health
- 4 = Religious Nonmedical (Hospital)
- 5 = Reserved for national assignment (discontinued effective 10/1/05).
- 6 = Intermediate Care
- 7 = Clinic or Hospital Based Renal Dialysis Facility (requires special information in second digit below).
- 8 = Special facility or hospital ASC surgery (requires special information in second digit below).
- 9 = Reserved for National Assignment

3rd Digit — Bill Classification (Except Clinics and Special Facilities)
- 1 = Inpatient
- 2 = Inpatient
- 3 = Outpatient
- 4 = Other
- 5 = Intermediate Care — Level I
- 6 = Intermediate Care — Level II
- 7 = Reserved for national assignment (discontinued effective 10/1/05).
- 8 = Swing Bed (may be used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement).
- 9 = Reserved for National Assignment

3rd Digit — Classification (Clinics Only)
- 1 = Rural Health Clinic (RHC)
- 2 = Hospital Based or Independent Renal Dialysis Facility
- 3 = Free Standing Provider-Based Federally Qualified Health Center (FQHC)
- 4 = Other Rehabilitation Facility (ORF)
- 5 = Comprehensive Outpatient Rehabilitation Facility (CORF)
- 6 = Community Mental Health Center (CMHC)
- 7 = Federally Qualified Health Center (FQHC)
- 8 = Licensed Freestanding Emergency Medical Facility
- 9 = Other

3rd Digit — Classification (Special Facilities Only)
- 1 = Hospice (Nonhospital Based)
- 2 = Hospice (Hospital Based)
- 3 = Ambulatory Surgical Center Services to Hospital Outpatients
- 4 = Free Standing Birthing Center
- 5 = Critical Access Hospital
- 6 = Residential Facility
- 7 = Freestanding Non-residential Opioid Treatment Program (effective 1/1/21)
- 8 = Reserved for National Assignment
- 9 = Other

4th Digit — Frequency
- A = Admission/Election Notice
- B = Hospice/Medicare Coordinated Care Demonstration/Religious Nonmedical Health Care Institution Termination/Revocation Notice
- C = Hospice Change of Provider Notice
- D = Hospice/Medicare Coordinated Care Demonstration/Religious Nonmedical Health Care Institution Void/Cancel
- E = Hospice Change of Ownership
- F = Beneficiary Initiated Adjustment Claim
- G = CWF Initiated Adjustment Claim
- H = CMS Initiated Adjustment Claim
- I = FI Adjustment Claim (Other than QIO or Provider
- J = Initiated Adjustment Claim — Other
- K = OIG Initiated Adjustment Claim
- M = MSP Initiated Adjustment Claim
- P = QIO Adjustment Claim
- 0 = Nonpayment/Zero Claims
- 1 = Admit Through Discharge Claim
- 2 = Interim — First Claim
- 3 = Interim — Continuing Claims (Not valid for PPS Bills)
- 4 = Interim — Last Claim (Not valid for PPS Bills)
- 5 = Late Charge Only
- 7 = Replacement of Prior Claim
- 8 = Void/Cancel of a Prior Claim
- 9 = Final Claim for a Home Health PPS Episode
- Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

BILLED_AMT

LABEL: Total Claim Billed Amount

DESCRIPTION: The total amount billed for this claim, at the header claim level, as submitted by the provider

SHORT NAME: BILLED_AMT

LONG NAME: BILLED_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: Dollar amount with two decimal places (e.g., 98.76); may be negative or null/missing.

COMMENT: Not available for managed care claims. CMS has required redaction of some payment fields for managed care claims due to the proprietary and confidential nature of this information. The managed care records are identified as those where the claim type code (CLM_TYPE_CD) = 3, C or W.

^ Back to TOC ^

BIRTH_DT

LABEL: Date of Birth

DESCRIPTION: The beneficiary's date of birth from the claim

SHORT NAME: BIRTH_DT

LONG NAME: BIRTH_DT

TYPE: DATE

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: Date (numeric, system dependent)

COMMENT: —

^ Back to TOC ^

BIRTH_WT

LABEL: Birth Weight in Grams

DESCRIPTION: The weight of a newborn at time of birth in grams (applicable to newborns only).

SHORT NAME: BIRTH_WT

LONG NAME: BIRTH_WT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header

VALUES: Numeric value with up to three decimal places

COMMENT: Data users should use caution with this variable as it is often inaccurate

^ Back to TOC ^

BLG_PRVDR_ID

LABEL: Billing Provider Identification Number

DESCRIPTION: A unique identification number assigned by the state to a provider. This should represent the entity billing for the service.

SHORT NAME: BLG_PRVDR_ID

LONG NAME: BLG_PRVDR_ID

TYPE: CHAR

LENGTH: 30

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: Valid values are supplied by the state.

COMMENT: —

^ Back to TOC ^

BLG_PRVDR_NPI

LABEL: Billing Provider NPI

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

SHORT NAME: BLG_PRVDR_NPI

LONG NAME: BLG_PRVDR_NPI

TYPE: CHAR

LENGTH: 10

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/

Null/missing = source value is missing or unknown

COMMENT: Values and websites referenced may change over time.

To search CMS's NPI registry, you may use the following link: https://npiregistry.cms.hhs.gov/

^ Back to TOC ^

BLG_PRVDR_NPPES_TXNMY_CD

LABEL: Billing Provider NPPES Taxonomy Code

DESCRIPTION: The taxonomy code for the provider billing for the service.

SHORT NAME: BLG_PRVDR_NPPES_TXNMY_CD

LONG NAME: BLG_PRVDR_NPPES_TXNMY_CD

TYPE: CHAR

LENGTH: 12

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header

VALUES: alphanumeric string
Ex: 207KA0200X = Allergy Physician
Null/missing = source value is missing or unknown

COMMENT: Values and websites referenced may change over time.

The Provider Taxonomy Codes valid values can be found in the following link:
https://x12.org/codes/provider-taxonomy-codes

This variable is not sourced from T-MSIS data as reported by states. Rather, the value is derived by CMS through mapping the billing provider NPI to the National Plan and Provider Enumeration System (NPPES) to obtain the NPPES taxonomy code.

^ Back to TOC ^

BLG_PRVDR_SPCLTY_CD

LABEL: Billing Provider Specialty Code

DESCRIPTION: This code describes the area of specialty for the billing provider.

SHORT NAME: BLG_PRVDR_SPCLTY_CD

LONG NAME: BLG_PRVDR_SPCLTY_CD

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S):
IP Header
LT Header
OT Header
RX Header

VALUES:
01 = General Practice
02 = General Surgery
03 = Allergy/Immunology
04 = Otolaryngology
05 = Anesthesiology
06 = Cardiology
07 = Dermatology
08 = Family Practice
09 = Interventional Pain Management
10 = Gastroenterology
11 = Internal Medicine
12 = Osteopathic Manipulative Therapy
13 = Neurology
14 = Neurosurgery
15 = Speech Language Pathologist
16 = Obstetrics/Gynecology
17 = Hospice and Palliative Care
18 = Ophthalmology
19 = Oral Surgery (dentists only)
20 = Orthopedic Surgery
21 = Cardiac Electrophysiology
22 = Pathology
23 = Sports Medicine
24 = Plastic and Reconstructive Surgery
25 = Physical Medicine and Rehabilitation
26 = Psychiatry
27 = Geriatric Psychiatry
28 = Colorectal Surgery (formerly proctology)
29 = Pulmonary Disease

30 = Diagnostic Radiology
31 = Cardiac Rehabilitation and Intensive Cardiac Rehabilitation
32 = Anesthesiologist Assistant
33 = Thoracic Surgery
34 = Urology
35 = Chiropractic
36 = Nuclear Medicine
37 = Pediatric Medicine
38 = Geriatric Medicine
39 = Nephrology
40 = Hand Surgery
41 = Optometry
42 = Certified Nurse Midwife
43 = Certified Registered Nurse Anesthetist (CRNA)
44 = Infectious Disease
45 = Mammography Center
46 = Endocrinology
47 = Independent Diagnostic Testing Facility (IDTF)
48 = Podiatry
49 = Ambulatory Surgical Center
50 = Nurse Practitioner
51 = Medical Supply Company with Orthotist
52 = Medical Supply Company with Prosthetist
53 = Medical Supply Company with Orthotist-Prosthetist
54 = Other Medical Supply Company
55 = Individual Certified Orthotist
56 = Individual Certified Prosthetist
57 = Individual Certified Orthotist-Prosthetist
58 = Medical Supply Company with Pharmacist
59 = Ambulance Service Provider
60 = Public Health or Welfare Agency
61 = Voluntary Health or Charitable Agency
62 = Psychologist, Clinical
63 = Portable X-Ray Supplier
64 = Audiologist
65 = Physical Therapist in Private Practice
66 = Rheumatology
67 = Occupational Therapist in Private Practice
68 = Psychologist, Clinical
69 = Clinical Laboratory
70 = Single or Multispecialty Clinic or Group Practice
71 = Registered Dietitian or Nutrition Professional
72 = Pain Management
73 = Mass Immunization Roster Biller
74 = Radiation Therapy Center
75 = Slide Preparation Facility
76 = Peripheral Vascular Disease
77 = Vascular Surgery

78 = Cardiac Surgery
79 = Addiction Medicine
80 = Licensed Clinical Social Worker
81 = Critical Care (Intensivists)
82 = Hematology
83 = Hematology/Oncology
84 = Preventive Medicine
85 = Maxillofacial Surgery
86 = Neuropsychiatry
87 = All Other Suppliers
88 = Unknown Supplier/Provider Specialty (T-MSIS DD v2.1)
89 = Certified Clinical Nurse Specialist
90 = Medical Oncology
91 = Surgical Oncology
92 = Radiation Oncology
93 = Emergency Medicine
94 = Interventional Radiology
95 = Advance Diagnostic Imaging
96 = Optician
97 = Physician Assistant
98 = Gynecological/Oncology
99 = Undefined physician type (provider is an MD) (T-MSIS DD v2.1)
A0 = Hospital-General
A1 = Skilled Nursing Facility
A2 = Intermediate Care Nursing Facility
A3 = Other Nursing Facility
A4 = Home Health Agency
A5 = Pharmacy
A6 = Medical Supply Company with Respiratory Therapist
A7 = Department Store
A8 = Grocery Store
A9= Indian Health Service facility
B1 = Oxygen supplier
B2 = Pedorthic personnel
B3 = Medical supply company with pedorthic personnel
B4 = Rehabilitation Agency
B5 = Ocularist
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

BLG_PRVDR_TXNMY_CD

LABEL: Billing Provider Taxonomy Code

DESCRIPTION: The taxonomy code for the provider billing for the service.

SHORT NAME: BLG_PRVDR_TXNMY_CD

LONG NAME: BLG_PRVDR_TXNMY_CD

TYPE: CHAR

LENGTH: 12

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: http://www.wpc-edi.com/reference/

Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

BLG_PRVDR_TYPE_CD

LABEL: Billing Provider Type Code

DESCRIPTION: A code describing the type of entity billing for the service.

SHORT NAME: BLG_PRVDR_TYPE_CD

LONG NAME: BLG_PRVDR_TYPE_CD

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header

VALUES:
01 = Physician
02 = Speech Language Pathologist
03 = Oral Surgery (Dentist only)
04 = Cardiac Rehabilitation and Intensive Cardiac Rehabilitation
05 = Anesthesiology Assistant
06 = Chiropractic
07 = Optometry
08 = Certified Nurse Midwife
09 = Certified Registered Nurse Anesthetist (CRNA)
10 = Mammography Center
11 = Independent Diagnostic Testing Facility (IDTF)
12 = Podiatry
13 = Ambulatory Surgical Center
14 = Nurse Practitioner
15 = Medical Supply Company with Orthotist
16 = Medical Supply Company with Prosthetist
17 = Medical Supply Company with Orthotist-Prosthetist
18 = Other Medical Supply Company
19 = Individual Certified Orthotist
20 = Individual Certified Prosthetist
21 = Individual Certified Prosthetist-Orthotist
22 = Medical Supply Company with Pharmacist
23 = Ambulance Service Provider
24 = Public Health or Welfare Agency
25 = Voluntary Health or Charitable Agency
26 = Psychologist, Clinical
27 = Portable X-Ray Supplier
28 = Audiologist
29 = Physical Therapist in Private Practice
30 = Occupational Therapist in Private Practice

31 = Clinical Laboratory
32 = Clinic or Group Practice
33 = Registered Dietitian or Nutrition Professional
34 = Mass Immunizer Roster Biller
35 = Radiation Therapy Center
36 = Slide Preparation Facility
37 = Licensed Clinical Social Worker
38 = Certified Clinical Nurse Specialist
39 = Advance Diagnostic Imaging
40 = Optician
41 = Physician Assistant
42 = Hospital-General
43 = Skilled Nursing Facility
44 = Intermediate Care Nursing Facility
45 = Other Nursing Facility
46 = Home Health Agency
47 = Pharmacy
48 = Medical Supply Company with Respiratory Therapist
49 = Department Store
50 = Grocery Store
51 = Indian Health Service Facility
52 = Oxygen supplier
53 = Pedorthic personnel
54 = Medical supply company with pedorthic personnel
55 = Rehabilitation Agency
56 = Ocularist
57 = All Other
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

BLG_UOM_CD

LABEL: Service Billing Unit of Measure Code

DESCRIPTION: Unit of billing that is used for billing services by the facility

SHORT NAME: BLG_UOM_CD

LONG NAME: BLG_UOM_CD

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): LT Line

VALUES:
01 = Per Day
02 = Per Hour
03 = Per Case
04 = Per Encounter
05 = Per Week
06 = Per Month
07 = Other Arrangements
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

BNFT_TYPE_CD

LABEL: Benefit Type Code

DESCRIPTION: The benefit category corresponding to the service reported on the claim or encounter record.

SHORT NAME: BNFT_TYPE_CD

LONG NAME: BNFT_TYPE_CD

TYPE: CHAR

LENGTH: 3

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Line
LT Line
OT Line
RX Line

VALUES:

Mandatory Benefits for Categorically Needy (Mandatory and Options for Coverage) Individuals and Optional Benefits for Medically Needy Individuals

001 = Inpatient Hospital Services
002 = Outpatient Hospital Services
003 = Rural health clinic services
004 = FQHC services
005 = Other Laboratory and X-Ray Services
006 = Nursing Facility Services for 21 and over
007 = EPSDT
008 = Family Planning Services
009 = Mandatory tobacco cessation counseling for pregnant women under 1905(a)(4)(D)
010 = Physicians' Services
011 = Medical and Surgical Services Furnished by a Dentist
012 = Nurse-midwife services
013 = Certified pediatric or family nurse practitioners' services
014 = Free Standing Birth Center Services
015 = Home Health Services — Intermittent or part-time nursing services provided by a home health agency
016 = Home Health Services — Home Health Aide Services Provided by a Home Health Agency
017 = Home Health Services — Medical supplies, equipment, and appliances suitable for use in the home

Optional Benefits for Categorically Needy (Mandatory and Options for Coverage) and Medically Needy Individuals

018 = Medical care and any type of remedial care recognized under state law — Podiatrists' Services
019 = Medical care and any type of remedial care recognized under state law — Optometrists' Services
020 = Medical care and any type of remedial care recognized under state law — Chiropractors' Services

021 = Medical care and any type of remedial care recognized under State law — Other Practitioners' Services within scope of practice as defined by state law
022 = Home Health Services — Physical therapy; occupational therapy; speech pathology; audiology provided by a home health agency
023 = Private Duty Nursing
024 = Clinic Services
025 = Dental Services
026 = Physical Therapy and Related Services — Physical Therapy
027 = Physical Therapy and Related Services — Occupational Therapy
028 = Physical Therapy and Related Services — Services for individuals with speech, hearing and language disorders
029 = Prescription drugs, dentures, and prosthetic devices; and eyeglasses — Prescribed Drugs
030 = Prescription drugs, dentures, and prosthetic devices; and eyeglasses — Dentures
031 = Prescription drugs, dentures, and prosthetic devices; and eyeglasses — Prosthetic Devices
032 = Prescription drugs, dentures, and prosthetic devices; and eyeglasses — Eyeglasses
033 = Other diagnostic, screening, preventive, and rehabilitative services — Diagnostic Services
034 = Other diagnostic, screening, preventive, and rehabilitative services — Screening Services
035 = Other diagnostic, screening, preventive, and rehabilitative services — Preventive Services
036 = Other diagnostic, screening, preventive, and rehabilitative services — Rehabilitative Services
037 = Services for individuals over age 65 in IMDs — Inpatient hospital services
038 = Services for individuals over age 65 in IMDs — Nursing facility services
039 = Intermediate Care Facility Services for individuals with intellectual disabilities or persons with related conditions
040 = Inpatient psychiatric facility services for under 21
041 = Hospice Care
042 = Case Management Services and TB related services — Case management services as defined in the State Plan in accordance with section 1905(a)(19) or 1915(g)
043 = Case Management Services and TB related services — Special TB related services under section 1902(z)(2)
044 = Respiratory care services under 1902(e)9)(A) through (C)
045 = Personal care services
046 = Primary care case management services
047 = Special sickle-cell anemia-related services
048 = Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary — Transportation
049 = Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary — Services provided in religious non-medical health care facilities
050 = Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary — Nursing facility services for patients under 21
051 = Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary — Emergency hospital services
052 = Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary — Critical Access Hospitals
053 = Extended services for pregnant women — Additional Services for any other medical conditions that may complicate pregnancy
054 = Community First Choice
055 = Health Home Services

Special Benefit Provisions

056 = Limited Pregnancy-Related Services for Pregnant Women with Income Above the Applicable Income Limit
057 = Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period
058 = Benefits for Families Receiving Transitional Medical Assistance
059 = Standards for Coverage of Transplant Services
060 = School-Based Services Payment Methodologies
061 = Indian Health Services and Tribal Health Facilities
062 = Methods and Standards to Assure High Quality Care

Coordination of Medicaid with Medicare and Other Insurance

063 = Medicare Premium Payments
064 = Medicare Coinsurance and Deductibles
065 = Other Medical Insurance Premium Payments

Special Benefit Programs

066 = Programs for Distribution of Pediatric Vaccines

Home and Community-Based Services

067 = Laboratory and X-Ray services
068 = Home Health Services — Home health aide services provided by a home health agency
069 = Private duty nursing services
070 = Physical Therapy and Related Services — Audiology services
071 = Extended services for pregnant women — Additional Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.
072 = Home and Community Care for Functionally Disabled Elderly individuals as defined and described in the State Plan
073 = Emergency services for certain legalized aliens and undocumented aliens
074 = Licensed or Otherwise State-Approved Free-Standing Birthing Center and other ambulatory services that are offered by a freestanding birth center
075 = Homemaker
076 = Home Health Aide
077 = Adult Day Health services
078 = Habilitation
079 = Habilitation: Residential Habilitation
080 = Habilitation: Supported Employment
081 = Habilitation: Education (non-IDEA available)
082 = Habilitation: Day Habilitation
083 = Habilitation: Pre-Vocational
084 = Habilitation: Other Habilitative Services
085 = Respite
086 = Day Treatment (mental health service)
087 = Psychosocial rehabilitation
088 = Environmental Modifications (Home Accessibility Adaptations)
089 = Vehicle Modifications

090 = Non-Medical Transportation
091 = Special Medical Equipment (minor assistive Devices)
092 = Home Delivered meals
093 = Assistive Technology (i.e., communication devices)
094 = Personal Emergency Response (PERS)
095 = Nursing Services
096 = Community Transition Services
097 = Adult Foster Care
098 = Day Supports (non-habilitative)
099 = Supported Employment
100 = Supported Living Arrangements
101 = Supports for Consumer Direction (Supports Facilitation)
102 = Participant Directed Goods and Services
103 = Senior Companion (Adult Companion Services)
104 = Assisted Living

Other

105 = Program for All-inclusive Care for the Elderly (PACE) Services
106 = Self-directed Personal Assistance Services under 1915(j)
107 = In vitro diagnostic products for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19, and the administration of such in vitro diagnostic products
108 = COVID–19 testing-related services
Null/missing = source value is missing or unknown

COMMENT: The code definitions in the valid value list originate from the Medicaid and CHIP Program Data System's (MACPro's) benefit type list.

^ Back to TOC ^

BRDR_STATE_IND

LABEL: Border State Indicator

DESCRIPTION: This code indicates whether a beneficiary received services or equipment across state borders. (The provider location is out of state, but for payment purposes the provider is treated as an in-state provider.)

SHORT NAME: BRDR_STATE_IND

LONG NAME: BRDR_STATE_IND

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: 0 = No
1 = Yes
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

BRND_GNRC_CD

LABEL: Brand — Generic Code

DESCRIPTION: Indicates whether the drug is a brand name, generic, single-source, or multi-source drug.

SHORT NAME: BRND_GNRC_CD

LONG NAME: BRND_GNRC_CD

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): RX Line

VALUES:
0 = Non-Drug
1 = Generic
2 = Brand
3 = Multi-Source
4 = Single-Source
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

CCW_LD_DT

LABEL: CCW Load Date

DESCRIPTION: The Date Source File was loaded to the CCW

SHORT NAME: CCW_LD_DT

LONG NAME: CCW_LD_DT

TYPE: DATE

LENGTH: 8

SOURCE: CCW (derived)

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: Date (numeric, system dependent)

COMMENT: States may resubmit T-MSIS claims data to CMS. This date indicates when the claims were obtained and loaded into the CCW database. If state data were replaced, then data users should use the version of the claims with the latest/most current CCW_LD_DT.

^ Back to TOC ^

CLL_CNT

LABEL: Claim Line Count — Original

DESCRIPTION: The total number of lines on the claim as recorded by the state when TMSIS data submitted

SHORT NAME: CLL_CNT

LONG NAME: CLL_CNT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: 1 – XXX
Null/missing = source value is missing or unknown
Equals the count of the claim lines submitted on the original claim.

COMMENT: The value is what the provider submitted on the claim. There can be inaccuracies. Refer to CLL_CNT_CALC.

^ Back to TOC ^

CLL_CNT_CALC

LABEL: Claim Line Count — Calculated

DESCRIPTION: The total number of lines on the claim within the TAF

SHORT NAME: CLL_CNT_CALC

LONG NAME: CLL_CNT_CALC

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims (derived)

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: 0–XXX
Equals the count of the claim lines for this record in the TAF.

COMMENT: This value is the total number of claim lines in TAF, including denied claim lines. May not always match the original claim line count — variable CLL_CNT.

^ Back to TOC ^

CLM_ID

LABEL: CCW Claim Identifier

DESCRIPTION: This is the unique identification number for the claim

SHORT NAME: CLM_ID

LONG NAME: CLM_ID

TYPE: CHAR

LENGTH: 64

SOURCE: CCW (derived)

FILE(S): All Header Claim, Line, and Occurrence Code Files

VALUES: —

COMMENT: The CLM_ID is assigned by the CCW. The CLM_ID is specific to the CCW and is not applicable to any other identification system or data source.

All line/revenue/occurrence records on a given claim have the same CLM_ID. It is used to link the lines together and/or to the header claim.

^ Back to TOC ^

CLM_NUM_ADJ

LABEL: Adjustment Claim Identifier

DESCRIPTION: A unique claim number assigned by the state's payment system that identifies the adjustment claim for an original transaction

SHORT NAME: CLM_NUM_ADJ

LONG NAME: CLM_NUM_ADJ

TYPE: CHAR

LENGTH: 50

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): All Header Claim and Line Files

VALUES: The field can contain any alphanumeric characters, digits or symbols

COMMENT: —

^ Back to TOC ^

CLM_NUM_ORIG

LABEL: Original Claim Identifier

DESCRIPTION: A unique number assigned by the state's payment system that identifies an original claim

SHORT NAME: CLM_NUM_ORIG

LONG NAME: CLM_NUM_ORIG

TYPE: CHAR

LENGTH: 50

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): All Header Claim and Line Files

VALUES: The field can contain any alphanumeric characters, digits or symbols

COMMENT: —

^ Back to TOC ^

CLM_TYPE_CD

LABEL: Claim Type Code

DESCRIPTION: A code indicating what kind of payment is covered in this claim

SHORT NAME: CLM_TYPE_CD

LONG NAME: CLM_TYPE_CD

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: 1 = A Fee-For-Service (FFS) Medicaid or Medicaid-expansion Claim

2 = Medicaid or Medicaid-expansion Capitated Payment

3 = Medicaid or Medicaid-expansion Managed Care Encounter (a.k.a. "Dummy") record that simulates a bill for a service rendered to a patient covered under some form of Capitation Plan. This includes billing records submitted by providers to non-state entities (e.g., MCOs, health plans) for which the State has no financial liability since the at-risk entity has already received a capitated payment from the State.

4 = Medicaid or Medicaid-expansion CHIP Service Tracking Claim

5 = Medicaid or Medicaid-expansion Supplemental Payment (above capitation fee or above negotiated rate) (e.g., FQHC additional reimbursement)

A = Separate CHIP (Title XXI) claim: A Fee-for-Service (FFS) Claim

B = Separate CHIP (Title XXI) claim: Capitated Payment

C = Separate CHIP (Title XXI) Encounter record that simulates a bill for a service or items rendered to a patient covered under some form of Capitation Plan. This includes billing records submitted by providers to non-state entities (e.g., MCOs, health plans) for which a state has no financial liability as the at-risk entity has already received a capitated payment from the state

D = Separate CHIP (Title XXI) Service Tracking Claim

E = Separate CHIP (Title XXI) claim for a supplemental payment (above capitation fee or above negotiated rate) (e.g., FQHC additional reimbursement)

U = Other FFS claim

V = Other Capitated Payment

W = Other Managed Care Encounter

X = Non-Medicaid/CHIP service tracking claims

Y = Other Supplemental Payment

Null/missing = source value is missing or unknown

COMMENT: Some claim types are for service tracking claims (notably, those where CLM_TYPE_CD = 4, D or X), which do not indicate a service for an individual (e.g., they may be used for lump sum payments such as those made to Disproportionate Share Hospitals (DSH) and have no corresponding diagnosis or procedure information). RIFs prior to August 2021 did not include these service tracking claims.

^ Back to TOC ^

CMPND_DRUG_IND

LABEL: Compound Drug Indicator

DESCRIPTION: Indicator to specify whether the drug is compound or not

SHORT NAME: CMPND_DRUG_IND

LONG NAME: CMPND_DRUG_IND

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): RX Header

VALUES: 0 = Not Compound
1 = Compound
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

CMS_64_FED_CTGRY_CD

LABEL: CMS-64 Form Code for Federal Reimbursement

DESCRIPTION: This code indicates if the claim was matched with Title XIX or Title XXI, ACA, or funding under other legislation

SHORT NAME: CMS_64_FED_CTGRY_CD

LONG NAME: CMS_64_FED_CTGRY_CD

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): All Line Files

VALUES:
01 = Federal funding under Title XIX
02 = Federal funding under Title XXI
03 = Federal funding under ACA
04 = Federal funding under other legislation
Null/missing = source value is missing, unknown, or not on the valid value list or within the range of valid values

COMMENT: —

^ Back to TOC ^

COINSRNC_AMT

LABEL: Beneficiary Coinsurance Amount

DESCRIPTION: The amount of money the beneficiary paid towards coinsurance

SHORT NAME: COINSRNC_AMT

LONG NAME: COINSRNC_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: Dollar amount with two decimal places (e.g., 98.76)

COMMENT: —

^ Back to TOC ^

COINSRNC_PD_DT

LABEL: Beneficiary Coinsurance Paid Date

DESCRIPTION: The date the beneficiary paid the coinsurance amount

SHORT NAME: COINSRNC_PD_DT

LONG NAME: COINSRNC_PD_DT

TYPE: DATE

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Header

VALUES: Date (numeric, system dependent)

Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

COPAY_AMT

LABEL: Beneficiary Copayment Amount

DESCRIPTION: The amount of money the beneficiary paid towards a copayment

SHORT NAME: COPAY_AMT

LONG NAME: COPAY_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: Dollar amount with two decimal places (e.g., 98.76); may be negative.

COMMENT: —

^ Back to TOC ^

COPAY_PD_DT

LABEL: Beneficiary Copayment Paid Date

DESCRIPTION: The date the beneficiary paid the copayment amount

SHORT NAME: COPAY_PD_DT

LONG NAME: COPAY_PD_DT

TYPE: DATE

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Header

VALUES: Date (numeric, system dependent)
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

COPAY_WVD_IND

LABEL: Indicator Signifying Copay was Waived by Provider

DESCRIPTION: An indicator signifying that the copay was waived by the provider.

SHORT NAME: COPAY_WVD_IND

LONG NAME: COPAY_WVD_IND

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: 0 = Not Waived: The provider did not waive the beneficiary's copayment
1 = Waived: The provider waived the beneficiary's copayment
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

CPTATD_PYMT_BILLED_AMT

LABEL: Capitated Payment Billed Amount

DESCRIPTION: The amount of the capitated payment bill submitted by the managed care entity to the state.

SHORT NAME: CPTATD_PYMT_BILLED_AMT

LONG NAME: CPTATD_PYMT_BILLED_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Header

VALUES: Dollar amount with two decimal places (e.g., 98.76); may be negative.
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

CPTATD_PYMT_BILLED_DT

LABEL: Capitated Payment Billed Date

DESCRIPTION: The date that the managed care entity submitted the capitated payment bill to the state.

SHORT NAME: CPTATD_PYMT_BILLED_DT

LONG NAME: CPTATD_PYMT_BILLED_DT

TYPE: DATE

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Header

VALUES: Date (numeric, system dependent)
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

CROSSOVER_CLM_IND

LABEL: Code To Indicate if a Portion of Claim is Paid by Medicare

DESCRIPTION: An indicator specifying whether the claim is a crossover claim where Medicare pays a portion.

SHORT NAME: CROSSOVER_CLM_IND

LONG NAME: CROSSOVER_CLM_IND

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: 0 = Not Crossover Claim
1 = Crossover Claim
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

CVRD_DAYS

LABEL: Medicaid Covered Inpatient Days Count

DESCRIPTION: The number of inpatient days covered by Medicaid on this claim. For states that combine delivery/birth services on a single claim, include covered days for both the mother and the neonate in this field.

SHORT NAME: CVRD_DAYS

LONG NAME: CVRD_DAYS

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header

VALUES: 0–XXXXXX; may be negative

COMMENT: Number of inpatient days covered by Medicaid. Note that other payers may also provide coverage; therefore, the total number of days actually covered may be higher than the value in this variable.

^ Back to TOC ^

CVRD_DAYS_ICF_IID

LABEL: Count of Medicaid Covered Days in ICF for Patients with Intellectual Disability

DESCRIPTION: The number of days in an intermediate care facility (ICF) for beneficiaries with an intellectual disability (IID) that were paid for in whole or in part by Medicaid.

SHORT NAME: CVRD_DAYS_ICF_IID

LONG NAME: CVRD_DAYS_ICF_IID

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): LT Header

VALUES: 0–XXXXXX; may be negative.
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

CVRD_DAYS_IP_PSYCH

LABEL: Count of Medicaid Covered Days in an Inpatient Psychiatric Facility (IPF)

DESCRIPTION: The number of inpatient psychiatric days covered by Medicaid on this claim.

SHORT NAME: CVRD_DAYS_IP_PSYCH

LONG NAME: CVRD_DAYS_IP_PSYCH

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): LT Header

VALUES: 0–XXXXXX; may be negative.
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

CVRD_DAYS_IP_PSYCH_OVER_65

LABEL: Count of Medicaid Covered Days in an Inpatient Psychiatric Facility (IPF); Beneficiary Over 65 Years

DESCRIPTION: The number of inpatient psychiatric days covered by Medicaid on this claim.

SHORT NAME: CVRD_DAYS_IP_PSYCH_OVER_65

LONG NAME: CVRD_DAYS_IP_PSYCH_OVER_65

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): LT Header

VALUES: 0–XXXXXX; may be negative
Null/missing = source value is missing or unknown

COMMENT: If type of service code (TOS_CD) = 044 (Inpatient hospital services for individuals aged 65 or older in institutions for mental diseases) or 045 (Nursing facility services for individuals aged 65 or older in institutions for mental diseases) then value is equal to value of Medicaid covered inpatient days (CVRD_DAYS), otherwise it is set to 0.

^ Back to TOC ^

CVRD_DAYS_IP_PSYCH_UNDER_21

LABEL: Count of Medicaid Covered Days in an Inpatient Psychiatric Facility (IPF); Beneficiary Under 21 Years

DESCRIPTION: The number of inpatient psychiatric days covered by Medicaid on this claim.

SHORT NAME: CVRD_DAYS_IP_PSYCH_UNDER_21

LONG NAME: CVRD_DAYS_IP_PSYCH_UNDER_21

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): LT Header

VALUES: 0–XXXXXX; may be negative
Null/missing = source value is missing or unknown

COMMENT: If type of service code (TOS_CD) = 048 (Inpatient psychiatric services for individuals under age 21) then value is equal to value of Medicaid covered inpatient days (CVRD_DAYS), otherwise it is set to 0.

^ Back to TOC ^

CVRD_DAYS_NF

LABEL: Count of Medicaid Covered Days in a Nursing Facility

DESCRIPTION: The number of days of nursing care included in this claim that were paid for, in whole or in part, by Medicaid. Includes days during which nursing facility received partial payment for holding a bed during patient leave days.

SHORT NAME: CVRD_DAYS_NF

LONG NAME: CVRD_DAYS_NF

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): LT Header

VALUES: 0–XXXXXX; may be negative
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

DA_RUN_ID

LABEL: TAF Production Run Identifier (unique for each TAF run)

DESCRIPTION: A unique identifier that identifies the TAF production run that produced the TAF file

SHORT NAME: DA_RUN_ID

LONG NAME: DA_RUN_ID

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): All Header Claim and Line Files

VALUES: —

COMMENT: —

^ Back to TOC ^

DAILY_RATE

LABEL: Daily Rate that a Policy will Pay for a Covered Service

DESCRIPTION: The amount a policy will pay per day for a covered service. In some cases for OT claims this is referred to as a flat rate.

SHORT NAME: DAILY_RATE

LONG NAME: DAILY_RATE

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): LT Header
OT Header

VALUES: Dollar amount with two decimal places (e.g., 98.76); may be negative.
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

DAYS_SUPPLY

LABEL: Days' Supply

DESCRIPTION: Number of days' supply dispensed.

SHORT NAME: DAYS_SUPPLY

LONG NAME: DAYS_SUPPLY

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): RX Line

VALUES: Values should be between 365 and 365

COMMENT: A negative value may be present if a negative adjustment is made (e.g., incorrect prescription was issued, etc.).

^ Back to TOC ^

DDCTBL_AMT

LABEL: Beneficiary Deductible Amount

DESCRIPTION: The amount of money the beneficiary paid towards an annual deductible.

SHORT NAME: DDCTBL_AMT

LONG NAME: DDCTBL_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: Dollar amount with two decimal places (e.g., 98.76)

COMMENT: —

^ Back to TOC ^

DDCTBL_PD_DT

LABEL: Beneficiary Deductible Paid Date

DESCRIPTION: The date the beneficiary paid the deductible amount.

SHORT NAME: DDCTBL_PD_DT

LONG NAME: DDCTBL_PD_DT

TYPE: DATE

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Header

VALUES: Date (numeric, system dependent)
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

DGNS_1_CCSR_CTGRY_CD

LABEL: AHRQ Clinical Classifications Software Refined (CCSR) Diagnosis 1 Category Code

DESCRIPTION: AHRQ Clinical Classifications Software Refined (CCSR) Diagnosis Category Code. The CCSR aggregates International Classification of Diseases, 10th Revision, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) codes into clinically meaningful categories. The CCSR for ICD-10-CM diagnoses aggregates more than 70,000 ICD-10-CM diagnosis codes into over 530 clinical categories across 21 body systems.

SHORT NAME: DGNS_1_CCSR_CTGRY_CD

LONG NAME: DGNS_1_CCSR_CTGRY_CD

TYPE: CHAR

LENGTH: 6

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header

VALUES: Six-character alpha-numeric value; first three characters classify the body system (refer to COMMENT)
Ex - INF005 = Foodborne intoxications
Null/missing = source value is missing or unknown

COMMENT: AHRQ maintains the list of values at the following link; scroll to the "Downloading Information for the Tool and Documentation" portion of the page: https://www.hcup-us.ahrq.gov/toolssoftware/ccsr/ccs_refined.jsp

CMS used the CCSR software v2021.2 to populate this field. CCSR uses the first three characters to indicate which of the 21 body systems applies. In the TAF the CCSR was mapped to the Primary or Principal Diagnosis Code (variable called DGNS_CD_1) The 21 systems are:

Abbreviation CCSR Body Systems
INF = Certain Infectious and Parasitic Diseases
NEO = Neoplasms
BLD = Diseases of the Blood and Blood Forming Organs and Certain Disorders Involving the Immune Mechanism
END = Endocrine, Nutritional and Metabolic Diseases
MBD = Mental, Behavioral and Neurodevelopmental Disorders
NVS = Diseases of the Nervous System
EYE = Diseases of the Eye and Adnexa
EAR = Diseases of the Ear and Mastoid Process
CIR = Diseases of the Circulatory System
RSP = Diseases of the Respiratory System

DIG = Diseases of the Digestive System
SKN = Diseases of the Skin and Subcutaneous Tissue
MUS = Diseases of the Musculoskeletal System and Connective Tissue
GEN = Diseases of the Genitourinary System
PRG = Pregnancy, Childbirth, and the Puerperium
PNL = Certain Conditions Originating in the Perinatal Period
MAL = Congenital Malformations, Deformations and Chromosomal Abnormalities
SYM = Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified
INJ = Injury, Poisoning and Certain Other Consequences of External Causes
EXT = External Causes of Morbidity
FAC = Factors Influencing Health Status and Contact with Health Services

^ Back to TOC ^

DGNS_CD_1

DGNS_CD_2

DGNS_CD_3

DGNS_CD_4

DGNS_CD_5

DGNS_CD_6

DGNS_CD_7

DGNS_CD_8

DGNS_CD_9

DGNS_CD_10

DGNS_CD_11

DGNS_CD_12

LABEL: Diagnosis Code (1–12)

DESCRIPTION: The diagnosis code on the claim. There are up to 12 diagnosis codes on the IP header claim, up to five (5) for LT, and up to two (2) for OT. The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., DGNS_CD_1 is considered the primary diagnosis).

SHORT NAME:

DGNS_CD_1	DGNS_CD_7
DGNS_CD_2	DGNS_CD_8
DGNS_CD_3	DGNS_CD_9
DGNS_CD_4	DGNS_CD_10
DGNS_CD_5	DGNS_CD_11
DGNS_CD_6	DGNS_CD_12

LONG NAME:

DGNS_CD_1	DGNS_CD_7
DGNS_CD_2	DGNS_CD_8
DGNS_CD_3	DGNS_CD_9
DGNS_CD_4	DGNS_CD_10
DGNS_CD_5	DGNS_CD_11
DGNS_CD_6	DGNS_CD_12

TYPE: CHAR

LENGTH: 7

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header

VALUES: http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html
https://www.cms.gov/Medicare/Coding/ICD10
Null/missing = source value is missing, unknown

COMMENT: The code is either an ICD-9 or an ICD-10-CM code, depending on the date. For ICD-9 diagnosis codes, this is a 3–5 digit numeric or alpha/numeric value; it can include leading zeros. On October 1, 2015, the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred. The Diagnosis Version Code associated with each of the diagnosis codes, indicates whether the version was ICD9 or 10 (refer to the DGNS_VRSN_CD_1–12 fields).

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DGNS_POA_IND_1

DGNS_POA_IND_2

DGNS_POA_IND_3

DGNS_POA_IND_4

DGNS_POA_IND_5

DGNS_POA_IND_6

DGNS_POA_IND_7

DGNS_POA_IND_8

DGNS_POA_IND_9

DGNS_POA_IND_10

DGNS_POA_IND_11

DGNS_POA_IND_12

LABEL: Diagnosis Present on Admission Indicator (1–12)

DESCRIPTION: A code to indicate that the diagnosis (in DGNS_CD_1–12 fields) was present at the time the order for inpatient admission (POA) occurred.

SHORT NAME:

DGNS_POA_IND_1	DGNS_POA_IND_7
DGNS_POA_IND_2	DGNS_POA_IND_8
DGNS_POA_IND_3	DGNS_POA_IND_9
DGNS_POA_IND_4	DGNS_POA_IND_10
DGNS_POA_IND_5	DGNS_POA_IND_11
DGNS_POA_IND_6	DGNS_POA_IND_12

LONG NAME:

DGNS_POA_IND_1	DGNS_POA_IND_7
DGNS_POA_IND_2	DGNS_POA_IND_8
DGNS_POA_IND_3	DGNS_POA_IND_9
DGNS_POA_IND_4	DGNS_POA_IND_10
DGNS_POA_IND_5	DGNS_POA_IND_11
DGNS_POA_IND_6	DGNS_POA_IND_12

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header

LT Header
OT Header

VALUES:
Y = Diagnosis was present at time of inpatient admission
N = Diagnosis was not present at time of inpatient admission
U = Documentation insufficient to determine if condition was present at the time of inpatient admission
W = Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission
1 = Unreported/Not used. Exempt from POA reporting
Null/missing = source value is missing, unknown, or not on the valid value list or within the range of valid values

COMMENT: POA indicator is used to identify certain preventable conditions that are:

(a) high cost or high volume or both,

(b) result in the assignment of a case to a Diagnosis Related Group (DRG)* that has a higher payment when present as a secondary diagnosis, and

(c) could reasonably have been prevented through the application of evidence-based guidelines.

*States that do not use the grouper methodology may use CMS-approved methodology that is prospective in nature.

There is a POA indicator code associated with each diagnosis code (principal and secondary).

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DGNS_VRSN_CD_1

DGNS_VRSN_CD_2

DGNS_VRSN_CD_3

DGNS_VRSN_CD_4

DGNS_VRSN_CD_5

DGNS_VRSN_CD_6

DGNS_VRSN_CD_7

DGNS_VRSN_CD_8

DGNS_VRSN_CD_9

DGNS_VRSN_CD_10

DGNS_VRSN_CD_11

DGNS_VRSN_CD_12

LABEL: Diagnosis Version Code (1–12) (ICD-9 or ICD-10)

DESCRIPTION: This variable identifies the coding system (ICD-9 or ICD-10) used for the Diagnosis Codes 1 through 12 (DGNS_CD_1–12 fields).

SHORT NAME:

DGNS_VRSN_CD_1	DGNS_VRSN_CD_7
DGNS_VRSN_CD_2	DGNS_VRSN_CD_8
DGNS_VRSN_CD_3	DGNS_VRSN_CD_9
DGNS_VRSN_CD_4	DGNS_VRSN_CD_10
DGNS_VRSN_CD_5	DGNS_VRSN_CD_11
DGNS_VRSN_CD_6	DGNS_VRSN_CD_12

LONG NAME:

DGNS_VRSN_CD_1	DGNS_VRSN_CD_7
DGNS_VRSN_CD_2	DGNS_VRSN_CD_8
DGNS_VRSN_CD_3	DGNS_VRSN_CD_9
DGNS_VRSN_CD_4	DGNS_VRSN_CD_10
DGNS_VRSN_CD_5	DGNS_VRSN_CD_11
DGNS_VRSN_CD_6	DGNS_VRSN_CD_12

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header

LT Header
OT Header

VALUES:
1 = ICD-9
2 = ICD-10
3 = Other/invalid code
Null/missing = source value is missing, unknown, or not on the valid value list or within the range of valid values

COMMENT: If the discharge date is prior to October 1, 2015, the diagnosis code flag (and corresponding diagnosis code) should be ICD-9. Beginning October 1, 2015, the diagnosis code/flag should be ICD-10.

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DOSAGE_FORM_CD

LABEL: Medication Dosage Form Code

DESCRIPTION: The physical form of a dose of medication, such as a capsule or injection.

SHORT NAME: DOSAGE_FORM_CD

LONG NAME: DOSAGE_FORM_CD

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): RX Line

VALUES:
01 = Capsule
02 = Ointment
03 = Cream
04 = Suppository
05 = Powder
06 = Emulsion
07 = Liquid
10 = Tablet
11 = Solution
12 = Suspension
13 = Lotion
14 = Shampoo
15 = Elixir
16 = Syrup
17 = Lozenge
18 = Enema
Null/missing = source value is missing or unknown

COMMENT: States and providers do not necessarily restrict the use of this field to just compound drugs.

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DRCTNG_PRVDR_NPI

LABEL: NPI of Provider Directing the Patient's Care

DESCRIPTION: The National Provider ID (NPI) of the provider who directed the care of a patient that another provider administered.

SHORT NAME: DRCTNG_PRVDR_NPI

LONG NAME: DRCTNG_PRVDR_NPI

TYPE: CHAR

LENGTH: 10

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Header

VALUES: https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/

Null/missing = source value is missing or unknown

COMMENT: Values and websites referenced may change over time.

To search CMS's NPI registry, you may use the following link: https://npiregistry.cms.hhs.gov/

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DRCTNG_PRVDR_TXNMY_CD

LABEL: Taxonomy Code of Provider Directing the Patient's Care

DESCRIPTION: The Provider Taxonomy of the provider who directed the care of a patient that another provider administered.

SHORT NAME: DRCTNG_PRVDR_TXNMY_CD

LONG NAME: DRCTNG_PRVDR_TXNMY_CD

TYPE: CHAR

LENGTH: 12

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Header

VALUES: http://www.wpc-edi.com/reference/

Null/missing = source value is missing or unknown

COMMENT: Values and websites referenced may change over time.

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DRG_CD

LABEL: Diagnosis Related Group (DRG) Code

DESCRIPTION: Code representing the Diagnosis Related Group (DRG) that is applicable for the inpatient services being rendered.

SHORT NAME: DRG_CD

LONG NAME: DRG_CD

TYPE: CHAR

LENGTH: 7

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header

VALUES: DRG Code (Ex. 141, which is for Asthma)

COMMENT: Note that the DRG_CD is not always a CMS DRG. Refer to the DRG Code System/Nomenclature variable (called DRG_CD_SYS). There is also a DRG code description (variable called DRG_DESC) that may be helpful.

More information regarding CMS DRGs (currently referred to as MS-DRGs) can be found on the CMS website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software.html

^ Back to TOC ^

DRG_CD_SYS

LABEL: DRG Code System/Nomenclature

DESCRIPTION: An indicator identifying the grouping algorithm used to assign Diagnosis Related Group (DRG) values.

SHORT NAME: DRG_CD_SYS

LONG NAME: DRG_CD_SYS

TYPE: CHAR

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header

VALUES: The value has intelligence. Values are generated by combining two types of information:

Position 1–2, State/Group generating DRG:

- If state specific system, fill with two-digit US postal code representation for state.
- If CMS Grouper, fill with “HG”. (e.g., common to refer to HG33; also a lot of 3M##)
- If any other system, fill with “XX”.

Position 3–4, fill with the number that represents the DRG version used (01–98).
For example, “HG33" would represent CMS Grouper version 33
Null/missing = source value is missing, unknown, or not on the valid value list or within the range of valid values

COMMENT: —

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DRG_DESC

LABEL: Description of DRG Code

DESCRIPTION: Description of the associated state specific DRG code.

SHORT NAME: DRG_DESC

LONG NAME: DRG_DESC

TYPE: CHAR

LENGTH: 20

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header

VALUES: —

COMMENT: If using standard MS-DRG classification system, this may be blank/missing. This variable describes the code used in the DRG_CD field.

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DRG_OUTLIER_AMT

LABEL: DRG Outlier Additional Payment Amount

DESCRIPTION: The additional payment on a claim that is associated with either a cost outlier or length of stay outlier.

SHORT NAME: DRG_OUTLIER_AMT

LONG NAME: DRG_OUTLIER_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header

VALUES: Dollar amount with two decimal places (e.g., 98.76); may be negative.

COMMENT: Outlier payments compensate hospitals paid on a fixed amount per "diagnosis related group" discharge with extra dollars for patient stays that substantially exceed the typical requirements for patient stays in the same DRG category.

^ Back to TOC ^

DRG_RLTV_WT

LABEL: DRG Relative Weight

DESCRIPTION: The relative weight for the DRG on the claim. Each year CMS assigns a relative weight to each DRG. These weights indicate the relative costs for treating patients during the prior year. The national average charge for each DRG is compared to the overall average.

SHORT NAME: DRG_RLTV_WT

LONG NAME: DRG_RLTV_WT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header

VALUES: Valid numeric, four decimal places (e.g., 1.0329)
Null/missing = source value is missing or unknown

COMMENT: This ratio is published annually in the Federal Register for each DRG. A DRG with a weight of 2.0000 means that charges were historically twice the average; a DRG with a weight of 0.5000 was half the average.

Note that the DRG_CD is not always a CMS DRG. Refer to the DRG Code System/Nomenclature variable (called DRG_CD_SYS).

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DRUG_UTLZTN_CD

LABEL: Drug Utilization Code

DESCRIPTION: A code indicating the conflict, intervention and outcome of a prescription presented for fulfillment.

SHORT NAME: DRUG_UTLZTN_CD

LONG NAME: DRUG_UTLZTN_CD

TYPE: CHAR

LENGTH: 6

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): RX Line

VALUES: Six-character field that concatenates three 2-digit codes.

The 2 leftmost digits (1st and 2nd characters) are the Reason for Service Code:
AD = Additional Drug Needed
AN = Prescription Authentication
AR = Adverse Drug Reaction
AT = Additive Toxicity
CD = Chronic Disease Management
CH = Call Help Desk
CS = Patient Complaint/Symptom
DA = Drug — Allergy
DC = Drug — Disease (Inferred)
DD = Drug — Drug Interaction
DF = Drug — Food interaction
DI = Drug Incompatibility
DL = Drug — Lab Conflict
DM = Apparent Drug Misuse
DS = Tobacco Use
ED = Patient Education/Instruction
ER = Overuse
EX = Excessive Quantity
HD = High Dose
IC = Iatrogenic Condition
ID = Ingredient Duplication
LD = Low Dose
LK = Lock In Recipient
LR = Underuse
MC = Drug — Disease (Reported)
MN = Insufficient Duration
MS = Missing Information/Clarification
MX = Excessive Duration
NA = Drug Not Available
NC = Non-covered Drug Purchase

ND = New Disease/Diagnosis
NF = Non-Formulary Drug
NN = Unnecessary Drug
NP = New Patient Processing
NR = Lactation/Nursing Interaction
NS = Insufficient Quantity
OH = Alcohol Conflict
PA = Drug — Age
PC = Patient Question/Concern
PG = Drug — Pregnancy
PH = Preventive Health Care
PN = Prescriber Consultation
PP = Plan Protocol
PR = Prior Adverse Reaction
PS = Product Selection Opportunity
RE = Suspected Environmental Risk
RF = Health Provider Referral
SC = Suboptimal Compliance
SD = Suboptimal Drug/Indication
SE = Side Effect
SF = Suboptimal Dosage Form
SR = Suboptimal Regimen
SX = Drug — Gender
TD = Therapeutic
TN = Laboratory Test Needed
TP = Payer/Processor Question

The 3rd and 4th digits are the Professional Service Code:
00 = No intervention
AS = Patient assessment
CC = Coordination of care
DE = Dosing evaluation/determination
FE = Formulary enforcement
GP = Generic product selection
MA = Medication administration
M0 = Prescriber consulted
MR = Medication review
PE = Patient education/instruction
PH = Patient medication history
PM = Patient monitoring
P0 = Patient consulted
PT = Perform laboratory test
R0 = Pharmacist consulted other source
RT = Recommend laboratory test
SC = Self-care consultation
SW = Literature search/review
TC = Payer/processor consulted
TH = Therapeutic product interchange

The two rightmost digits (5th and 6th characters) are the Result of Service Code:
00 = Not Specified
1A = Filled As Is, False Positive
1B = Filled Prescription As Is
1C = Filled, With Different Dose
1D = Filled, With Different Directions
1E = Filled, With Different Drug
1F = Filled, With Different Quantity
1G = Filled, With Prescriber Approval
1H = Brand-to-Generic Change
1J = Rx-to-OTC Change
1K = Filled with Different Dosage Form
2A = Prescription Not Filled
2B = Not Filled, Directions Clarified
3A = Recommendation Accepted
3B = Recommendation Not Accepted
3C = Discontinued Drug
3D = Regimen Changed
3E = Therapy Changed
3F = Therapy Changed — cost increased acknowledged
3G = Drug Therapy Unchanged
3H = Follow-Up/Report
3J = Patient Referral
3K = Instructions Understood
3M = Compliance Aid Provided
3N = Medication Administered
Null/missing = source value is missing or unknown

COMMENT: The T-MSIS Drug Utilization Code data element is composite field comprised of three distinct NCPDP data elements: "Reason for Service Code" (439-E4); "Professional Service Code" (440-E5); and "Result of Service Code" (441-E6). All 3 of these NCPDP fields are situationally required and independent of one another. Pharmacists may report none, one, two or all three. NCPDP situational rules call for one or more of these values in situations where the field(s) could result in different coverage, pricing, patient financial responsibility, drug utilization review outcome, or if the information affects payment for, or documentation of, professional pharmacy service.

1. The NCPDP "Reason of Service Code" (bytes 1 and 2 of this variable) explains whether the pharmacist filled the prescription, filled part of the prescription, etc. This variable is called RSN_SRVC_CD in the data file.

2. The NCPDP "Professional Service Code" (bytes 3 and 4 of this variable) describes what the pharmacist did for the patient. This variable is called PROF_SRVC_CD in the data file.

3. The NCPDP "Result of Service Code" (bytes 5 and 6 of this variable) describes the action the pharmacist took in response to a conflict or the result of a pharmacist's professional service. This variable is called RSLT_SRVC_CD in the data file.

All six bytes should be populated if any of the three NCPDP fields has a value. ^ Back to TOC ^

DSCHRG_DT

LABEL: Discharge Date

DESCRIPTION: The date on which the recipient was discharged from a hospital, psychiatric, or long-term care facility.

SHORT NAME: DSCHRG_DT

LONG NAME: DSCHRG_DT

TYPE: DATE

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header

VALUES: Date (numeric, system dependent)
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

DSCHRG_HR

LABEL: Discharge Hour

DESCRIPTION: The time of discharge from a hospital or long-term care/psychiatric facility.

SHORT NAME: DSCHRG_HR

LONG NAME: DSCHRG_HR

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header

VALUES:
00 = 0:00–0:59
01 = 1:00–1:59
02 = 2:00–2:59
03 = 3:00–3:59
04 = 4:00–4:59
05 = 5:00–5:59
06 = 6:00–6:59
07 = 7:00–7:59
08 = 8:00–8:59
09 = 9:00–9:59
10 = 10:00–10:59
11 = 11:00–11:59
12 = 12:00–12:59
13 = 13:00–13:59
14 = 14:00–14:59
15 = 15:00–15:59
16 = 16:00–16:59
17 = 17:00–17:59
18 = 18:00–18:59
19 = 19:00–19:59
20 = 20:00–20:59
21 = 21:00–21:59
22 = 22:00–22:59
23 = 23:00–23:59
Null/missing = source value is missing or unknown

COMMENT: A 24-hour clock is used (e.g., 5:00 am is 05:00 and 5:00 pm is 17:00).

^ Back to TOC ^

DSPNSNG_FEE_AMT

LABEL: Dispensing Fee Amount

DESCRIPTION: The charge to cover the cost of dispensing the prescription. Dispensing costs include overhead, supplies, and labor, etc. to fill the prescription.

SHORT NAME: DSPNSNG_FEE_AMT

LONG NAME: DSPNSNG_FEE_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): RX Line

VALUES: Dollar amount with two decimal places (e.g., 98.76)
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

DSPNSNG_PRVDR_ID

LABEL: Dispensing Provider Identification Number

DESCRIPTION: The state-specific provider ID of the provider who actually dispensed the prescription medication

SHORT NAME: DSPNSNG_PRVDR_ID

LONG NAME: DSPNSNG_PRVDR_ID

TYPE: CHAR

LENGTH: 30

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): RX Header

VALUES: Valid values are supplied by the state
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

DSPNSNG_PRVDR_NPI

LABEL: Dispensing Provider NPI

DESCRIPTION: The National Provider ID (NPI) of the provider responsible for dispensing the prescription drug

SHORT NAME: DSPNSNG_PRVDR_NPI

LONG NAME: DSPNSNG_PRVDR_NPI

TYPE: CHAR

LENGTH: 10

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): RX Header

VALUES: Valid characters include only numbers (0–9)

https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/

Null/missing = source value is missing or unknown

COMMENT: Values and websites referenced may change over time.

To search CMS's NPI registry, you may use the following link: https://npiregistry.cms.hhs.gov/

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FED_SRVC_CTGRY_CD

LABEL: Federally Assigned Service Category Code Added During TAF Production

DESCRIPTION: A federally-assigned service category code added during TAF production using a standard methodology to classify similar types of service use records across all claim files and across both fee-for-service and managed care encounter records. It also allows for consistent identification of non-claim financial transactions, including managed care capitation records, other per-member-per-month payments, and DSH payments.

SHORT NAME: FED_SRVC_CTGRY_CD

LONG NAME: FED_SRVC_CTGRY_CD

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S):
IP Header
LT Header
OT Header
RX Header

VALUES:
11 = Managed care capitation payments (CMC, PHP)
12 = Other per-member per-month (PMPM) payments (PCCM, premium assistance payments, other)
13 = Disproportionate share hospital (DSH) claims
14 = Other financial transactions
21 = Inpatient hospital
22 = Nursing facility
23 = Intermediate care
24 = Any other overnight or residential facility
25 = Hospice
26 = Outpatient hospital
27 = Clinic
28 = Any other outpatient facility/institutional claims
31 = Radiology
32 = Laboratory
33 = Home health
34 = Transportation services
35 = Dental
36 = Other home and community-based services (HCBS)
37 = Durable medical equipment
38 = Physician and all other professional claims
41 = Prescription drug
Null/missing = source value is missing or unknown

COMMENT: Not all FASC codes are applicable to each claim type. Technical documentation for the Federally-Assigned Service Category Code is available in DQ Atlas. Navigate to the "DQ Atlas Resources" page, and then expand the "Additional data quality information" box: https://www.medicaid.gov/dq-atlas/landing/resources/downloads

In Illinois, because of the unique situation with their final action claims, FED_SRVC_CTGRY_CD is assigned to only original claims.

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FIXD_PYMT_IND

LABEL: Fixed Payment Indicator

DESCRIPTION: This indicator indicates that the reimbursement amount included on the claim is for a fixed payment

SHORT NAME: FIXD_PYMT_IND

LONG NAME: FIXD_PYMT_IND

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: 0 = Not Fixed Payment
1 = Fee-for-service (FFS) Fixed Payment
Null/missing = source value is missing or unknown

COMMENT: Fixed payments are made by the state to insurers or providers for premiums or eligible coverage, not for a particular service. For example, some states have Primary Care Case Management (PCCM) programs where the state pays providers a monthly patient management fee of $3.50 for each eligible participant under their care. This fee is considered a fixed payment.

It is very important for states to correctly identify fixed payments. Fixed payments do not have a defined “medical record” associated with the payment; therefore, fixed payments are not subject to medical record request and medical record review.

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FUNDNG_CD

LABEL: Code to Indicate Source of Non-Federal Funding

DESCRIPTION: A code to indicate the source of non-federal share funds

SHORT NAME: FUNDNG_CD

LONG NAME: FUNDNG_CD

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: A = Medicaid Agency
B = Children's Health Insurance Program (CHIP) Agency
C = Mental Health Service Agency
D = Education Agency
E = Child and Family Services Agency
F = County
G = City
H = Providers
I = Other
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

FUNDNG_SRC_NON_FED_SHR_CD

LABEL: Funding Source Non-Federal Share Code

DESCRIPTION: A code to indicate the type of non-federal share used by the state to finance its expenditure to the provider

SHORT NAME: FUNDNG_SRC_NON_FED_SHR_CD

LONG NAME: FUNDNG_SRC_NON_FED_SHR_CD

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: 01 = State appropriations to the Medicaid agency
02 = Intergovernmental transfers (IGT)
03 = Certified public expenditures (CPE)
04 = Provider taxes
05 = Donations
06 = State appropriations to the Children's Health Insurance Program (CHIP) agency
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

HAC_IND

LABEL: Health Care Acquired Condition (HAC) Indicator

DESCRIPTION: This code indicates whether the beneficiary included on the claim has a Health Care Acquired Condition (HAC)

SHORT NAME: HAC_IND

LONG NAME: HAC_IND

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header

VALUES: 0 = No
1 = Yes
Null/missing = source value is missing or unknown

COMMENT: —

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HCBS_SRVC_CD

LABEL: Home- and Community-Based Services Service Code

DESCRIPTION: Codes indicating that the service represents a long-term care home and community-based service (HCBS) or support for an individual with chronic medical and/or mental conditions. The codes are to help clearly delineate between acute care and long-term care provided in the home and community setting (e.g., 1915(c), 1915(i), 1915(j), and 1915(k) services).

SHORT NAME: HCBS_SRVC_CD

LONG NAME: HCBS_SRVC_CD

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Line

VALUES:
1 = The HCBS service was provided under 1915(i)
2 = The HCBS service was provided under 1915(j)
3 = The HCBS service was provided under 1915(k)
4 = The HCBS service was provided under a 1915(c) HCBS Waiver
5 = The HCBS service was provided under an 1115 waiver
6 = The HCBS service was not provided under the statutes identified above and was of an acute care nature
7 = The HCBS service was not provided under the statutes identified above and was of a long-term care nature
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

HCBS_TXNMY_CD

LABEL: Home- and Community-Based Services Taxonomy Code

DESCRIPTION: A code that classifies home and community-based services (HCBS) listed on the claim into the HCBS taxonomy.

SHORT NAME: HCBS_TXNMY_CD

LONG NAME: HCBS_TXNMY_CD

TYPE: CHAR

LENGTH: 5

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Line

VALUES:
01010 = Case Management
02011 = Group Living, Residential Habilitation
02012 = Group Living, Mental Health Services
02013 = Group Living, Other
02021 = Shared Living, Residential Habilitation
02022 = Shared Living, Mental Health Services
02023 = Shared Living, Other
02031 = In-e Residential Habilitation
02032 = In-Home Round-The-Clock Mental Health Services
02033 = In-Home Round-The-Clock Services, Other
03010 = Job Development
03021 = Ongoing Supported Employment, Individual
03022 = Ongoing Supported Employment, Group
03030 = Career Planning
04010 = Prevocational Services
04020 = Day Habilitation
04030 = Education Services
04040 = Day Treatment/Partial Hospitalization
04050 = Adult Day Health
04060 = Adult Day Services (Social Model)
04070 = Community Integration
04080 = Medical Day Care for Children
05010 = Private Duty Nursing
05020 = Skilled Nursing
06010 = Home Delivered Meals
07010 = Rent and Food Expenses For Live-In Caregiver
08010 = Home-Based Habilitation
08020 = Home Health Aide
08030 = Personal Care
08040 = Companion
08050 = Homemaker

08060 = Chore
09011 = Respite, Out-Of-Home
09012 = Respite, In-Home
09020 = Caregiver Counseling and/or Training
10010 = Mental Health Assessment
10020 = Assertive Community Treatment
10030 = Crisis Intervention
10040 = Behavior Support
10050 = Peer Specialist
10060 = Counseling
10070 = Psychosocial Rehabilitation
10080 = Clinic Services
10090 = Other Mental Health and Behavioral Services
11010 = Health Monitoring
11020 = Health Assessment
11030 = Medication Assessment and/or Management
11040 = Nutrition Consultation
11050 = Physician Services
11060 = Prescription Drugs
11070 = Dental Services
11080 = Occupational Therapy
11090 = Physical Therapy
11100 = Speech, Hearing, And Language Therapy
11110 = Respiratory Therapy
11120 = Cognitive Rehabilitative Therapy
11130 = Other Therapies
12010 = Financial Management Services In Support Of Participant Direction
12020 = Information and Assistance In Support Of Participant Direction
13010 = Participant Training
14010 = Personal Emergency Response System (Pers)
14020 = Home and/or Vehicle Accessibility Adaptations
14031 = Equipment and Technology
14032 = Supplies
15010 = Non-Medical Transportation
16010 = Community Transition Services
17010 = Goods and Services
17020 = Interpreter
17030 = Housing Consultation
17990 = Other
Null/missing = source value is missing or unknown

COMMENT: Values containing digits will include leading zeros.

Values and websites referenced may change over time.

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HLTH_HOME_ENT_NAME

LABEL: Health Home Entity Name

DESCRIPTION: A free-form text field to indicate the health home program that authorized payment for the service on the claim. The name entered should be the name that the state uses to uniquely identify the team. A "Health Home Entity" can be a designated provider (e.g., physician, clinic, behavioral health organization), a health team which links to a designated provider, or a health team (physicians, nurses, behavioral health professionals).

SHORT NAME: HLTH_HOME_ENT_NAME

LONG NAME: HLTH_HOME_ENT_NAME

TYPE: CHAR

LENGTH: 50

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Header

VALUES: The field can contain any alphanumeric characters, digits or symbols
Null/missing = source value is missing or unknown

COMMENT: Because an identification numbering schema has not been established, the entities' names are being used instead.

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HLTH_HOME_PRVDR_IND

LABEL: Health Home Provider Indicator

DESCRIPTION: This code indicates whether the claim is submitted by a provider or provider group enrolled in the Health Home care model. Health home providers provide service for patients with chronic illnesses.

SHORT NAME: HLTH_HOME_PRVDR_IND

LONG NAME: HLTH_HOME_PRVDR_IND

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Header

VALUES: 0 = No
1 = Yes
Null/missing = source value is missing or unknown

COMMENT: —

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HLTH_HOME_PRVDR_NPI

LABEL: Health Home Provider NPI

DESCRIPTION: The National Provider ID (NPI) of the health home provider.

SHORT NAME: HLTH_HOME_PRVDR_NPI

LONG NAME: HLTH_HOME_PRVDR_NPI

TYPE: CHAR

LENGTH: 10

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Header

VALUES: https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/

Null/missing = source value is missing or unknown

COMMENT: Values and websites referenced may change over time.

To search CMS's NPI registry, you may use the following link: https://npiregistry.cms.hhs.gov/

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HOSP_TYPE_CD

LABEL: Hospital Type Code

DESCRIPTION: This code denotes the type of hospital on the claim (servicing provider)

SHORT NAME: HOSP_TYPE_CD

LONG NAME: HOSP_TYPE_CD

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header

VALUES:
00 = Not a hospital
01 = Inpatient Hospital
02 = Outpatient Hospital
03 = Critical Access Hospital
04 = Swing Bed Hospital
05 = Inpatient Psychiatric Hospital
06 = IHS Hospital
07 = Children's Hospital
08 = Other
Null/missing = source value is missing or unknown

COMMENT: —

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IMNZTN_TYPE_CD

LABEL: Immunization Type Code

DESCRIPTION: This field identifies the type of immunization provided in order to track additional detail not currently contained in CPT codes.

SHORT NAME: IMNZTN_TYPE_CD

LONG NAME: IMNZTN_TYPE_CD

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): All Line Files

VALUES:

00 = None
01 = Anthrax
02 = Cervical Cancer
03 = Diphtheria
04 = Hepatitis A
05 = Hepatitis B
06 = Haemophilus Influenza Type B (HIB)
07 = Human Papillomavirus (HPV)
08 = H1N1 Flu
09 = Seasonal Flu
10 = Japanese Encephalitis
11 = Lyme Disease
12 = Measles
13 = Meningococcal
14 = Monkey pox
15 = Mumps
16 = Pertussis
17 = Pneumococcal
18 = Poliomyelitis
19 = Rabies
20 = Rotavirus
21 = Rubella
22 = Shingles
23 = Smallpox
24 = Tetanus
25 = Tuberculosis
26 = Typhoid Fever
27 = Varicella
28 = Yellow Fever
29 = Other
Null/missing = source value is missing or unknown

COMMENT: —

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IP_ACCMDTN_HCPCS_RATE

LABEL: Inpatient Hospital Accommodation Rate

DESCRIPTION: For inpatient hospital facility claims, the accommodation rate is captured here.

SHORT NAME: IP_ACCMDTN_HCPCS_RATE

LONG NAME: IP_ACCMDTN_HCPCS_RATE

TYPE: CHAR

LENGTH: 14

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Line

VALUES: Null/missing = source value is missing or unknown

COMMENT: This data element is expected to capture data from the HIPAA 837I claim loop 2400 SV206 or UB-04 FL 44 (only if the value represents an accommodation rate).

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IP_FIL_DT

LABEL: Inpatient File Date — Represents the Year and Month of the Reporting Period

DESCRIPTION: This field represents the year and month of the reporting period.

SHORT NAME: IP_FIL_DT

LONG NAME: IP_FIL_DT

TYPE: DATE

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header

VALUES: YYYYMM (e.g., 201507 is the date for the July 2015 file)

COMMENT: Claims for this time period are in the file.

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IP_MH_DGNS_IND

LABEL: Mental Health Diagnosis Indicator

DESCRIPTION: Indicator that identifies if diagnosis code on claim is related to mental health care.

SHORT NAME: IP_MH_DGNS_IND

LONG NAME: IP_MH_DGNS_IND

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS Analytic File (TAF) Claims (derived)

FILE(S): IP Header

VALUES: 0 = Not a Mental Health (MH) claim
1 = MH Claim
Null/missing = source value is missing or unknown

COMMENT: This variable is derived in the TAF using ICD-9 codes 290–302 and 306–319 and ICD-10 codes F01–F09 and F20–F99 to identify mental health-related claims.

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IP_MH_TXNMY_IND

LABEL: Mental Health Provider Taxonomy Indicator

DESCRIPTION: Indicator that identifies if the provider taxonomy on the claim is related to mental health care. Taxonomies for mental health treatment providers and facilities used to identify claims for mental health care.

SHORT NAME: IP_MH_TXNMY_IND

LONG NAME: IP_MH_TXNMY_IND

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS Analytic File (TAF) Claims (derived)

FILE(S): IP Header

VALUES:
0: Neither billing provider nor servicing provider(s) on claim are Mental health (MH) providers
1: Both MH billing provider and servicing provider(s) on claim
2: Only MH billing provider on claim
3: Only MH servicing provider(s) on claim
Null/missing = Source value is missing or unknown

COMMENT: This variable is derived in the TAF using Taxonomy codes for MH:

Codes	Classification and area of specialization
(a) Individual or Groups of Individuals	
101200000X	Drama Therapist
101Y00000X	Behavioral Health and Social Service Providers: Counselor
101YM0800X	Behavioral Health and Social Service Providers: Counselor, Mental Health
101YP1600X	Behavioral Health and Social Service Providers: Counselor, Pastoral
101YP2500X	Behavioral Health and Social Service Providers: Counselor, Professional
101YS0200X	Behavioral Health and Social Service Providers: Counselor, School
102L00000X	Behavioral Health and Social Service Providers: Psychoanalyst
102X00000X	Behavioral Health and Social Service Providers: Poetry Therapist
103G00000X	Behavioral Health and Social Service Providers: Clinical Neuropsychologist
103GC0700X	Behavioral Health and Social Service Providers: Clinical Neuropsychologist, Clinical
103K00000X	Behavioral Health and Social Service Providers: Behavior Analyst
103T00000X	Behavioral Health and Social Service Providers: Psychologist
103TA0700X	Behavioral Health and Social Service Providers: Psychologist, Adult Development and Aging
103TB0200X	Behavioral Health and Social Service Providers: Psychologist, Cognitive and Behavioral
103TC0700X	Behavioral Health and Social Service Providers: Psychologist, Clinical
103TC1900X	Behavioral Health and Social Service Providers: Psychologist, Counseling
103TC2200X	Behavioral Health and Social Service Providers: Psychologist, Clinical Child and Adolescent
103TE1000X	Behavioral Health and Social Service Providers: Psychologist, Educational

103TE1100X	Behavioral Health and Social Service Providers: Psychologist, Exercise and Sports
103TF0000X	Behavioral Health and Social Service Providers: Psychologist, Family
103TF0200X	Behavioral Health and Social Service Providers: Psychologist, Forensic
103TH0004X	Behavioral Health and Social Service Providers: Psychologist, Health
103TH0100X	Behavioral Health and Social Service Providers: Psychologist, Health Service
103TM1700X	Behavioral Health and Social Service Providers: Psychologist, Men and Masculinity
103TM1800X	Behavioral Health and Social Service Providers: Psychologist, Mental Retardation and Developmental Disabilities
103TP0016X	Behavioral Health and Social Service Providers: Psychologist, Prescribing (Medical)
103TP0814X	Behavioral Health and Social Service Providers: Psychologist, Psychoanalysis
103TP2700X	Behavioral Health and Social Service Providers: Psychologist, Psychotherapy
103TP2701X	Behavioral Health and Social Service Providers: Psychologist, Group Psychotherapy
103TR0400X	Behavioral Health and Social Service Providers: Psychologist, Rehabilitation
103TS0200X	Behavioral Health and Social Service Providers: Psychologist, School
103TW0100X	Behavioral Health and Social Service Providers: Psychologist, Women
104100000X	Behavioral Health and Social Service Providers: Social Worker
1041C0700X	Behavioral Health and Social Service Providers: Social Worker, Clinical
1041S0200X	Behavioral Health and Social Service Providers: Social Worker, School
106E00000X	Behavioral Health and Social Service Providers: Assistant Behavior Analyst
106H00000X	Behavioral Health and Social Service Providers: Marriage and Family Therapist
106S00000X	Behavioral Health and Social Service Providers: Behavior Technician
163WP0807X	Nursing Service Providers: Registered Nurse, Psychiatric/Mental Health, Child and Adolescent
163WP0808X	Nursing Service Providers: Registered Nurse, Psychiatric/Mental Health
163WP0809X	Nursing Service Providers: Registered Nurse, Psychiatric/Mental Health, Adult
167G00000X	Nursing Service Providers: Licensed Psychiatric Technician
1835P1300X	Pharmacy Service Providers: Pharmacist, Psychiatric
2080P0006X	Allopathic and Osteopathic Physicians: Pediatrics, Developmental — Behavioral Pediatrics
2080P0008X	Allopathic and Osteopathic Physicians: Pediatrics, Neurodevelopmental Disabilities
2084B0040X	Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Behavioral Neurology and Neuropsychiatry
2084F0202X	Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Forensic Psychiatry
2084P0005X	Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Neurodevelopmental Disabilities
2084P0015X	Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Psychosomatic Medicine
2084P0800X	Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Psychiatry
2084P0804X	Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Child and Adolescent Psychiatry
2084P0805X	Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Geriatric Psychiatry
225XM0800X	Respiratory, Developmental, Rehabilitative and Restorative Service Providers: Occupational Therapist, Mental Health
363LP0808X	Physician Assistants and Advanced Practice Nursing Providers: Nurse Practitioner, Psychiatric/Mental Health
364SP0807X	Physician Assistants and Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health, Child and Adolescent

364SP0808X	Physician Assistants and Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health
364SP0809X	Physician Assistants and Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health, Adult
364SP0810X	Physician Assistants and Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health, Child and Family
364SP0811X	Physician Assistants and Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health, Chronically Ill
364SP0812X	Physician Assistants and Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health, Community
364SP0813X	Physician Assistants and Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health, Geropsychiatric

(b) Non-Individual

251S00000X	Agencies: Community/Behavioral Health
252Y00000X	Agencies: Early Intervention Provider Agency
261QM0801X	Ambulatory Health Care Facilities: Clinic/Center, Mental Health (Including Community Mental Health Center)
261QM0850X	Ambulatory Health Care Facilities: Clinic/Center, Adult Mental Health
261QM0855X	Ambulatory Health Care Facilities: Clinic/Center, Adolescent and Children Mental Health
273R00000X	Hospital Units: Psychiatric Unit
283Q00000X	Hospitals: Psychiatric Hospital
3104A0625X	Nursing and Custodial Care Facilities: Assisted Living Facility, Assisted Living, Mental Illness
3104A0630X	Nursing and Custodial Care Facilities: Assisted Living Facility, Assisted Living, Behavioral Disturbances
310500000X	Nursing and Custodial Care Facilities: Intermediate Care Facility, Mental Illness
311500000X	Nursing and Custodial Care Facilities: Alzheimer Center (Dementia Center)
315P00000X	Nursing and Custodial Care Facilities: Intermediate Care Facility, Mentally Retarded
320600000X	Residential Treatment Facilities: Residential Treatment Facility, Mental Retardation and/or Developmental Disabilities
320800000X	Residential Treatment Facilities: Community Based Residential Treatment Facility, Mental Illness
320900000X	Residential Treatment Facilities: Community Based Residential Treatment Facility, Mental Retardation and/or Developmental Disabilities
320900000X	Residential Treatment Facilities: Community Based Residential Treatment Facility, Mental Retardation and/or Developmental Disabilities
322D00000X	Residential Treatment Facilities: Residential Treatment Facility, Emotionally Disturbed Children
323P00000X	Residential Treatment Facilities: Psychiatric Residential Treatment Facility
385HR2055X	Respite Care Facility: Respite Care, Respite Care, Mental Illness, Child
385HR2060X	Respite Care Facility: Respite Care, Respite Care, Mental Retardation and/or Developmental Disabilities

For Mental Health Taxonomy Codes visit: http://www.wpc-edi.com/reference/

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IP_SUD_DGNS_IND

LABEL: Substance Use Disorder Diagnosis Indicator

DESCRIPTION: Indicator that identifies if diagnosis code on the claim is related to substance use.

SHORT NAME: IP_SUD_DGNS_IND

LONG NAME: IP_SUD_DGNS_IND

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS Analytic File (TAF) Claims (derived)

FILE(S): IP Header

VALUES: 0 = Not substance use diagnosis (SUD) claim
1 = SUD Claim
Null/missing = source value is missing or unknown

COMMENT: This variable is derived in the TAF using ICD-9 codes 303–305 and ICD-10 codes F10–F19 to identify substance use-related claims.

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IP_SUD_TXNMY_IND

LABEL: Substance Use Disorder Provider Taxonomy Indicator

DESCRIPTION: Indicator that identifies whether the billing and/or servicing provider are substance use disorders (SUD) providers. Taxonomies for substance use treatment providers and facilities are used to identify substance use-related claims.

SHORT NAME: IP_SUD_TXNMY_IND

LONG NAME: IP_SUD_TXNMY_IND

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS Analytic File (TAF) Claims (derived)

FILE(S): IP Header

VALUES:
0 = Neither billing provider nor servicing provider(s) on claim are substance use disorders (SUD) providers
1 = Both SUD billing provider and servicing provider(s) on claim
2 = Only SUD billing provider on claim
3 = Only SUD servicing provider(s) on claim
Null/missing = source value is missing or unknown

COMMENT: This variable is derived in the TAF using Taxonomy codes for SUD:

Codes	Classification and area of specialization
(a) Individual or Groups of Individuals	
101YA0400X	Behavioral Health and Social Service Providers: Counselor, Addiction (Substance Use Disorder)
103TA0400X	Behavioral Health and Social Service Providers: Psychologist, Addiction (Substance Use Disorder)
163WA0400X	Nursing Service Providers: Registered Nurse, Addiction (Substance Use Disorder)
207LA0401X	Allopathic and Osteopathic Physicians: Anesthesiology, Addiction Medicine
207QA0401X	Allopathic and Osteopathic Physicians: Family Medicine, Addiction Medicine
207RA0401X	Allopathic and Osteopathic Physicians: Internal Medicine, Addiction Medicine
2084A0401X	Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Addiction Medicine
2084P0802X	Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Addiction Psychiatry
2083A0300X	Preventive Medicine — Addiction Medicine
(b) Non-Individual	
261QM2800X	Ambulatory Health Care Facilities: Clinic/Center, Methadone
261QR0405X	Ambulatory Health Care Facilities: Clinic/Center, Rehabilitation, Substance Use Disorder
276400000X	Hospital Units: Rehabilitation, Substance Use Disorder Unit
324500000X	Residential Treatment Facilities: Substance Abuse Rehabilitation Facility

3245S0500X	Residential Treatment Facilities: Substance Abuse Rehabilitation Facility, Substance Abuse Treatment, Children

For Substance Use Disorder Taxonomy Codes, please visit http://www.wpc-edi.com/reference/

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IP_VRSN

LABEL: Inpatient Version Representing the Iteration of the File

DESCRIPTION: Indicator representing the iteration of the file.

SHORT NAME: IP_VRSN

LONG NAME: IP_VRSN

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims (derived)

FILE(S): IP Header

VALUES: Two-digit values from 01–XX

COMMENT: A version number where the value 01 is assigned to the original monthly file, and the version number is increased by one for each subsequent month in which one or more replacement files are generated after the original month in which the file was generated. The higher the number, the more time has elapsed following the dates of service in the file.

This variable will never contain NULL values

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LEAVE_DAYS

LABEL: Count of Days During Medicaid Coverage Period when Patient was not Residing in LTC

DESCRIPTION: The number of days, during the period covered by Medicaid, on which the patient did not reside in the long-term care (LTC) facility.

SHORT NAME: LEAVE_DAYS

LONG NAME: LEAVE_DAYS

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): LT Header

VALUES: Numeric
Null/missing = source value is missing or unknown

COMMENT: —

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LINE_ADJUST_CD

LABEL: Claim Line Adjustment Code

DESCRIPTION: Code indicating type of adjustment record claim/encounter represents at claim detail level.

SHORT NAME: LINE_ADJUST_CD

LONG NAME: LINE_ADJUST_CD

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): All Line Files

VALUES:
0 = Original Claim/Encounter
1 = Void/Reversal of a prior submission
2 = Re-submittal
3 = Credit Adjustment (negative supplemental)
4 = Replacement/Resubmission of a prior submission
5 = Gross Credit/Gross Credit Adjustment
6 = Gross Debit/Debit Credit Adjustment
Null/missing = Source value is missing, unknown, or not on the valid value list or within the range of valid values

COMMENT: —

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LINE_ADJUST_RSN_CD

LABEL: Claim Line Adjustment Reason Code

DESCRIPTION: Claim adjustment reason codes communicate why a service line was paid differently than it was billed.

SHORT NAME: LINE_ADJUST_RSN_CD

LONG NAME: LINE_ADJUST_RSN_CD

TYPE: CHAR

LENGTH: 3

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Line

VALUES: http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/

Null/missing = source value is missing or unknown

COMMENT: Values will include leading zeros.

Values and websites referenced may change over time.

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LINE_BILLED_AMT

LABEL: Line Billed Amount

DESCRIPTION: The amount billed at the claim detail level as submitted by the provider.

SHORT NAME: LINE_BILLED_AMT

LONG NAME: LINE_BILLED_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Line
RX Line

VALUES: Dollar amount with two decimal places (e.g., 98.76); may be negative.
Null/missing = source value is missing or unknown

COMMENT: Not available for managed care claims. CMS has required redaction of some payment fields for managed care claims due to the proprietary and confidential nature of this information. The managed care records are identified as those where the claim type code (CLM_TYPE_CD) = 3, C, or W.

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LINE_CLAIM_STUS_CD

LABEL: Claim Line Status Code

DESCRIPTION: The claim line status codes identify the status of a specific detail claim line rather than the entire claim.

SHORT NAME: LINE_CLAIM_STUS_CD

LONG NAME: LINE_CLAIM_STUS_CD

TYPE: CHAR

LENGTH: 3

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): All Line Files

VALUES: https://x12.org/codes/claim-status-codes

Null/missing = source value is missing or unknown

COMMENT: Values and websites referenced may change over time.

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LINE_COPAY_AMT

LABEL: Line Beneficiary Copayment Amount

DESCRIPTION: The copayment amount paid by an enrollee for the service, which does not include the amount paid by the insurance company.

SHORT NAME: LINE_COPAY_AMT

LONG NAME: LINE_COPAY_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Line
RX Line

VALUES: Dollar amount with two decimal places (e.g., 98.76); may be negative.

COMMENT: —

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LINE_MDCD_ALOWD_AMT

LABEL: Line Medicaid Allowed Amount

DESCRIPTION: The maximum amount displayed at the claim line level as determined by the payer as being "allowable" under the provisions of the contract prior to the determination of actual payment.

SHORT NAME: LINE_MDCD_ALOWD_AMT

LONG NAME: LINE_MDCD_ALOWD_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): All Line Files

VALUES: Dollar amount with two decimal places (e.g., 98.76); may be negative.
Null/missing = source value is missing or unknown

COMMENT: Not available for managed care claims. CMS has required redaction of some payment fields for managed care claims due to the proprietary and confidential nature of this information. The managed care records are identified as those where the claim type code (CLM_TYPE_CD) = 3, C, or W.

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LINE_MDCD_FFS_EQUIV_AMT

LABEL: Line Medicaid Fee For Service Equivalent Amount

DESCRIPTION: This field should be populated with the amount that would have been paid had the services been provided on a fee-for-service (FFS) basis.

SHORT NAME: LINE_MDCD_FFS_EQUIV_AMT

LONG NAME: LINE_MDCD_FFS_EQUIV_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): All Line Files

VALUES: Dollar amount with two decimal places (e.g., 98.76); may be negative.
Null/missing = source value is missing or unknown

COMMENT: —

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LINE_MDCD_PD_AMT

LABEL: Line Medicaid Paid Amount

DESCRIPTION: The total amount paid by Medicaid or the managed care plan on this claim or adjustment at the claim detail level.

SHORT NAME: LINE_MDCD_PD_AMT

LONG NAME: LINE_MDCD_PD_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): All Line Files

VALUES: Dollar amount with two decimal places (e.g., 98.76); may be negative.
Null/missing = source value is missing or unknown

COMMENT: Not available for managed care claims. CMS has required redaction of some payment fields for managed care claims due to the proprietary and confidential nature of this information. The managed care records are identified as those where the claim type code (CLM_TYPE_CD) = 3, C, or W.

- If CLM_TYPE_CD = (1, A, U) then the amount paid by the state or their fiscal agent to a provider is found in the Line Medicaid Paid Amount (LINE_MDCD_PD_AMT) and the Total Amount Paid By Medicaid (MDCD_PD_AMT, found on the header claim) variables.
- If CLM_TYPE_CD = (2, B, V) then the amount paid by the state or their fiscal agent to a managed care plan is found in the MDCD_PD_AMT and TOT_MDCD_PD_AMT variables.
- If CLM_TYPE_CD = (5, E, Y) then the amount paid by the state or their fiscal agent to a provider of managed care plan is found in the MDCD_PD_AMT and TOT_MDCD_PD_AMT variables.
- If CLM_TYPE_CD = (3, C, W) then the amount paid by a managed care plan to a provider is found in the MDCD_PD_AMT and TOT_MDCD_PD_AMT variables. The data for some data elements that capture dollar amounts on managed care encounters, including the values reported by states in the MDCD_PD_AMT and TOT_MDCD_PD_AMT variables, are suppressed for most data users because of the proprietary nature of that information to a managed care plan's business. Data users who do have access to those dollar amounts should avoid double counting the amount paid by the state or their fiscal agent to managed care plans AND the amount paid by the managed care plan to providers.

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LINE_MDCR_COINSRNC_PD_AMT

LABEL: Line Medicare Coinsurance Amount

DESCRIPTION: The amount paid by Medicaid/CHIP or the managed care plan on this claim on the claim line level toward the beneficiary's Medicare coinsurance.

SHORT NAME: LINE_MDCR_COINSRNC_PD_AMT

LONG NAME: LINE_MDCR_COINSRNC_PD_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): RX Line

VALUES: Dollar amount with two decimal places (e.g., 98.76); may be negative.
Null/missing = source value is missing or unknown

COMMENT: Dollar amounts in this field represent payments made either by the state or their fiscal agent to providers, managed care plans, and beneficiaries or they represent payments made by managed care plans to their providers. Refer to the LINE_MDCD_PD_AMT for more information.

Not available for managed care claims. CMS has required redaction of some payment fields for managed care claims due to the proprietary and confidential nature of this information. The managed care records are identified as those where the claim type code (CLM_TYPE_CD) = 3, C, or W.

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LINE_MDCR_DDCTBL_PD_AMT

LABEL: Line Medicare Deductible Amount

DESCRIPTION: The amount paid by Medicaid/CHIP or the managed care plan on this claim at the claim line level toward the beneficiary's Medicare deductible.

SHORT NAME: LINE_MDCR_DDCTBL_PD_AMT

LONG NAME: LINE_MDCR_DDCTBL_PD_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): RX Line

VALUES: Dollar amount with two decimal places (e.g., 98.76); may be negative.
Null/missing = source value is missing or unknown

COMMENT: Dollar amounts in this field represent payments made either by the state or their fiscal agent to providers, managed care plans, and beneficiaries or they represent payments made by managed care plans to their providers. Refer to LINE_MDCD_PD_AMT for more information.

Not available for managed care claims. CMS has required redaction of some payment fields for managed care claims due to the proprietary and confidential nature of this information. The managed care records are identified as those where the claim type code (CLM_TYPE_CD) = 3, C, or W.

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LINE_MDCR_PD_AMT

LABEL: Line Medicare Paid Amount

DESCRIPTION: The amount paid by Medicare on this claim line or adjustment line.

SHORT NAME: LINE_MDCR_PD_AMT

LONG NAME: LINE_MDCR_PD_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Line
RX Line

VALUES: Dollar amount with two decimal places (e.g., 98.76); may be negative.
Null/missing = source value is missing or unknown

COMMENT: —

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LINE_NUM

LABEL: Sequential Claim Line Number

DESCRIPTION: This variable identifies an individual line number on a claim.

SHORT NAME: LINE_NUM

LONG NAME: LINE_NUM

TYPE: NUM

LENGTH: 3

SOURCE: T-MSIS Analytic File (TAF) Claims (derived)

FILE(S): All Line Files

VALUES: 1–XXX

COMMENT: Each claim line has a sequential line number to distinguish distinct services that are submitted on the same claim. They will have the same CLM_ID.

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LINE_NUM_ADJ

LABEL: Adjustment Claim Line Number

DESCRIPTION: A unique number to identify the transaction line number that is being reported on the adjustment internal control number (ICN).

SHORT NAME: LINE_NUM_ADJ

LONG NAME: LINE_NUM_ADJ

TYPE: CHAR

LENGTH: 3

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): All Line Files

VALUES: Valid characters in the text string are limited to alpha characters (A–Z), numbers (0–9)
Null/missing = source value is missing or unknown

COMMENT: State assigned number used to identify/link an adjustment record with a header claim record.

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LINE_NUM_ORIG

LABEL: Original Claim Line Number

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

SHORT NAME: LINE_NUM_ORIG

LONG NAME: LINE_NUM_ORIG

TYPE: CHAR

LENGTH: 3

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): All Line Files

VALUES: Valid characters in the text string are limited to alpha characters (A–Z), numbers (0–9)
Null/missing = source value is missing or unknown

COMMENT: —

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LINE_OTHR_INSRNC_PD_AMT

LABEL: Line Other Than Medicare or Medicaid-Insurance Paid Amount

DESCRIPTION: The amount paid by insurance other than Medicare or Medicaid on this claim.

SHORT NAME: LINE_OTHR_INSRNC_PD_AMT

LONG NAME: LINE_OTHR_INSRNC_PD_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): All Line Files

VALUES: Dollar amount with two decimal places (e.g., 98.76); may be negative.
Null/missing = source value is missing or unknown

COMMENT: —

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LINE_PRCDR_CCS_CTGRY_CD

LABEL: Line Procedure AHRQ Clinical Classifications Software Refined (CCSR) Category Cd

DESCRIPTION: AHRQ Clinical Classifications Software (CCS) procedure category code. The Clinical Classifications Software Refined (CCSR) aggregates International Classification of Diseases, 10th Revision, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) codes into clinically meaningful categories. The CCSR for ICD-10-PCS procedures aggregates more than 80,000 ICD-10-PCS procedure codes into over 320 clinical categories across 31 clinical domains.

SHORT NAME: LINE_PRCDR_CCS_CTGRY_CD

LONG NAME: LINE_PRCDR_CCS_CTGRY_CD

TYPE: CHAR

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Line

VALUES: Eight-character alpha-numeric value; first three characters classify the clinical domains (refer to COMMENT)
Ex: ADM010 = Vaccinations
Null/missing = source value is missing or unknown

COMMENT: AHRQ maintains the list of values at the following link; scroll to the "Downloading Information for the Tool and Documentation" portion of the page: https://www.hcup-us.ahrq.gov/toolssoftware/ccsr/prccsr.jsp.

CMS used the CCSR v2021.2 software to populate this field. CCSR uses the first three characters to indicate which of the 31 clinical domains applies. In the TAF the CCSR was mapped to the OT Line Procedure Code (variable called LINE_PRCDR_CD) The 31 clinical domains are:

Abbreviation **CCSR Clinical Domain**
ADM = Administration of Therapeutic Substances
CAR = Cardiovascular Procedures
CHP = Chiropractic Treatment
CNS = Central Nervous System Procedures
ENP = Endocrine Procedures
ENT = Ear, Nose, and Throat Procedures
ESA = Extracorporeal or Systemic Assistance and Performance
EST = Extracorporeal or Systemic Therapies
EYP = Eye Procedures
FRS = Female Reproductive System Procedures
GIS = Gastrointestinal System Procedures
GNR = General Region Procedures
HEP = Hepatobiliary and Pancreas Procedures
IMG = Imaging
LYM = Lymphatic and Hemic System Procedures

MAM = Measurement and Monitoring
MHT = Mental Health Therapy
MRS = Male Reproductive System Procedures
MST = Musculoskeletal, Subcutaneous Tissue, and Fascia Procedures
NCM = Nuclear Medicine
OST = Osteopathic Treatment
OTR = Other Procedures
PGN = Pregnancy-Related Procedures
PLC = Dressings and Other Placements
PNS = Peripheral Nervous System Procedures
RAD = Radiation Therapy
RES = Respiratory System Procedures
RHB = Rehabilitation, Evaluation, and Treatment
SKB = Skin and Breast Procedures
SUD = Substance Use Disorder Treatment
URN = Urinary System Procedures

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LINE_PRCDR_CD

LABEL: Line Procedure Code

DESCRIPTION: A field to capture the CPT or HCPCS code that describes a service or good rendered by the provider to an enrollee on the specified date of service.

SHORT NAME: LINE_PRCDR_CD

LONG NAME: LINE_PRCDR_CD

TYPE: CHAR

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Line

VALUES: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html

Null/missing = source value is missing or unknown

COMMENT: The variable called Line procedure code system/nomenclature (LINE_PRCDR_CD_SYS) is used to identify whether a CPT or HCPCS code is used.

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LINE_PRCDR_CD_DT

LABEL: Date Line Procedure Performed

DESCRIPTION: The date upon which the procedure was performed.

SHORT NAME: LINE_PRCDR_CD_DT

LONG NAME: LINE_PRCDR_CD_DT

TYPE: DATE

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Line

VALUES: Date (numeric, system dependent)
Null/missing = source value is missing or unknown

COMMENT: Date of the LINE_PRCDR_CD.

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LINE_PRCDR_CD_SYS

LABEL: Line Procedure Code System/Nomenclature

DESCRIPTION: A flag that identifies the coding system used for the procedure code on the line file (variable called LINE_PRCDR_CD).

SHORT NAME: LINE_PRCDR_CD_SYS

LONG NAME: LINE_PRCDR_CD_SYS

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Line

VALUES:
01 = CPT 4
02 = ICD-9 CM
06 = HCPCS (Both National and Regional HCPCS) and Current Dental Terminology (CDT)
07 = ICD-10-PCS (Was implemented on 10/1/2015)
10–87 = State-specific coding systems
Null/missing = Source value is missing or unknown

COMMENT: —

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LINE_PRCDR_MDFR_CD_1

LINE_PRCDR_MDFR_CD_2

LINE_PRCDR_MDFR_CD_3

LINE_PRCDR_MDFR_CD_4

LABEL: Line Procedure Code Modifier Code (1–4)

DESCRIPTION: These are fields to capture a modifier code associated with the LINE_PRCDR_CD field on the OT claim line. The first modifier is reported in LINE_PRCDR_MDFR_CD_1. If more than one modifier is reported, the additional codes are in fields LINE_PRCDR_MDFR_CD_2 through LINE_PRCDR_MDFR_CD_4.

SHORT NAME:

LINE_PRCDR_MDFR_CD_1	LINE_PRCDR_MDFR_CD_3
LINE_PRCDR_MDFR_CD_2	LINE_PRCDR_MDFR_CD_4

LONG NAME:

LINE_PRCDR_MDFR_CD_1	LINE_PRCDR_MDFR_CD_3
LINE_PRCDR_MDFR_CD_2	LINE_PRCDR_MDFR_CD_4

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Line

VALUES: CMS HCPCS modifier codes:
https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html
AMA CPT modifier codes:
https://www.ama-assn.org/practice-management/cpt/finding-coding-resources
Ambulance modifier codes:
https://www.cms.gov/files/document/origin-and-destination-codes-specific-ambulance-service-claims-and-emergency-triage-treat-and.pdf
Null/missing = Source value is missing or unknown

COMMENT: Additional valid values can be supplied by the state.

Values and websites referenced may change over time.

There is no single comprehensive list for procedure modifier codes, since each payer publishes only the codes that are applicable to that payer's billing policy. Payers normally split the codes based on the group that holds the rights to them. Therefore, the user should refer to the links to CMS HCPCS modifier codes, AMA CPT modifier codes and ambulance modifier codes that are provided in the "VALUES" section above for a more comprehensive summary of the codes.

More information on procedure code modifiers can be found here: https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00003604 ^ Back to TOC ^

LINE_SRVC_BGN_DT

LABEL: Claim Line Beginning Date of Service

DESCRIPTION: For services received during a single encounter with a provider, the date the service was received. For services involving multiple encounters on different days, or periods of care extending over two or more days, this would be the date on which the service began. For capitation premium payments, the date on which the period of coverage related to this payment began.

SHORT NAME: LINE_SRVC_BGN_DT

LONG NAME: LINE_SRVC_BGN_DT

TYPE: DATE

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Line
LT Line
OT Line

VALUES: Date (numeric, system dependent)
Null/missing = source value is missing or unknown

COMMENT: —

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LINE_SRVC_END_DT

LABEL: Claim Line Ending Date of Service

DESCRIPTION: For services received during a single encounter with a provider, the date the service was received. For services involving multiple encounters on different days, or periods of care extending over two or more days, the date on which the service ended. For capitation premium payments, the date on which the period of coverage related to this payment ends/ended.

SHORT NAME: LINE_SRVC_END_DT

LONG NAME: LINE_SRVC_END_DT

TYPE: DATE

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Line
LT Line
OT Line

VALUES: Date (numeric, system dependent)
Null/missing = source value is missing or unknown

COMMENT: —

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LINE_TP_PD_AMT

LABEL: Line Third Party Liability Paid Amount

DESCRIPTION: Third Party Liability (TPL) refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a state plan. This is the total amount denoted at the header claim level paid by the third party.

SHORT NAME: LINE_TP_PD_AMT

LONG NAME: LINE_TP_PD_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): LT Line
OT Line
RX Line

VALUES: Dollar amount with two decimal places (e.g., 98.76)
Null/missing = source value is missing or unknown

COMMENT: —

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LT_ACCMDTN_HCPCS_RATE

LABEL: Long-Term Care Accommodation Rate

DESCRIPTION: For long-term care facility claims, the accommodation rate is captured here.

SHORT NAME: LT_ACCMDTN_HCPCS_RATE

LONG NAME: LT_ACCMDTN_HCPCS_RATE

TYPE: CHAR

LENGTH: 14

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): LT Line

VALUES: Null/missing = source value is missing or unknown

COMMENT: This data element is expected to capture data from the HIPAA 837I claim loop 2400 SV206 or UB-04 FL 44 (only if the value represents an accommodation rate).

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LT_FIL_DT

LABEL: Long-Term File Date — Represents the Year and Month of the Reporting Period

DESCRIPTION: This field represents the year and month of the reporting period.

SHORT NAME: LT_FIL_DT

LONG NAME: LT_FIL_DT

TYPE: DATE

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): LT Header

VALUES: YYYYMM (e.g., 201507 is the date for the July 2015 file)

COMMENT: Claims for this time period are in the file.

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LT_VRSN

LABEL: Long-Term Version Representing the Iteration of the File

DESCRIPTION: Indicator representing the iteration of the file.

SHORT NAME: LT_VRSN

LONG NAME: LT_VRSN

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims (derived)

FILE(S): LT Header

VALUES: Two-digit values from 01–XX

COMMENT: A version number where the value 01 is assigned to the original monthly file, and the version number is increased by one for each subsequent month in which one or more replacement files are generated after the original month in which the file was generated. The higher the number, the more time has elapsed following the dates of service in the file.

This variable will never contain NULL values

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MC_PLAN_ID

LABEL: Managed Care Plan Identification Number

DESCRIPTION: A unique number, assigned by the state, which represents the health plan under which the non-fee-for-service encounter was provided including through the state plan and a waiver.

SHORT NAME: MC_PLAN_ID

LONG NAME: MC_PLAN_ID

TYPE: CHAR

LENGTH: 12

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: The field can contain any alphanumeric characters, digits or symbols
Null/missing = source value is missing or unknown

COMMENT: —

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MDC_CD

LABEL: Major Diagnostic Category (MDC) Code

DESCRIPTION: Three-digit numeric code that groups beneficiary diagnosis codes into broad categories based on condition type and body region.

SHORT NAME: MDC_CD

LONG NAME: MDC_CD

TYPE: CHAR

LENGTH: 3

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header

VALUES:
000 = Ungroupable
001 = Nervous System
002 = Eye
003 = Ear, Nose, Mouth, And Throat
004 = Respiratory System
005 = Circulatory System
006 = Digestive System
007 = Hepatobiliary System and Pancreas
008 = Musculoskeletal System and Connective Tissue
009 = Skin, Subcutaneous Tissue, and Breast
010 = Endocrine, Nutritional, and Metabolic System
011 = Kidney and Urinary Tract
012 = Male Reproductive System
013 = Female Reproductive System
014 = Pregnancy, Childbirth, and Puerperium
015 = Newborn and Other Neonates (Perinatal Period)
016 = Blood and Blood Forming Organs and Immunological Disorders
017 = Myeloproliferative Diseases and Disorders (Poorly Differentiated Neoplasms)
018 = Infectious and Parasitic Diseases and Disorders
019 = Mental Diseases and Disorders
020 = Alcohol/Drug Use or Induced Mental Disorders
021 = Injuries, Poison, and Toxic Effect of Drugs
022 = Burns
023 = Factors Influencing Health Status
024 = Multiple Significant Trauma
025 = Human Immunodeficiency Virus (HIV) Infection
Null/missing = source value is missing or unknown

COMMENT: A link that describes the diagnoses and DRGs that make up the MDC codes is located here for version 31 of the MS-DRG system: https://www.cms.gov/Medicare/coding/ICD10/Downloads/ICD-10-MS-DRG-

v31R-Definitions-Manual-Text.zip ^ Back to TOC ^

MDCD_ACMDTN_PD_AMT

LABEL: Medicaid Amount Paid for All Accommodation (Room and Board) Revenue Lines

DESCRIPTION: A code which identifies a specific accommodation, ancillary service or billing calculation (as defined by UB-04 Billing Manual).

SHORT NAME: MDCD_ACMDTN_PD_AMT

LONG NAME: MDCD_ACMDTN_PD_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): LT Header

VALUES: Dollar amount with two decimal places (e.g., 98.76)
Null/missing = source value is missing or unknown

COMMENT: This field is calculated as the sum of the Medicaid Paid Amount (LINE_MDCD_PD_AMT) for all lines where the revenue center code (REV_CNTR_CD) = 0100–0219.

Not available for managed care claims. CMS has required redaction of some payment fields for managed care claims due to the proprietary and confidential nature of this information. The managed care records are identified as those where the claim type code (CLM_TYPE_CD) = 3, C or W.

Dollar amounts in this field represent payments made either by the state or their fiscal agent to providers, managed care plans, and beneficiaries or they represent payments made by managed care plans to their providers.

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MDCD_ALOWD_AMT

LABEL: Total Medicaid Allowed Amount

DESCRIPTION: The claim level maximum amount determined by the payer as being 'allowable' under the provisions of the contract prior to the determination of actual payment.

SHORT NAME: MDCD_ALOWD_AMT

LONG NAME: MDCD_ALOWD_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: Dollar amount with two decimal places (e.g., 98.76); may be negative.
Null/missing = source value is missing or unknown

COMMENT: Not available for managed care claims. CMS has required redaction of some payment fields for managed care claims due to the proprietary and confidential nature of this information. The managed care records are identified as those where the claim type code (CLM_TYPE_CD) = 3, C, or W.

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MDCD_ANCLRY_PD_AMT

LABEL: Medicaid Amount Paid for All Ancillary (Non-Room and Board) Revenue Lines

DESCRIPTION: A code which identifies a specific accommodation, ancillary service or billing calculation (as defined by UB-04 Billing Manual).

SHORT NAME: MDCD_ANCLRY_PD_AMT

LONG NAME: MDCD_ANCLRY_PD_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): LT Header

VALUES: Dollar amount with two decimal places (e.g., 98.76)
Null/missing = source value is missing or unknown

COMMENT: This field is calculated as the sum of the Medicaid Paid Amount (LINE_MDCD_PD_AMT) for all lines where the revenue center code (REV_CNTR_CD) is not equal to 0100–0219.
Not available for managed care claims. CMS has required redaction of some payment fields for managed care claims due to the proprietary and confidential nature of this information. The managed care records are identified as those where the claim type code (CLM_TYPE_CD) = 3, C, or W.

Dollar amounts in this field represent payments made either by the state or their fiscal agent to providers, managed care plans, and beneficiaries or they represent payments made by managed care plans to their providers.

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MDCD_COPAY_AMT

LABEL: Total Copay Amount Paid by Beneficiary

DESCRIPTION: The total amount paid by Medicaid/CHIP beneficiary for each office or emergency department visit or purchase of prescription drugs in addition to the amount paid by Medicaid/CHIP.

SHORT NAME: MDCD_COPAY_AMT

LONG NAME: MDCD_COPAY_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
OT Header
RX Header

VALUES: Dollar amount with two decimal places (e.g., 98.76)
Null/missing = source value is missing or unknown

COMMENT: —

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MDCD_DSH_PD_AMT

LABEL: Medicaid Amount Paid Disproportionate Share Hospital (DSH)

DESCRIPTION: The amount included in the MDCD_PD_AMT that is attributable to a Disproportionate Share Hospital (DSH) payment, when the state makes DSH payments by claim.

SHORT NAME: MDCD_DSH_PD_AMT

LONG NAME: MDCD_DSH_PD_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header

VALUES: Dollar amount with two decimal places (e.g., 98.76)
Null/missing = source value is missing or unknown

COMMENT: —

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MDCD_PD_AMT

LABEL: Total Amount Paid By Medicaid

DESCRIPTION: The total amount paid by Medicaid or the managed care plan on this claim or adjustment at the header claim level.

SHORT NAME: MDCD_PD_AMT

LONG NAME: MDCD_PD_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: Dollar amount with two decimal places (e.g., 98.76); may be negative.
Null/missing = source value is missing or unknown

COMMENT: Dollar amounts in this field represent payments made either by the state or their fiscal agent to providers, managed care plans, and beneficiaries or they represent payments made by managed care plans to their providers.

Not available for managed care claims. CMS has required redaction of some payment fields for managed care claims due to the proprietary and confidential nature of this information. The managed care records are identified as those where the claim type code (CLM_TYPE_CD) = 3, C, or W.

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MDCD_PD_DT

LABEL: Medicaid Paid Date

DESCRIPTION: The date Medicaid paid on this claim or adjustment.

SHORT NAME: MDCD_PD_DT

LONG NAME: MDCD_PD_DT

TYPE: DATE

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: Date (numeric, system dependent)
Null/missing = source value is missing or unknown

COMMENT: —

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MDCR_CMBND_DDCTBL_IND

LABEL: Medicare Combined Deductible and Coinsurance Indicator

DESCRIPTION: Code indicating that the amount paid by Medicaid/CHIP on this claim toward the recipient's Medicare deductible was combined with their coinsurance amount because the amounts could not be separated.

SHORT NAME: MDCR_CMBND_DDCTBL_IND

LONG NAME: MDCR_CMBND_DDCTBL_IND

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header

VALUES: 0 = Amount not combined with coinsurance amount
1 = Amount combined with coinsurance amount
Null/missing = source value is missing or unknown

COMMENT: —

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MDCR_COINSRNC_PD_AMT

LABEL: Total Medicare Coinsurance Amount

DESCRIPTION: The amount paid by Medicaid/CHIP or the managed care plan, on this claim, toward the beneficiary's Medicare coinsurance.

SHORT NAME: MDCR_COINSRNC_PD_AMT

LONG NAME: MDCR_COINSRNC_PD_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: Dollar amount with two decimal places (e.g., 98.76); may be negative.
Null/missing = source value is missing or unknown

COMMENT: Dollar amounts in this field represent payments made either by the state or their fiscal agent to providers, managed care plans, and beneficiaries or they represent payments made by managed care plans to their providers.

Not available for managed care claims. CMS has required redaction of some payment fields for managed care claims due to the proprietary and confidential nature of this information. The managed care records are identified as those where the claim type code (CLM_TYPE_CD) = 3, C, or W.

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MDCR_DDCTBL_PD_AMT

LABEL: Total Medicare Deductible Amount

DESCRIPTION: The amount paid by Medicaid/CHIP or the managed care plan, on this claim, toward the beneficiary's Medicare deductible.

SHORT NAME: MDCR_DDCTBL_PD_AMT

LONG NAME: MDCR_DDCTBL_PD_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: Dollar amount with two decimal places (e.g., 98.76); may be negative.
Null/missing = source value is missing or unknown

COMMENT: Dollar amounts in this field represent payments made either by the state or their fiscal agent to providers, managed care plans, and beneficiaries or they represent payments made by managed care plans to their providers.

Not available for managed care claims. CMS has required redaction of some payment fields for managed care claims due to the proprietary and confidential nature of this information. The managed care records are identified as those where the claim type code (CLM_TYPE_CD) = 3, C, or W.

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MDCR_PD_AMT

LABEL: Medicare Paid Amount

DESCRIPTION: The amount paid by Medicare on this claim or adjustment.

SHORT NAME: MDCR_PD_AMT

LONG NAME: MDCR_PD_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header

VALUES: Dollar amount with two decimal places (e.g., 98.76); may be negative.
Null/missing = source value is missing or unknown

COMMENT: —

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MDCR_REIMBRSMT_TYPE_CD

LABEL: Medicare Reimbursement Type Code

DESCRIPTION: This code indicates the type of Medicare reimbursement.

SHORT NAME: MDCR_REIMBRSMT_TYPE_CD

LONG NAME: MDCR_REIMBRSMT_TYPE_CD

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header

VALUES: 01 = IPPS — Acute Inpatient Prospective Payment system (PPS)
02 = LTCHPPS — Long-term Care Hospital (LTCH) PPS
03 = SNFPPS — Skilled Nursing Facility (SNF) PPS
04 = HHPPS — Home Health (HH) PPS
05 = IRFPPS — Inpatient Rehabilitation Facility (IRF) PPS
06 = IPFPPS — Inpatient Psychiatric Facility (IPF) PPS
07 = OPPS — Outpatient PPS
08 = Fee Schedules (for physicians, DME, ambulance, and clinical lab)
09 = Part C Hierarchical Condition Category Risk Assessment (CMS-HCC RA) Capitation Payment Model
Null/missing = source value is missing or unknown

COMMENT: —

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MH_DGNS_IND

LABEL: Mental Health Diagnosis Indicator

DESCRIPTION: Indicator that identifies if diagnosis code on claim is related to mental health care.

SHORT NAME: MH_DGNS_IND

LONG NAME: MH_DGNS_IND

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS Analytic File (TAF) Claims (derived)

FILE(S): LT Header
OT Header

VALUES: 0 = Not MH claim
1 = MH Claim
Null/missing = source value is missing or unknown

COMMENT: This variable is derived in the TAF usingICD-9 diagnosis codes 290–302 and 306–319 and ICD-10 diagnosis codes F01–F09 and F20–F99 to identify mental health-related claims.

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MH_TXNMY_IND

LABEL: Mental Health Provider Taxonomy Indicator

DESCRIPTION: Indicator that identifies if the provider taxonomy on the claim is related to mental health care. Taxonomies for mental health treatment providers and facilities are used to identify claims for mental health care.

SHORT NAME: MH_TXNMY_IND

LONG NAME: MH_TXNMY_IND

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS Analytic File (TAF) Claims (derived)

FILE(S): LT Header
OT Header

VALUES: 0 = Neither billing provider nor servicing provider(s) on claim are Mental health (MH) providers
1 = Both MH billing provider and servicing provider(s) on claim
2 = Only MH billing provider on claim
3 = Only MH servicing provider(s) on claim
Null/missing = source value is missing or unknown

COMMENT: This variable is derived in the TAF using Taxonomy codes for MH. A provider will be considered a mental health provider if either the T-MSIS taxonomy code or the NPPES taxonomy code (based on provider NPI) indicates a mental health provider:

Codes	Classification and area of specialization
(a) Individual or Groups of Individuals	
101200000X	Drama Therapist
101Y00000X	Behavioral Health and Social Service Providers: Counselor
101YM0800X	Behavioral Health and Social Service Providers: Counselor, Mental Health
101YP1600X	Behavioral Health and Social Service Providers: Counselor, Pastoral
101YP2500X	Behavioral Health and Social Service Providers: Counselor, Professional
101YS0200X	Behavioral Health and Social Service Providers: Counselor, School
102L00000X	Behavioral Health and Social Service Providers: Psychoanalyst
102X00000X	Behavioral Health and Social Service Providers: Poetry Therapist
103G00000X	Behavioral Health and Social Service Providers: Clinical Neuropsychologist
103GC0700X	Behavioral Health and Social Service Providers: Clinical Neuropsychologist, Clinical
103K00000X	Behavioral Health and Social Service Providers: Behavior Analyst
103T00000X	Behavioral Health and Social Service Providers: Psychologist
103TA0700X	Behavioral Health and Social Service Providers: Psychologist, Adult Development and Aging
103TB0200X	Behavioral Health and Social Service Providers: Psychologist, Cognitive and Behavioral
103TC0700X	Behavioral Health and Social Service Providers: Psychologist, Clinical

103TC1900X	Behavioral Health and Social Service Providers: Psychologist, Counseling
103TC2200X	Behavioral Health and Social Service Providers: Psychologist, Clinical Child and Adolescent
103TE1000X	Behavioral Health and Social Service Providers: Psychologist, Educational
103TE1100X	Behavioral Health and Social Service Providers: Psychologist, Exercise and Sports
103TF0000X	Behavioral Health and Social Service Providers: Psychologist, Family
103TF0200X	Behavioral Health and Social Service Providers: Psychologist, Forensic
103TH0004X	Behavioral Health and Social Service Providers: Psychologist, Health
103TH0100X	Behavioral Health and Social Service Providers: Psychologist, Health Service
103TM1700X	Behavioral Health and Social Service Providers: Psychologist, Men and Masculinity
103TM1800X	Behavioral Health and Social Service Providers: Psychologist, Mental Retardation and Developmental Disabilities
103TP0016X	Behavioral Health and Social Service Providers: Psychologist, Prescribing (Medical)
103TP0814X	Behavioral Health and Social Service Providers: Psychologist, Psychoanalysis
103TP2700X	Behavioral Health and Social Service Providers: Psychologist, Psychotherapy
103TP2701X	Behavioral Health and Social Service Providers: Psychologist, Group Psychotherapy
103TR0400X	Behavioral Health and Social Service Providers: Psychologist, Rehabilitation
103TS0200X	Behavioral Health and Social Service Providers: Psychologist, School
103TW0100X	Behavioral Health and Social Service Providers: Psychologist, Women
104100000X	Behavioral Health and Social Service Providers: Social Worker
1041C0700X	Behavioral Health and Social Service Providers: Social Worker, Clinical
1041S0200X	Behavioral Health and Social Service Providers: Social Worker, School
106E00000X	Behavioral Health and Social Service Providers: Assistant Behavior Analyst
106H00000X	Behavioral Health and Social Service Providers: Marriage and Family Therapist
106S00000X	Behavioral Health and Social Service Providers: Behavior Technician
163WP0807X	Nursing Service Providers: Registered Nurse, Psychiatric/Mental Health, Child and Adolescent
163WP0808X	Nursing Service Providers: Registered Nurse, Psychiatric/Mental Health
163WP0809X	Nursing Service Providers: Registered Nurse, Psychiatric/Mental Health, Adult
167G00000X	Nursing Service Providers: Licensed Psychiatric Technician
1835P1300X	Pharmacy Service Providers: Pharmacist, Psychiatric
2080P0006X	Allopathic and Osteopathic Physicians: Pediatrics, Developmental — Behavioral Pediatrics
2080P0008X	Allopathic and Osteopathic Physicians: Pediatrics, Neurodevelopmental Disabilities
2084B0040X	Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Behavioral Neurology and Neuropsychiatry
2084F0202X	Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Forensic Psychiatry
2084P0005X	Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Neurodevelopmental Disabilities
2084P0015X	Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Psychosomatic Medicine
2084P0800X	Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Psychiatry
2084P0804X	Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Child and Adolescent Psychiatry
2084P0805X	Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Geriatric Psychiatry
225XM0800X	Respiratory, Developmental, Rehabilitative and Restorative Service Providers: Occupational Therapist, Mental Health

363LP0808X	Physician Assistants and Advanced Practice Nursing Providers: Nurse Practitioner, Psychiatric/Mental Health
364SP0807X	Physician Assistants and Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health, Child and Adolescent
364SP0808X	Physician Assistants and Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health
364SP0809X	Physician Assistants and Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health, Adult
364SP0810X	Physician Assistants and Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health, Child and Family
364SP0811X	Physician Assistants and Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health, Chronically Ill
364SP0812X	Physician Assistants and Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health, Community
364SP0813X	Physician Assistants and Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health, Geropsychiatric

(b) Non-Individual

251S00000X	Agencies: Community/Behavioral Health
252Y00000X	Agencies: Early Intervention Provider Agency
261QM0801X	Ambulatory Health Care Facilities: Clinic/Center, Mental Health (Including Community Mental Health Center)
261QM0850X	Ambulatory Health Care Facilities: Clinic/Center, Adult Mental Health
261QM0855X	Ambulatory Health Care Facilities: Clinic/Center, Adolescent and Children Mental Health
273R00000X	Hospital Units: Psychiatric Unit
283Q00000X	Hospitals: Psychiatric Hospital
3104A0625X	Nursing and Custodial Care Facilities: Assisted Living Facility, Assisted Living, Mental Illness
3104A0630X	Nursing and Custodial Care Facilities: Assisted Living Facility, Assisted Living, Behavioral Disturbances
310500000X	Nursing and Custodial Care Facilities: Intermediate Care Facility, Mental Illness
311500000X	Nursing and Custodial Care Facilities: Alzheimer Center (Dementia Center)
315P00000X	Nursing and Custodial Care Facilities: Intermediate Care Facility, Mentally Retarded
320600000X	Residential Treatment Facilities: Residential Treatment Facility, Mental Retardation and/or Developmental Disabilities
320800000X	Residential Treatment Facilities: Community Based Residential Treatment Facility, Mental Illness
320900000X	Residential Treatment Facilities: Community Based Residential Treatment Facility, Mental Retardation and/or Developmental Disabilities
320900000X	Residential Treatment Facilities: Community Based Residential Treatment Facility, Mental Retardation and/or Developmental Disabilities
322D00000X	Residential Treatment Facilities: Residential Treatment Facility, Emotionally Disturbed Children
323P00000X	Residential Treatment Facilities: Psychiatric Residential Treatment Facility
385HR2055X	Respite Care Facility: Respite Care, Respite Care, Mental Illness, Child
385HR2060X	Respite Care Facility: Respite Care, Respite Care, Mental Retardation and/or Developmental Disabilities

For Mental Health Taxonomy Codes visit: http://www.wpc-edi.com/reference/

^ Back to TOC ^

MSIS_ID

LABEL: Encrypted State Assigned Beneficiary Unique Identifier

DESCRIPTION: A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled beneficiary and any claims submitted to the system. Also referred to as the Medicaid Statistical Information System Identifier (MSIS_ID).

SHORT NAME: MSIS_ID

LONG NAME: MSIS_ID

TYPE: CHAR

LENGTH: 32

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): All Header Claim, Line, and Occurrence Code Files

VALUES: Alphanumeric character string, 32 characters
(Ex. 9Q81866B302C768A539BBE79FFB835FB)
Null/missing = source value is missing or unknown

COMMENT: The MSIS ID is unique only within a state for a year; a beneficiary's MSIS ID may change longitudinally. Additional details are provided in the User Guide https://www2.ccwdata.org/web/guest/user-documentation

This variable is encrypted in the CCW and may not be joined to any other data sets without CMS permission.

^ Back to TOC ^

MTRC_DCML_QTY

LABEL: Metric Decimal Quantity of Product

DESCRIPTION: The quantity of a drug, service, or product that is rendered/dispensed for a prescription, specific date of service, or billing time span.

SHORT NAME: MTRC_DCML_QTY

LONG NAME: MTRC_DCML_QTY

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): RX Line

VALUES: Valid numeric value, three decimal places.
Null/missing = source value is missing or unknown

COMMENT: Please note that this variable and the NDC Quantity Dispensed variable (NDC_QTY) may, in some cases, represent the same thing.

Refer to the NDC Unit of Measure Code (UOM_CD) for the unit of measurement.

^ Back to TOC ^

NCVRD_CHRG_AMT

LABEL: Non-covered Charges Amount

DESCRIPTION: The charges for inpatient or institutional long-term care, which are not reimbursable by the primary payer.

SHORT NAME: NCVRD_CHRG_AMT

LONG NAME: NCVRD_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header

VALUES: Dollar amount with two decimal places (e.g., 98.76); may be negative.
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

NCVRD_DAYS

LABEL: Medicaid Non-covered Days Count

DESCRIPTION: The number of days of inpatient or institutional long-term care not covered by the payer for this sequence as qualified by the payer organization.

SHORT NAME: NCVRD_DAYS

LONG NAME: NCVRD_DAYS

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header

VALUES: 0–XXXX; may be negative
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

NDC

LABEL: National Drug Code

DESCRIPTION: A code in National Drug Code (NDC) format indicating the drug, device, or medical supply covered by this claim.

SHORT NAME: NDC

LONG NAME: NDC

TYPE: CHAR

LENGTH: 13

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): All Line Files

VALUES: 11-digit numeric value, can include leading zeros.
Ex. 00002060440
Null/missing = source value is missing or unknown

COMMENT: The NDC is reported in an 11-digit format, which is divided into three sections. The first five digits indicate the manufacturer or the labeler; the next four digits indicate the ingredient, strength, dosage form and route of administration; and the last two digits indicate the packaging. The FDA assigns the manufacturer portion of the code; the manufacturer supplies the rest.

Position 1–5 are Numeric
Position 6–9 are Alphanumeric
Position 10–11 are Alphanumeric or blank

The Food and Drug Administration (FDA) website has a searchable NDC Directory:
https://www.fda.gov/Drugs/InformationOnDrugs/ucm142438.htm

^ Back to TOC ^

NDC_QTY

LABEL: NDC Quantity Dispensed

DESCRIPTION: This field is to capture the actual quantity of the National Drug Code (NDC) being prescribed on the claim

SHORT NAME: NDC_QTY

LONG NAME: NDC_QTY

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): All Line Files

VALUES: Numeric value with three decimal places
Ex. 10.500
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

NDC_QTY_ALOWD

LABEL: NDC Quantity Allowed

DESCRIPTION: The maximum allowable quantity of a drug or service that may be dispensed per prescription per date of service or per month.

SHORT NAME: NDC_QTY_ALOWD

LONG NAME: NDC_QTY_ALOWD

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): RX Line

VALUES: Numeric value with three decimal places
Ex. 10.500
Null/missing = source value is missing or unknown

COMMENT: Quantity limits are applied to medications when the majority of appropriate clinical utilizations will be addressed within the quantity allowed.

^ Back to TOC ^

NDC_UOM_CD

LABEL: NDC Unit of Measure Code

DESCRIPTION: This field is a code to indicate the basis by which the quantity of the National Drug Code (NDC) is expressed.

SHORT NAME: NDC_UOM_CD

LONG NAME: NDC_UOM_CD

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): All Line Files

VALUES:
EA = Each
F2 = International Unit
GM or GR = Gram
ML = Milliliter
ME = Milligram
UN = Unit
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

NEW_RX_REFILL_NUM

LABEL: New Prescription Indicator (00) or Number of Refills

DESCRIPTION: 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 to-date (not to exceed the maximum number of refills allowed for the prescription).

SHORT NAME: NEW_RX_REFILL_NUM

LONG NAME: NEW_RX_REFILL_NUM

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): RX Line

VALUES: 00 = New Prescription
01–99 = Number of Refill(s)
Null/missing = source value is missing or unknown.

COMMENT: —

^ Back to TOC ^

OCRNC_CD

LABEL: Occurrence Code

DESCRIPTION: A code to describe to describe specific event(s) relating to this billing period covered by the claim. These codes are associated with specific date(s); refer to the occurrence code start (OCRNC_CD_START_DT) and end dates (OCRNC_CD_END_DT).

SHORT NAME: OCRNC_CD

LONG NAME: OCRNC_CD

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Occurrence File
LT Occurrence File
OT Occurrence File

VALUES:

01 THRU 09	=	Accident
10 THRU 19	=	Medical condition
20 THRU 39	=	Insurance related
40 THRU 69	=	Service related
A1–G3	=	Miscellaneous

==========

01 = Accident/Medical Coverage — accident-related injury for which there is medical payment coverage. Provide the date of accident/injury

02 = No-fault insurance involved, including auto accident/other — The date of an accident where the state has applicable no-fault liability laws, (i.e., legal basis for settlement without admission or proof of guilt)

03 = Accident/tort liability — The date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability.

04 = Accident/Employment related — The date of an accident relating to the patient's employment

05 = Accident/No Medical or Liability coverage — Code indicating accident-related injury for which there is no medical payment or third-party liability coverage

06 = Crime victim — Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties

07 = Reserved for national assignment.

08 = Reserved for national assignment.

09 = Start of Infertility Treatment Cycle — Code indicating the start of infertility treatment cycle

10 = Last Menstrual Period — Code indicating the date of the last menstrual period. ONLY applies when patient is being treated for maternity related condition.

11 = Onset of symptoms/illness — The date the patient first became aware of symptoms/illness.

12 = Date of onset for a chronically dependent individual (CDI) — (Home Health claims only.) Code indicates the date the patient/bene became a chronically dependent individual. This is the first month of the three-month period immediately prior to eligibility under Respite Care Benefit.

13 = Reserved for national assignment.

14 = Reserved for national assignment.

15 = Reserved for national assignment.

16 = Date of Last Therapy — Code indicates the last day of therapy services (e.g., physical, occupational or speech therapy).

17 = Date outpatient occupational therapy plan established or last reviewed — Code indicating the date an occupational therapy plan was established or last reviewed.

18 = Date of retirement (patient/bene) — Code indicates the date of retirement for the patient/bene.

19 = Date of retirement spouse — Code indicates the date of retirement for the patient's spouse.

20 = Guarantee of payment began — (Part A hospital claims only.) Date on which the hospital begins claiming payment under the guarantee of payment provision.

21 = UR notice received – (Part A SNF claims only.) Code indicating the date of receipt by the SNF of the UR committee's finding that the admission or future stay was not medically necessary.

22 = Active care ended — The date on which a covered level of care ended in a SNF or general hospital, or date active care ended in a psychiatric or tuberculosis hospital or date on which patient was released on a trial basis from a residential facility. Code is not required if code "21" is used.

23 = Cancellation of Hospice benefits — The date of cancellation of hospice election period. For FI Use Only. Providers Do Not Report.

24 = Date insurance denied — The date of receipt of the insurer's denial of coverage (by a higher priority payer).

25 = Date benefits terminated by primary payer — The date on which coverage (including worker's compensation benefits or no-fault coverage) is no longer available to the patient.

26 = Date skilled nursing facility (SNF) bed available — The date on which a SNF bed became available to a hospital inpatient who required only SNF level of care.

27 = Date of Hospice Certification or Re-Certification — code indicates the date of certification or recertification of the hospice benefit period, beginning with the first two initial benefit periods of 90 days each and the subsequent 60-day benefit periods.

28 = Date comprehensive outpatient rehabilitation facility (CORF) plan established or last reviewed — Code indicating the date a comprehensive outpatient rehabilitation plan was established or last reviewed.

29 = Date OPT plan established or last reviewed — the date a plan of treatment was established for outpatient physical therapy.

30 = Date speech pathology plan treatment established or last reviewed — The date a speech pathology plan of treatment was established or last reviewed.

31 = Date bene notified of intent to bill (accommodations) — The date of the notice provided to the patient by the hospital stating that he no longer required a covered level of inpatient care.

32 = Date bene notified of intent to bill (procedures or treatment) — The date of the notice provided to the patient by the hospital stating requested care (diagnostic procedures or treatments) is not considered reasonable or necessary.

33 = First day of the Medicare coordination period for ESRD bene — The first day of the Medicare coordination period during which Medicare benefits are secondary to benefits payable under an EGHP. Required only for ESRD beneficiaries.

34 = Date of election of extended care facilities — The date the guest elected to receive extended care services (used by Religious Nonmedical Health Care Institutions only).

35 = Date treatment started for physical therapy — The date services were initiated by the billing provider for physical therapy.

36 = Date of Inpatient hospital discharge for a covered transplant procedure(s) — The date of discharge for a hospital stay in which the patient received a covered transplant procedure. Entered on bills for which the hospital is billing for immunosuppressive drugs. NOTE: When the patient received a covered and a non-covered transplant, the covered transplant predominates.

37 = The date of inpatient hospital discharge when patient received a non-covered transplant procedure — The date of discharge for an inpatient hospital stay during which the patient received a noncovered transplant procedure. Entered on bills for which the hospital is billing for immunosuppressive drugs. Hospital is billing for immunosuppressive drugs.

38 = Date treatment started for home IV therapy — Date the patient was first treated in his home for IV therapy.

39 = Date discharged on a continuous course of IV therapy — Date the patient was discharged from the hospital on a continuous course of IV therapy.

40 = Scheduled date of admission — The date on which a patient will be admitted as an inpatient to the hospital. (This code may only be used on an outpatient claim.)

41 = Date of First Test for Pre-admission Testing — The date on which the first outpatient diagnostic test was performed as part of a pre-admission testing (PAT) program. This code may only be used if a date of admission was scheduled prior to the administration of the test(s).

42 = Date of discharge — (Hospice claims only.) The date on which a beneficiary terminated their election to receive hospice benefits from the facility rendering the bill.

43 = Scheduled Date of Canceled Surgery — date which ambulatory surgery was scheduled.

44 = Date treatment started for occupational therapy — The date the provider-initiated services for occupational therapy.

45 = Date treatment started for speech therapy — The date the provider-initiated services for speech therapy.

46 = Date treatment started for cardiac rehabilitation — The date the provider-initiated services for cardiac rehabilitation.

47 = Date Cost Outlier Status Begins — code indicates that this is the first day the cost outlier threshold is reached. For Medicare purposes, a bene must have regular coinsurance and/or lifetime reserve days available beginning on this date to allow coverage of additional daily charges for the purpose of making cost outlier payments.

48–49= Payer codes — Code reserved for internal use only by third party payers. CMS assigns as needed for your use. Providers will not report it.

50–69 = Reserved for state assignment

A1 = Birthdate, Insured A — The birthdate of the individual in whose name the insurance is carried.

A2 = Effective date, Insured A policy — A code indicating the first date insurance is in force.

A3 = Benefits exhausted — Code indicating the last date for which benefits are available and after which no payment can be made to payer A.

A4 = Split Bill Date — Date patient became Medicaid eligible due to medically needy spend down (sometimes referred to as “Split Bill Date”).

B1 = Birthdate, Insured B — The birthdate of the individual in whose name the insurance is carried.

B2 = Effective date, Insured B policy — A code indicating the first date insurance is in force.

B3 = Benefits exhausted — code indicating the last date for which benefits are available and after which no payment can be made to payer B.

C1 = Birthdate, Insured C — The birthdate of the individual in whose name the insurance is carried.

C2 = Effective date, Insured C policy — A code indicating the first date insurance is in force.

C3 = Benefits exhausted — Code indicating the last date for which benefits are available and after which no payment can be made to payer C.

E1 = Birthdate, Insured D — The birthdate of the individual in whose name the insurance is carried.

E2 = Effective date, Insured D policy — A code indicating the first date insurance is in force.

E3 = Benefits exhausted — Code indicating the last date for which benefits are available and after which no payment can be made to payer D.

F1 = Birthdate, Insured E — The birthdate of the individual in whose name the insurance is carried.

F2 = Effective date, Insured E policy — A code indicating the first date insurance is in force.

F3 = Benefits exhausted — Code indicating the last date for which benefits are available and after which no payment can be made to payer E.

G1 = Birthdate, Insured F — The birthdate of the individual in whose name the insurance is carried.

G2 = Effective date, Insured F policy — A code indicating the first date insurance is in force.

G3 = Benefits exhausted — Code indicating the last date for which benefits are available and after which no payment can be made to payer F.

Null/missing= source value is missing or unknown

COMMENT: There may be one or more occurrence codes that relate to a particular claim; refer to the occurrence code sequence number (OCRNC_CD_SEQ).

Values and websites referenced may change over time. Refer to https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R81CP.pdf

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OCRNC_CD_END_DT

LABEL: Occurrence Code Last End Date

DESCRIPTION: The last date that the corresponding occurrence code (variable called OCRNC_CD) or occurrence span code was applicable.

SHORT NAME: OCRNC_CD_END_DT

LONG NAME: OCRNC_CD_END_DT

TYPE: DATE

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Occurrence File
LT Occurrence File
OT Occurrence File

VALUES: Date (numeric, system dependent)
Null/missing = source value is missing or unknown

COMMENT: Occurrence codes are associated with specific date(s); refer to the occurrence code start (OCRNC_CD_START_DT) and end dates (OCRNC_CD_END_DT).

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OCRNC_CD_SEQ

LABEL: Occurrence Code Sequence

DESCRIPTION: The sequence number of the occurrence code that relates to the claim (variable called OCRNC_CD).

SHORT NAME: OCRNC_CD_SEQ

LONG NAME: OCRNC_CD_SEQ

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims (CCW derived)

FILE(S): IP Occurrence File
LT Occurrence File
OT Occurrence File

VALUES: 1–XX

COMMENT: There may be one or more occurrence codes that relate to a particular claim. However, many claims will not have any occurrence codes.

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OCRNC_CD_START_DT

LABEL: Occurrence Code Start Date

DESCRIPTION: The start date of the corresponding occurrence code (variable called OCRNC_CD) or occurrence span codes.

SHORT NAME: OCRNC_CD_START_DT

LONG NAME: OCRNC_CD_START_DT

TYPE: DATE

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Occurrence File
LT Occurrence File
OT Occurrence File

VALUES: Date (numeric, system dependent)
Null/missing = source value is missing or unknown

COMMENT: Occurrence codes are associated with specific date(s); refer to the occurrence code start (OCRNC_CD_START_DT) and end dates (OCRNC_CD_END_DT).

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OPRTG_PRVDR_NPI

LABEL: Operating Provider NPI

DESCRIPTION: The National Provider ID (NPI) of the provider who performed the surgical procedure(s).

SHORT NAME: OPRTG_PRVDR_NPI

LONG NAME: OPRTG_PRVDR_NPI

TYPE: CHAR

LENGTH: 10

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Line

VALUES: https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/Downloads/NPIcheckdigit.pdf

Null/missing = source value is missing or unknown

COMMENT: Values and websites referenced may change over time.

To search CMS's NPI registry, you may use the following link: https://npiregistry.cms.hhs.gov/

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OT_ACCMDTN_HCPCS_RATE

LABEL: Other Services Accommodation Rate

DESCRIPTION: For outpatient hospital facility claims, HCPCS/CPT is captured here.

SHORT NAME: OT_ACCMDTN_HCPCS_RATE

LONG NAME: OT_ACCMDTN_HCPCS_RATE

TYPE: CHAR

LENGTH: 14

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Line

VALUES: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html

Null/missing = source value is missing or unknown

COMMENT: This data element is expected to capture data from HIPAA 837I claim loop 2400 SV202 or UB-04 FL 44 (only if the value represents a HCPCS/CPT).

Values and websites referenced in the variable value Description may change over time. HCPCS_RATE is not a required variable after 10/23/20. Any record after that date would not be required nor expected to have this information.

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OT_FIL_DT

LABEL: Other Services File Date — Represents the Year and Month of the Reporting Period

DESCRIPTION: This field represents the year and month of the reporting period.

SHORT NAME: OT_FIL_DT

LONG NAME: OT_FIL_DT

TYPE: DATE

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Header

VALUES: YYYYMM (e.g., 201507 is the date for the July 2015 file)

COMMENT: Claims for this time period are in the file.

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OT_VRSN

LABEL: Other Services Version Representing the Iteration of the File

DESCRIPTION: Indicator representing the iteration of the file.

SHORT NAME: OT_VRSN

LONG NAME: OT_VRSN

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims (derived)

FILE(S): OT Header

VALUES: Two-digit values from 01–XX

COMMENT: A version number where the value 01 is assigned to the original monthly file, and the version number is increased by one for each subsequent month in which one or more replacement files are generated after the original month in which the file was generated. The higher the number, the more time has elapsed following the dates of service in the file.

This variable will never contain NULL values.

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OTHR_INSRNC_IND

LABEL: Indicator Insured is Covered by Another Plan (Not Medicare or Medicaid)

DESCRIPTION: The field denotes whether the insured party is covered under another insurance plan other than Medicare or Medicaid.

SHORT NAME: OTHR_INSRNC_IND

LONG NAME: OTHR_INSRNC_IND

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: 0 = No
1 = Yes

COMMENT: —

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OTHR_INSRNC_PD_AMT

LABEL: Total Other Than Medicare or Medicaid — Insurance Paid Amount

DESCRIPTION: The amount paid by insurance other than Medicare or Medicaid on this claim.

SHORT NAME: OTHR_INSRNC_PD_AMT

LONG NAME: OTHR_INSRNC_PD_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: Dollar amount with two decimal places (e.g., 98.76); may be negative
Null/missing = source value is missing or unknown

COMMENT: —

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OTHR_TP_CLCTN_CD

LABEL: Other Third-Party Collection Code

DESCRIPTION: This data element indicates that the claim is for a beneficiary for whom other third-party resource development and collection activities are in progress when the liability is not another health insurance plan for which the eligible is a beneficiary.

SHORT NAME: OTHR_TP_CLCTN_CD

LONG NAME: OTHR_TP_CLCTN_CD

TYPE: CHAR

LENGTH: 3

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S):
IP Header
LT Header
OT Header
RX Header

VALUES:
000 = Not applicable
001 = Third-Party Resource is Casualty/Tort
002 = Third-Party Resource is Estate
003 = Third-Party Resource is Lien (Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA))
004 = Third-Party Resource is Lien (Other)
005 = Third-Party Resource is Worker's Compensation
006 = Third-Party Resource is Medical Malpractice
007 = Third-Party Resource is Other
Null/missing = source value is missing or unknown

COMMENT: —

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OUTLIER_DAYS

LABEL: Outlier Days Count

DESCRIPTION: This field specifies the number of days paid as outliers under Prospective Payment System (PPS) and the days over the threshold for the DRG.

SHORT NAME: OUTLIER_DAYS

LONG NAME: OUTLIER_DAYS

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header

VALUES: 0–XXXXXX; may be negative
Null/missing = source value is missing or unknown

COMMENT: —

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OUTLIER_TYPE_CD

LABEL: Outlier Type Code

DESCRIPTION: This code indicates the Type of Outlier Code or DRG Source.

SHORT NAME: OUTLIER_TYPE_CD

LONG NAME: OUTLIER_TYPE_CD

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header

VALUES:
00 = No outlier
01 = Day Outlier
02 = Cost Outlier
06 = Valid DRG Received from the intermediary
07 = CMS Developed DRG
08 = CMS Developed DRG Using Patient Status Code
09 = Not Groupable
10 = Composite of cost outliers
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

PGM_TYPE_CD

LABEL: Program Type Code

DESCRIPTION: Code indicating special Medicaid program under which the service was provided.

SHORT NAME: PGM_TYPE_CD

LONG NAME: PGM_TYPE_CD

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S):
IP Header
LT Header
OT Header
RX Header

VALUES:
00 = No Special Program
01 = Early and periodic screening and diagnosis and treatment (EPSDT)
02 = Family Planning
03 = Rural Health Clinic (RHC)
04 = Federally Qualified Health Centers (FQHC)
05 = Indian Health Services (IHS)
07 = Home and Community Based Care Waiver Services (HCBS)
08 = Money Follows the Person (MFP)
10 = Balancing Incentive Payment (BIP)
11 = Community First Choice (1915(k))
12 = Medicaid Emergency Psychiatric Demonstration
13 = Home and Community Based Services (HCBS) State Plan Option (1915(i))
14 = State Plan Children's Health Insurance Program (CHIP)
15 = Psychiatric Residential Treatment Facilities Demonstration Grant Program (PRTF)
16 = 1915(j) (Self-directed personal assistance services/personal care under State Plan or 1915(c) waiver)
17 = COVID-19 Testing Services (1905(a)(3) and 2103(c))
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

POS_CD

LABEL: Place of Service Code

DESCRIPTION: A code indicating where the service was performed. CMS 1500 values are used for this data element.

SHORT NAME: POS_CD

LONG NAME: POS_CD

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Header

VALUES:

01 = Pharmacy. A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.

02 = Telehealth. The location where health services and health related services are provided or received, through a telecommunication system. (Effective January 1, 2017)

03 = School. A facility whose primary purpose is education.

04 = Homeless Shelter. A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).

05 = Indian Health Service — Free-standing Facility. A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.

06 = Indian Health Service — Provider-based Facility. A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.

07 = Tribal 638 — Free-standing Facility. A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.

08 = Tribal 638 Provider-based Facility. A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.

09 = Prison/Correctional Facility. A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.

10 = Unassigned. N/A

11 = Office. Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

12 = Home. Location, other than a hospital or other facility, where the patient receives care in a private residence.

13 = Assisted Living Facility. Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.

14 = Group Home. A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).

15 = Mobile Unit. A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.

16 = Temporary Lodging. A short-term accommodation such as a hotel, campground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.

17 = Walk-in Retail Health Clinic. A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, which is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.

18 = Place of Employment — Worksite. A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic or rehabilitative services to the individual. (This code is available for use effective January 1, 2013, but no later than May 1, 2013)

19 = Off Campus — Outpatient Hospital. A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective January 1, 2016)

20 = Urgent Care Facility. Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

21 = Inpatient Hospital. A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.

22 = Outpatient Hospital. A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

23 = Emergency Room – Hospital. A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.

24 = Ambulatory Surgical Center. A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

25 = Birthing Center. A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.

26 = Military Treatment Facility. A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).

27 = Unassigned. N/A

28 = Unassigned. N/A

29 = Unassigned. N/A

30 = Unassigned. N/A

31 = Skilled Nursing Facility. A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

32 = Nursing Facility. A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.

33 = Custodial Care Facility. A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.

34 = Hospice. A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.

35–40 = Unassigned. N/A

41 = Ambulance — Land. A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

42 = Ambulance — Air or Water. An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

43–48 = Unassigned. N/A

49 = Independent Clinic. A location, not part of a hospital and not described by any other Place of Service code, which is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only. (effective 10/1/03)

50 = Fed Qualified Health Ctr. A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.

51 = Inpatient Psych Facility. A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

52 = Psychiatric Facility — Partial Hospitalization. A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.

53 = Community Mental Health Ctr. A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.

54 = Intermediate Care/Mentally Retarded Facility. A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.

55 = Residential Substance Abuse Treatment Facility. A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

56 = Psychiatric Residential Treatment Center. A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.

57 = Non-residential Substance Abuse Treatment Facility. A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.

58 = Unassigned. N/A

59 = Unassigned. N/A

60 = Mass Immunization Center. A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.

61 = Comprehensive Inpatient Rehabilitation Facility. A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.

62 = Comprehensive Outpatient Rehabilitation Facility. A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.

63 = Unassigned. N/A

64 = Unassigned. N/A

65 = End-Stage Renal Disease Treatment Facility. A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.

66–70 =Unassigned. N/A

71 = Public Health Clinic. A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.

72 = Rural Health Clinic. A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.

73–80 =Unassigned. N/A

81 = Independent Laboratory. A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.

82–98 =Unassigned. N/A

99 = Other Place of Service. Other place of service not identified above.

Null/missing = source value is missing or unknown

COMMENT: Values containing digits will include leading zeros. https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html

Values and websites referenced may change over time.

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PRCDR_CD_1

PRCDR_CD_2

PRCDR_CD_3

PRCDR_CD_4

PRCDR_CD_5

PRCDR_CD_6

LABEL: Procedure Codes (1–6)

DESCRIPTION: A procedure code (ICD9/ICD10, CPT, HCPCS or other) used by the state to identify the procedures performed during the hospital stay.

The principal procedure is recorded in PRCDR_CD_1. The corresponding date is PRCDR_CD_DT_1, and PRCDR_CD_SYS_1 is the coding system/nomenclature used to identify the procedure. The principal procedure is performed for definitive treatment rather than for diagnostic or exploratory purposes. It is closely related to either the principal diagnosis or to complications that arise during other treatments.

SHORT NAME:

PRCDR_CD_1	PRCDR_CD_4
PRCDR_CD_2	PRCDR_CD_5
PRCDR_CD_3	PRCDR_CD_6

LONG NAME:

PRCDR_CD_1	PRCDR_CD_4
PRCDR_CD_2	PRCDR_CD_5
PRCDR_CD_3	PRCDR_CD_6

TYPE: CHAR
LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header

VALUES: —

COMMENT: The record layout allows for up to six procedure codes; PRCDR_CD_2 through PRCDR_CD_6 (and related data elements) record secondary, tertiary, etc. procedures.

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PRCDR_CD_DT_1

PRCDR_CD_DT_2

PRCDR_CD_DT_3

PRCDR_CD_DT_4

PRCDR_CD_DT_5

PRCDR_CD_DT_6

LABEL: Date Procedures Performed (1–6)

DESCRIPTION: The date upon which the procedure was performed (refer to the PRCDR_CD_1–6 fields).

SHORT NAME:

PRCDR_CD_DT_1	PRCDR_CD_DT_4
PRCDR_CD_DT_2	PRCDR_CD_DT_5
PRCDR_CD_DT_3	PRCDR_CD_DT_6

LONG NAME:

PRCDR_CD_DT_1	PRCDR_CD_DT_4
PRCDR_CD_DT_2	PRCDR_CD_DT_5
PRCDR_CD_DT_3	PRCDR_CD_DT_6

TYPE: DATE

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header

VALUES: Date (numeric, system dependent)
Null/missing = source value is missing or unknown

COMMENT: The procedure codes are in variables called PRCDR_CD_1–6, and the coding system used to identify the procedure is documented in variables called PRCDR_CD_SYS_1–6.

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PRCDR_CD_SYS_1

PRCDR_CD_SYS_2

PRCDR_CD_SYS_3

PRCDR_CD_SYS_4

PRCDR_CD_SYS_5

PRCDR_CD_SYS_6

LABEL: Procedure Code System/Nomenclature (1–6)

DESCRIPTION: This variable identifies the coding system used for the procedures 1–6 (PRCDR_CD_1–6 fields).

SHORT NAME:

PRCDR_CD_SYS_1	PRCDR_CD_SYS_4
PRCDR_CD_SYS_2	PRCDR_CD_SYS_5
PRCDR_CD_SYS_3	PRCDR_CD_SYS_6

LONG NAME:

PRCDR_CD_SYS_1	PRCDR_CD_SYS_4
PRCDR_CD_SYS_2	PRCDR_CD_SYS_5
PRCDR_CD_SYS_3	PRCDR_CD_SYS_6

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header

VALUES:
01 = CPT 4
02 = ICD-9 CM
06 = HCPCS (Both national and regional HCPCS)
07 = ICD-10-CM/PCS (implemented on 10/1/2015)
10–87 = Other systems
Null/missing = source value is missing or unknown

COMMENT: Refer to the procedure code variables called PRCDR_CD_1–6.

^ Back to TOC ^

PRE_AUTHRZTN_NUM

LABEL: Pre-Authorization Number

DESCRIPTION: A number, code, or other value that indicates the services provided on this claim have been authorized by the payee or other service organization, or that a referral for services has been approved. (Also called Prior Authorization or Referral Number).

SHORT NAME: PRE_AUTHRZTN_NUM

LONG NAME: PRE_AUTHRZTN_NUM

TYPE: CHAR

LENGTH: 18

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Line

VALUES: The field can contain any alphanumeric characters, digits or symbols
Null/missing = source value is missing or unknown

COMMENT: —

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PROF_SRVC_CD

LABEL: Professional Service Code

DESCRIPTION: Describes what the pharmacist did for the patient.

This is the value reported in the Professional Service Code field of the NCPDP claim form.

SHORT NAME: PROF_SRVC_CD

LONG NAME: PROF_SRVC_CD

TYPE: CHAR

LENGTH: 6

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): RX Line

VALUES:

00 =	No intervention
AS =	Patient assessment
CC =	Coordination of care
DE =	Dosing evaluation/determination
FE =	Formulary enforcement
GP =	Generic product selection
MA =	Medication administration
M0 =	Prescriber consulted
MR =	Medication review
PE =	Patient education/instruction
PH =	Patient medication history
PM =	Patient monitoring
P0 =	Patient consulted
PT =	Perform laboratory test
R0 =	Pharmacist consulted other source
RT =	Recommend laboratory test
SC =	Self-care consultation
SW =	Literature search/review
TC =	Payer/processor consulted
TH =	Therapeutic product interchange

COMMENT: This Professional Service Code is data element 440-E5 of the NCPDP data dictionary. It is one of three fields concatenated into the drug utilization code field (DRUG_UTLZTN_CD) in this file.

^ Back to TOC ^

PRSCRBD_DT

LABEL: Prescribed Date

DESCRIPTION: The date the drug, device, or supply was prescribed by the physician or other practitioner. This should not be confused with the prescription fill date (RX_FILL_DT), which represents the date the prescription was actually filled by the provider.

SHORT NAME: PRSCRBD_DT

LONG NAME: PRSCRBD_DT

TYPE: DATE

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): RX Header
RX Line

VALUES: Date (numeric, system dependent)
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

PRSCRBNG_PRVDR_ID

LABEL: Prescribing Provider Identification Number

DESCRIPTION: A unique identification number assigned by the state to the provider who prescribed the drug, device, or supply. This must be the individual's ID number, not a group identification number.

SHORT NAME: PRSCRBNG_PRVDR_ID

LONG NAME: PRSCRBNG_PRVDR_ID

TYPE: CHAR

LENGTH: 30

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): RX Header

VALUES: Valid values are supplied by the state
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

PRSCRBNG_PRVDR_NPI

LABEL: Prescribing Provider NPI

DESCRIPTION: The National Provider ID (NPI) of the provider who prescribed a medication to a patient.

SHORT NAME: PRSCRBNG_PRVDR_NPI

LONG NAME: PRSCRBNG_PRVDR_NPI

TYPE: CHAR

LENGTH: 10

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): RX Header

VALUES: Valid characters include only numbers (0–9)

https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/index

Null/missing = source value is missing or unknown

COMMENT: Values and websites referenced may change over time.

To search CMS's NPI registry, use the following link: https://www.npiregistry.cms.hhs.gov/

^ Back to TOC ^

PRSN_CLM_IND

LABEL: Indicator of a Claim for a Person

DESCRIPTION: A flag to indicate that the claim is for a person and not a service tracking claim or a non-person claim.

SHORT NAME: PRSN_CLM_IND

LONG NAME: PRSN_CLM_IND

TYPE: NUM

LENGTH: 1

FILE(S): All Header Claim Files

SOURCE: CCW (derived)

VALUES: 0 = Not a claim for a person; one (or more) of four non-person scenarios listed in COMMENT
1 = Yes, claim has a normal MSIS_ID and it is not a service tracking claim

COMMENT: This indicator distinguishes between claims for services for a person, versus claims that fit any of four scenarios: 1) missing MSIS_ID, 2) ampersand-leading MSIS_ID (&MSIS_ID), 3) service tracking claim, and/or 4) missing claim type code

Following are some scenarios that describe in more detail claims where the PRSN_CLM_IND is 0:

- Although CMS requires states to include an MSIS_ID on every claim, there are rare instances where this ID may be null/missing for data quality reasons.
- Some states pay an insurance premium for a family rather than an individual. The state may include an ampersand (&) in front of an MSIS_ID in these types of claims to indicate a multiple-person premium assistance payment.
- Some states submit data files that include “service tracking claims” that are lump-sum payments to providers or plans (e.g., for drug rebates or disproportionate share hospital payments). You can identify these service tracking claims when the variable called CLM_TYPE_CD=4, D, or X.

^ Back to TOC ^

PRVDR_FAC_TYPE_CD

LABEL: Provider Facility Type Code

DESCRIPTION: The type of facility for the servicing provider using the HIPAA provider taxonomy codes.

SHORT NAME: PRVDR_FAC_TYPE_CD

LONG NAME: PRVDR_FAC_TYPE_CD

TYPE: CHAR

LENGTH: 9

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Line
LT Line

VALUES: 100000000 = Individuals or Groups (of Individuals)
170000000 = Non-Individual — Other Service Providers
250000000 = Non-Individual — Agencies
260000000 = Non-Individual — Ambulatory Health Care Facilities
270000000 = Non-Individual — Hospital Units
280000000 = Non-Individual — Hospitals
290000000 = Non-Individual — Laboratories
300000000 = Non-Individual — Managed Care Organizations
310000000 = Non-Individual — Nursing and Custodial Care Facilities
320000000 = Non-Individual — Residential Treatment Facilities
330000000 = Non-Individual — Suppliers
340000000 = Non-Individual — Transportation Services
380000000 = Non-Individual — Respite Care Facility
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

PRVDR_LCTN_CD

LABEL: Provider Location Code

DESCRIPTION: A code to uniquely identify the geographic location where the provider's services were performed.

SHORT NAME: PRVDR_LCTN_CD

LONG NAME: PRVDR_LCTN_CD

TYPE: CHAR

LENGTH: 5

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: The field can contain any alphanumeric characters or symbols
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

PTNT_DSCHRG_STUS_CD

LABEL: Patient Status at Ending Date of Service

DESCRIPTION: A code indicating the Patients status as of the Claim Line Ending Date of Service (variable in the Line file called LINE_SRVC_END_DT).

SHORT NAME: PTNT_DSCHRG_STUS_CD

LONG NAME: PTNT_DSCHRG_STUS_CD

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header

VALUES:
01 = Discharged to home/self-care (routine charge).
02 = Discharged/transferred to other short term general hospital for inpatient care.
03 = Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care — (For hospitals with an approved swing bed arrangement, use Code 61 — swing bed. For reporting discharges/transfers to a non-certified SNF, the hospital must use Code 04 — ICF.
04 = Discharged/transferred to intermediate care facility (ICF).
05 = Discharged/transferred to another type of institution for inpatient care (including distinct parts).
06 = Discharged/transferred to home 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. In situations where a patient is admitted before midnight of the third day following the day of an outpatient service, the outpatient services are considered inpatient.
20 = Expired (patient did not recover).
21 = Discharged/transferred to court/law enforcement.
30 = Still patient.
40 = Expired at home (hospice claims only).
41 = Expired in a medical facility such as hospital, SNF, ICF, or freestanding hospice. (Hospice claims only).
42 = Expired — place unknown (Hospice claims only).
43 = Discharged/transferred to a federal hospital.
50 = Discharged/transferred to a Hospice — home.
51 = Discharged/transferred to a Hospice — medical facility.
61 = Discharged/transferred within this institution to a hospital-based Medicare approved swing bed.
62 = Discharged/transferred to an inpatient rehabilitation facility including distinct parts units of a hospital.
63 = Discharged/transferred to a long-term care hospital.
64 = Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare.

65 = Discharged/Transferred to a psychiatric hospital or psychiatric distinct unit of a hospital (these types of hospitals were pulled from patient/discharge status code '05' and given their own code).
66 = Discharged/transferred to a Critical Access Hospital (CAH)
69 = Discharged/transferred to a designated disaster alternative care site (starting 10/2013; applies only to particular MS-DRGs*).
70 = Discharged/transferred to another type of health care institution not defined elsewhere in code list.
71 = Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (effective 9/01) (discontinued effective 10/1/05)
72 = Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (effective 9/01) (discontinued effective 10/1/05)

The following codes apply only to particular MS-DRGs*, and were new in 10/2013:
81 = Discharged to home or self-care with a planned acute care hospital inpatient readmission.
82 = Discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission.
83 = Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission.
84 = Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission.
85 = Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission.
86 = Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission.
87 = Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission.
88 = Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission.
89 = Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission.
90 = Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission.
91 = Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission.
92 = Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission.
93 = Discharged/transferred to a psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission.
94 = Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission.
95 = Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission.

Null/missing = source value is missing or unknown

***MS-DRG codes where additional codes were available in October 2013**
280 = (Acute Myocardial Infarction, Discharged Alive with MCC)
281 = (Acute Myocardial Infarction, Discharged Alive with CC)
282 = (Acute Myocardial Infarction, Discharged Alive without CC/MCC)

789 = (Neonates, Died or Transferred to Another Acute Care Facility)

COMMENT: —

^ Back to TOC ^

PYMT_LVL_IND

LABEL: Payment Level Indicator – Header or Line

DESCRIPTION: The field denotes whether the claim payment is made at the header level or the line level.

SHORT NAME: PYMT_LVL_IND

LONG NAME: PYMT_LVL_IND

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: 1 = Claim Header — Sum of Line-Item payments
2 = Claim Line — Individual Line-Item payments
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

REBT_ELGBL_CD

LABEL: Rebate Eligible Code

DESCRIPTION: An indicator to identify claim lines with a National Drug Code (NDC) that is eligible for the drug rebate program.

SHORT NAME: REBT_ELGBL_CD

LONG NAME: REBT_ELGBL_CD

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): RX Line

VALUES: 0 = NDC is not eligible for drug rebate program. (Manufacturer does not have a rebate agreement.)
1 = NDC is eligible for drug rebate program
2 = NDC is exempt from the drug rebate program (biological and medical devices)
Null/missing = source value is missing, or unknown

COMMENT: —

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REMITTANCE_NUM

LABEL: Remittance Number

DESCRIPTION: The Remittance Advice Number is a sequential number that identifies the current Remittance Advice (RA) produced for a provider. The number is incremented by one each time a new RA is generated. The first five (5) positions are Julian date YYDDD format. The RA is the detailed explanation of the reason for the payment amount. The RA number is not the check number.

SHORT NAME: REMITTANCE_NUM

LONG NAME: REMITTANCE_NUM

TYPE: CHAR

LENGTH: 30

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Header

VALUES: The field can contain any alphanumeric characters, digits or symbols.
Null/missing = source value is missing or unknown

COMMENT: —

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REV_CNTR_CD

LABEL: Revenue Center Code

DESCRIPTION: A code which identifies a specific accommodation, ancillary service or billing calculation (as defined by UB-04 Billing Manual).

SHORT NAME: REV_CNTR_CD

LONG NAME: REV_CNTR_CD

TYPE: CHAR

LENGTH: 4

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Line
LT Line
OT Line

VALUES:
0001 = Total charge
0022 = SNF claim paid under PPS submitted as type of bill (TOB) 21X. NOTE: This code may appear multiple times on a claim to identify different HIPPS Rate Code/assessment periods.
0023 = Home Health services paid under PPS submitted as TOB 32X and 33X, effective 10/00. This code may appear multiple times on a claim to identify different HIPPS/Home Health Resource Groups (HRG).
0024 = Inpatient Rehabilitation Facility services paid under PPS submitted as TOB 11X, effective for cost reporting periods beginning on or after 1/1/2002 (dates of service after 12/31/01). This code may appear only once on a claim.
0100 = All-inclusive rate — room and board plus ancillary
0101 = All-inclusive rate — room and board
0110 = Private medical or general — general classification
0111 = Private medical or general — medical/surgical/GYN
0112 = Private medical or general — OB
0113 = Private medical or general — pediatric
0114 = Private medical or general — psychiatric
0115 = Private medical or general — hospice
0116 = Private medical or general — detoxification
0117 = Private medical or general — oncology
0118 = Private medical or general — rehabilitation
0119 = Private medical or general — other
0120 = Semi-private 2 bed (medical or general) general classification
0121 = Semi-private 2 bed (medical or general) medical/surgical/GYN
0122 = Semi-private 2 bed (medical or general) — OB
0123 = Semi-private 2 bed (medical or general) — pediatric
0124 = Semi-private 2 bed (medical or general) — psychiatric
0125 = Semi-private 2 bed (medical or general) — hospice
0126 = Semi-private 2 bed (medical or general) — detoxification
0127 = Semi-private 2 bed (medical or general) — oncology

0128 = Semi-private 2 bed (medical or general) — rehabilitation
0129 = Semi-private 2 bed (medical or general) — other
0130 = Semi-private 3 and 4 beds — general classification
0131 = Semi-private 3 and 4 beds — medical/surgical/GYN
0132 = Semi-private 3 and 4 beds — OB
0133 = Semi-private 3 and 4 beds — pediatric
0134 = Semi-private 3 and 4 beds — psychiatric
0135 = Semi-private 3 and 4 beds — hospice
0136 = Semi-private 3 and 4 beds — detoxification
0137 = Semi-private 3 and 4 beds — oncology
0138 = Semi-private 3 and 4 beds — rehabilitation
0139 = Semi-private 3 and 4 beds — other
0140 = Private (deluxe) — general classification
0141 = Private (deluxe) — medical/surgical/GYN
0142 = Private (deluxe) — OB
0143 = Private (deluxe) — pediatric
0144 = Private (deluxe) — psychiatric
0145 = Private (deluxe) — hospice
0146 = Private (deluxe) — detoxification
0147 = Private (deluxe) — oncology
0148 = Private (deluxe) — rehabilitation
0149 = Private (deluxe) — other
0150 = Room and Board ward (medical or general) — general classification
0151 = Room and Board ward (medical or general) — medical/surgical/GYN
0152 = Room and Board ward (medical or general) — OB
0153 = Room and Board ward (medical or general) — pediatric
0154 = Room and Board ward (medical or general) — psychiatric
0155 = Room and Board ward (medical or general) — hospice
0156 = Room and Board ward (medical or general) — detoxification
0157 = Room and Board ward (medical or general) — oncology
0158 = Room and Board ward (medical or general) — rehabilitation
0159 = Room and Board ward (medical or general) — other
0160 = Other Room and Board — general classification
0164 = Other Room and Board — sterile environment
0167 = Other Room and Board — self care
0169 = Other Room and Board — other
0170 = Nursery — general classification
0171 = Nursery — newborn level I (routine)
0172 = Nursery — premature newborn-level II (continuing care)
0173 = Nursery — newborn-level III (intermediate care)
0174 = Nursery — newborn-level IV (intensive care)
0179 = Nursery — other
0180 = Leave of absence — general classification
0182 = Leave of absence — patient convenience charges billable
0183 = Leave of absence — therapeutic leave
0184 = Leave of absence — ICF mentally retarded-any reason
0185 = Leave of absence — nursing home (hospitalization)
0189 = Leave of absence — other leave of absence

0190 = Subacute care — general classification
0191 = Subacute care — level I
0192 = Subacute care — level II
0193 = Subacute care — level III
0194 = Subacute care — level IV
0199 = Subacute care — other
0200 = Intensive care — general classification
0201 = Intensive care — surgical
0202 = Intensive care — medical
0203 = Intensive care — pediatric
0204 = Intensive care — psychiatric
0206 = Intensive care — post ICU; redefined as intermediate ICU
0207 = Intensive care — burn care
0208 = Intensive care — trauma
0209 = Intensive care — other intensive care
0210 = Coronary care — general classification
0211 = Coronary care — myocardial infraction
0212 = Coronary care — pulmonary care
0213 = Coronary care — heart transplant
0214 = Coronary care — post CCU; redefined as intermediate CCU
0219 = Coronary care — other coronary care
0220 = Special charges — general classification
0221 = Special charges — admission charge
0222 = Special charges — technical support charge
0223 = Special charges — UR service charge
0224 = Special charges — late discharge, medically necessary
0229 = Special charges — other special charges
0230 = Incremental nursing charge rate — general classification
0231 = Incremental nursing charge rate — nursery
0232 = Incremental nursing charge rate — OB
0233 = Incremental nursing charge rate — ICU (include transitional care)
0234 = Incremental nursing charge rate — CCU (include transitional care)
0235 = Incremental nursing charge rate — hospice
0239 = Incremental nursing charge rate — other
0240 = All-inclusive ancillary — general classification
0241 = All-inclusive ancillary — basic
0242 = All-inclusive ancillary — comprehensive
0243 = All-inclusive ancillary —specialty
0249 = All-inclusive ancillary — other inclusive ancillary
0250 = Pharmacy — general classification
0251 = Pharmacy — generic drugs
0252 = Pharmacy — nongeneric drugs
0253 = Pharmacy — take home drugs
0254 = Pharmacy — drugs incident to other diagnostic service-subject to payment limit
0255 = Pharmacy — drugs incident to radiology-subject to payment limit
0256 = Pharmacy — experimental drugs
0257 = Pharmacy — non-prescription
0258 = Pharmacy — IV solutions

0259 = Pharmacy — other pharmacy
0260 = IV therapy — general classification
0261 = IV therapy — infusion pump
0262 = IV therapy — pharmacy services
0263 = IV therapy — drug supply/delivery
0264 = IV therapy — supplies
0269 = IV therapy — other IV therapy
0270 = Medical/surgical supplies — general classification (also refer to 062X)
0271 = Medical/surgical supplies — nonsterile supply
0272 = Medical/surgical supplies — sterile supply
0273 = Medical/surgical supplies — take home supplies
0274 = Medical/surgical supplies — prosthetic/orthotic devices
0275 = Medical/surgical supplies — pacemaker
0276 = Medical/surgical supplies — intraocular lens
0277 = Medical/surgical supplies — oxygen-take home
0278 = Medical/surgical supplies — other implants
0279 = Medical/surgical supplies — other devices
0280 = Oncology — general classification
0289 = Oncology — other oncology
0290 = DME (other than renal) — general classification
0291 = DME (other than renal) — rental
0292 = DME (other than renal) — purchase of new DME
0293 = DME (other than renal) — purchase of used DME
0294 = DME (other than renal) — related to and listed as DME
0299 = DME (other than renal) — other
0300 = Laboratory — general classification
0301 = Laboratory — chemistry
0302 = Laboratory — immunology
0303 = Laboratory — renal patient (home)
0304 = Laboratory — non-routine dialysis
0305 = Laboratory — hematology
0306 = Laboratory — bacteriology and microbiology
0307 = Laboratory — urology
0309 = Laboratory — other laboratory
0310 = Laboratory pathological — general classification
0311 = Laboratory pathological — cytology
0312 = Laboratory pathological — histology
0314 = Laboratory pathological — biopsy
0319 = Laboratory pathological — other
0320 = Radiology diagnostic — general classification
0321 = Radiology diagnostic — angiocardiography
0322 = Radiology diagnostic — arthrography
0323 = Radiology diagnostic — arteriography
0324 = Radiology diagnostic — chest X-ray
0329 = Radiology diagnostic — other
0330 = Radiology therapeutic — general classification
0331 = Radiology therapeutic — chemotherapy injected
0332 = Radiology therapeutic — chemotherapy oral

0333 = Radiology therapeutic — radiation therapy
0335 = Radiology therapeutic — chemotherapy IV
0339 = Radiology therapeutic — other
0340 = Nuclear medicine — general classification
0341 = Nuclear medicine — diagnostic
0342 = Nuclear medicine — therapeutic
0349 = Nuclear medicine — other
0350 = Computed tomographic (CT) scan-general classification
0351 = CT scan-head scan
0352 = CT scan-body scan
0359 = CT scan-other CT scans
0360 = Operating room services — general classification
0361 = Operating room services — minor surgery
0362 = Operating room services — organ transplant, other than kidney
0367 = Operating room services — kidney transplant
0369 = Operating room services — other operating room services
0370 = Anesthesia — general classification
0371 = Anesthesia — incident to RAD and subject to the payment limit
0372 = Anesthesia — incident to other diagnostic service and subject to the payment limit
0374 = Anesthesia — acupuncture
0379 = Anesthesia — other anesthesia
0380 = Blood — general classification
0381 = Blood — packed red cells
0382 = Blood — whole blood
0383 = Blood — plasma
0384 = Blood — platelets
0385 = Blood — leukocytes
0386 = Blood — other components
0387 = Blood — other derivatives (cryoprecipitates)
0389 = Blood — other blood
0390 = Blood — storage and processing-general classification
0391 = Blood — storage and processing-blood administration
0399 = Blood — storage and processing-other
0400 = Other imaging services — general classification
0401 = Other imaging services — diagnostic mammography
0402 = Other imaging services — ultrasound
0403 = Other imaging services — screening mammography
0404 = Other imaging services — positron emission tomography
0409 = Other imaging services — other
0410 = Respiratory services — general classification
0412 = Respiratory services — inhalation services
0413 = Respiratory services — hyperbaric oxygen therapy
0419 = Respiratory services — other
0420 = Physical therapy — general classification
0421 = Physical therapy — visit charge
0422 = Physical therapy — hourly charge
0423 = Physical therapy — group rate
0424 = Physical therapy — evaluation or re-evaluation

0429 = Physical therapy — other
0430 = Occupational therapy — general classification
0431 = Occupational therapy — visit charge
0432 = Occupational therapy — hourly charge
0433 = Occupational therapy — group rate
0434 = Occupational therapy — evaluation or re-evaluation
0439 = Occupational therapy — other (may include restorative therapy)
0440 = Speech language pathology — general classification
0441 = Speech language pathology — visit charge
0442 = Speech language pathology — hourly charge
0443 = Speech language pathology — group rate
0444 = Speech language pathology — evaluation or re-evaluation
0449 = Speech language pathology — other
0450 = Emergency room — general classification
0451 = Emergency room — EMTALA emergency medical screening services
0452 = Emergency room — ER beyond EMTALA screening
0456 = Emergency room — urgent care
0459 = Emergency room — other
0460 = Pulmonary function — general classification
0469 = Pulmonary function — other
0470 = Audiology — general classification
0471 = Audiology — diagnostic
0472 = Audiology — treatment
0479 = Audiology — other
0480 = Cardiology — general classification
0481 = Cardiology — cardiac cath lab
0482 = Cardiology — stress test
0483 = Cardiology — Echocardiology
0489 = Cardiology — other
0490 = Ambulatory surgical care — general classification
0499 = Ambulatory surgical care — other
0500 = Outpatient services — general classification
0509 = Outpatient services — other
0510 = Clinic — general classification
0511 = Clinic — chronic pain center
0512 = Clinic — dental center
0513 = Clinic — psychiatric
0514 = Clinic — OB-GYN
0515 = Clinic — pediatric
0516 = Clinic — urgent care clinic
0517 = Clinic — family practice clinic
0519 = Clinic — other
0520 = Free-standing clinic — general classification
0521 = Free-standing clinic — Clinic visit by a member to RHC/FQHC (effective 7/1/06). Prior to 7/1/06 — Rural Health-Clinic
0522 = Free-standing clinic — Home visit by RHC/FQHC practitioner (effective 7/1/06). Prior to 7/1/06 — Rural Health-Home
0523 = Free-standing clinic — family practice

0524 = Free-standing clinic — visit by RHC/FQHC practitioner to a member in a covered Part A stay at the SNF. (effective 7/1/06)
0525 = Free-standing clinic — visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility. (effective 7/1/06)
0526 = Free-standing clinic — urgent care (effective 10/96)
0527 = Free-standing clinic — RHC/FQHC visiting nurse service(s) to a member's home when in a home health shortage area. (effective 7/1/06)
0528 = Free-standing clinic — visit by RHC/FQHC practitioner to other non-RHC/FQHC site (e.g., scene of accident). (effective 7/1/06)
0529 = Free-standing clinic — other
0530 = Osteopathic services — general classification
0531 = Osteopathic services — osteopathic therapy
0539 = Osteopathic services — other
0540 = Ambulance — general classification
0541 = Ambulance — supplies
0542 = Ambulance — medical transport
0543 = Ambulance — heart mobile
0544 = Ambulance — oxygen
0545 = Ambulance — air ambulance
0546 = Ambulance — neo-natal ambulance
0547 = Ambulance — pharmacy
0548 = Ambulance — telephone transmission EKG
0549 = Ambulance — other
0550 = Skilled nursing — general classification
0551 = Skilled nursing — visit charge
0552 = Skilled nursing — hourly charge
0559 = Skilled nursing — other
0560 = Medical social services — general classification
0561 = Medical social services — visit charge
0562 = Medical social services — hourly charges
0569 = Medical social services — other
0570 = Home health aid (home health) — general classification
0571 = Home health aid (home health) — visit charge
0572 = Home health aid (home health) — hourly charge
0579 = Home health aid (home health) — other
0580 = Other visits (home health) — general classification (under HHPPS, not allowed as covered charges)
0581 = Other visits (home health) — visit charge (under HHPPS, not allowed as covered charges)
0582 = Other visits (home health) — hourly charge (under HHPPS, not allowed as covered charges)
0589 = Other visits (home health) — other (under HHPPS, not allowed as covered charges)
0590 = Units of service (home health) — general classification (under HHPPS, not allowed as covered charges)
0599 = Units of service (home health) — other (under HHPPS, not allowed as covered charges)
0600 = Oxygen/Home Health — general classification
0601 = Oxygen/Home Health — stat or port equip/supply or count
0602 = Oxygen/Home Health — stat/equip/under 1 LPM
0603 = Oxygen/Home Health — stat/equip/over 4 LPM
0604 = Oxygen/Home Health — stat/equip/portable add-on

0610 = Magnetic resonance technology (MRT) — general classification
0611 = MRT/MRI — brain (including brainstem)
0612 = MRT/MRI — spinal cord (including spine)
0614 = MRT/MRI — other
0615 = MRT/MRA — Head and Neck
0616 = MRT/MRA — Lower Extremities
0618 = MRT/MRA — other
0619 = MRT/Other MRI
0621 = Medical/surgical supplies-incident to radiology-subject to the payment limit — extension of 027X
0622 = Medical/surgical supplies-incident to other diagnostic service-subject to the payment limit — extension of 027X
0623 = Medical/surgical supplies-surgical dressings — extension of 027X
0624 = Medical/surgical supplies-medical investigational devices and procedures with FDA approved IDE's — extension of 027X
0630 = Reserved
0631 = Drugs requiring specific identification — single drug source
0632 = Drugs requiring specific identification — multiple drug source
0633 = Drugs requiring specific identification — restrictive prescription
0634 = Drugs requiring specific identification — EPO under 10,000 units
0635 = Drugs requiring specific identification — EPO 10,000 units or more
0636 = Drugs requiring specific identification — detailed coding
0637 = Self-administered drugs administered in an emergency situation — not requiring detailed coding
0640 = Home IV therapy — general classification
0641 = Home IV therapy — nonroutine nursing
0642 = Home IV therapy — IV site care, central line
0643 = Home IV therapy — IV start/change peripheral line
0644 = Home IV therapy — nonroutine nursing, peripheral line
0645 = Home IV therapy — train patient/caregiver, central line
0646 = Home IV therapy — train disabled patient, central line
0647 = Home IV therapy — train patient/caregiver, peripheral line
0648 = Home IV therapy — train disabled patient, peripheral line
0649 = Home IV therapy — other IV therapy services
0650 = Hospice services — general classification
0651 = Hospice services — routine home care
0652 = Hospice services — continuous home care-1/2
0655 = Hospice services — inpatient care
0656 = Hospice services — general inpatient care (non-respite)
0657 = Hospice services — physician services
0659 = Hospice services — other
0660 = Respite care (HHA) — general classification
0661 = Respite care (HHA) — hourly charge/skilled nursing
0662 = Respite care (HHA) — hourly charge/home health aide/homemaker
0670 = OP special residence charges — general classification
0671 = OP special residence charges — hospital based
0672 = OP special residence charges — contracted
0679 = OP special residence charges — other special residence charges

0700 = Cast room — general classification
0709 = Cast room — other
0710 = Recovery room — general classification
0719 = Recovery room — other
0720 = Labor room/delivery — general classification
0721 = Labor room/delivery — labor
0722 = Labor room/delivery — delivery
0723 = Labor room/delivery — circumcision
0724 = Labor room/delivery — birthing center
0729 = Labor room/delivery — other
0730 = EKG/ECG — general classification
0731 = EKG/ECG — Holter monitor
0732 = EKG/ECG — telemetry
0739 = EKG/ECG — other
0740 = EEG — general classification
0749 = EEG (electroencephalogram) — other
0750 = Gastro-intestinal services — general classification
0759 = Gastro-intestinal services — other
0760 = Treatment or observation room — general classification
0761 = Treatment or observation room — treatment room
0762 = Treatment or observation room — observation room
0769 = Treatment or observation room — other
0770 = Preventative care services — general classification
0771 = Preventative care services — vaccine administration
0779 = Preventative care services — other
0780 = Telemedicine — general classification
0789 = Telemedicine — telemedicine
0790 = Lithotripsy — general classification
0799 = Lithotripsy — other
0800 = Inpatient renal dialysis — general classification
0801 = Inpatient renal dialysis — inpatient hemodialysis
0802 = Inpatient renal dialysis — inpatient peritoneal (non-CAPD)
0803 = Inpatient renal dialysis — inpatient CAPD
0804 = Inpatient renal dialysis — inpatient CCPD
0809 = Inpatient renal dialysis — other inpatient dialysis
0810 = Organ acquisition — general classification
0811 = Organ acquisition — living donor
0812 = Organ acquisition —cadaver donor
0813 = Organ acquisition — unknown donor
0814 = Organ acquisition — unsuccessful organ search-donor bank charges
0815 = Allogeneic Stem Cell Acquisition/Donor Services
0819 = Organ acquisition — other donor
0820 = Hemodialysis OP or home dialysis — general classification
0821 = Hemodialysis OP or home dialysis — hemodialysis-composite or other rate
0822 = Hemodialysis OP or home dialysis — home supplies
0823 = Hemodialysis OP or home dialysis — home equipment
0824 = Hemodialysis OP or home dialysis — maintenance/100%
0825 = Hemodialysis OP or home dialysis — support services

0829 = Hemodialysis OP or home dialysis — other
0830 = Peritoneal dialysis OP or home — general classification
0831 = Peritoneal dialysis OP or home-peritoneal — composite or other rate
0832 = Peritoneal dialysis OP or home — home supplies
0833 = Peritoneal dialysis OP or home — home equipment
0834 = Peritoneal dialysis OP or home — maintenance/100%
0835 = Peritoneal dialysis OP or home — support services
0839 = Peritoneal dialysis OP or home — other
0840 = CAPD outpatient — general classification
0841 = CAPD outpatient — CAPD/composite or other rate
0842 = CAPD outpatient — home supplies
0843 = CAPD outpatient — home equipment
0844 = CAPD outpatient — maintenance/100%
0845 = CAPD outpatient — support services
0849 = CAPD outpatient — other
0850 = CCPD outpatient — general classification
0851 = CCPD outpatient — CCPD/composite or other rate
0852 = CCPD outpatient — home supplies
0853 = CCPD outpatient — home equipment
0854 = CCPD outpatient — maintenance/100%
0855 = CCPD outpatient — support services
0859 = CCPD outpatient — other
0880 = Miscellaneous dialysis — general classification
0881 = Miscellaneous dialysis — ultrafiltration
0882 = Miscellaneous dialysis — home dialysis aide visit
0889 = Miscellaneous dialysis — other
0890 = Other donor bank-general classification; changed to reserved for national assignment
0891 = Other donor bank — bone; changed to reserved for national assignment
0892 = Other donor bank — organ (other than kidney); changed to reserved for national assignment
0893 = Other donor bank — skin; changed to reserved for national assignment
0899 = Other donor bank — other; changed to reserved for national assignment
0900 = Behavior Health Treatment/Services — general classification (effective 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments-general classification
0901 = Behavior Health Treatment/Services — electroshock treatment (effective 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments-electroshock treatment
0902 = Behavior Health Treatment/Services — milieu therapy (effective 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments- milieu therapy
0903 = Behavior Health Treatment/Services — play therapy (effective 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments- play therapy
0904 = Behavior Health Treatment/Services — activity therapy (effective 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments- activity therapy
0905 = Behavior Health Treatment/Services — intensive outpatient services- psychiatric (effective 10/2004)
0906 = Behavior Health Treatment/Services — intensive outpatient services-chemical dependency (effective 10/2004)
0907 = Behavior Health Treatment/Services — community behavioral health program-day treatment (effective 10/2004)

0909 = Reserved for National Use (effective 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments-other
0910 = Behavioral Health Treatment/Services — Reserved for National Assignment (effective 10/2004); prior to 10/2004 defined as Psychiatric/ psychological services-general classification
0911 = Behavioral Health Treatment/Services — rehabilitation (effective 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-rehabilitation
0912 = Behavioral Health Treatment/Services — partial hospitalization-less intensive (effective 10/2004); prior to 10/2004 defined as Psychiatric/ psychological services-less intensive
0913 = Behavioral Health Treatment/Services — partial hospitalization-intensive (effective 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-intensive
0914 = Behavioral Health Treatment/Services — individual therapy (effective 10/2004)prior to 10/2004 defined as Psychiatric/psychological services-individual therapy
0915 = Behavioral Health Treatment/Services — group therapy (effective 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-group therapy
0916 = Behavioral Health Treatment/Services — family therapy (effective 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-family therapy
0917 = Behavioral Health Treatment/Services — biofeedback (effective 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-biofeedback
0918 = Behavioral Health Treatment/Services — testing (effective 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-testing
0919 = Behavioral Health Treatment/Services — other (effective 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-other
0920 = Other diagnostic services — general classification
0921 = Other diagnostic services — peripheral vascular lab
0922 = Other diagnostic services — electro myelogram
0923 = Other diagnostic services — pap smear
0924 = Other diagnostic services — allergy test
0925 = Other diagnostic services — pregnancy test
0929 = Other diagnostic services — other
0931 = Medical Rehabilitation Day Program — Half Day
0932 = Medical Rehabilitation Day Program — Full Day
0940 = Other therapeutic services — general classification
0941 = Other therapeutic services — recreational therapy
0942 = Other therapeutic services — education/training (include diabetes diet training)
0943 = Other therapeutic services — cardiac rehabilitation
0944 = Other therapeutic services — drug rehabilitation
0945 = Other therapeutic services — alcohol rehabilitation
0946 = Other therapeutic services — routine complex medical equipment
0947 = Other therapeutic services — ancillary complex medical equipment
0949 = Other therapeutic services — other
0951 = Professional Fees — athletic training (extension of 094X)
0952 = Professional Fees — kinesiotherapy (extension of 094X)
0960 = Professional fees — general classification
0961 = Professional fees — psychiatric
0962 = Professional fees — ophthalmology
0963 = Professional fees — anesthesiologist (MD)
0964 = Professional fees — anesthetist (CRNA)
0969 = Professional fees — other (NOTE: 097X is an extension of 096X)

0971 = Professional fees — laboratory
0972 = Professional fees — radiology diagnostic
0973 = Professional fees — radiology therapeutic
0974 = Professional fees — nuclear medicine
0975 = Professional fees — operating room
0976 = Professional fees — respiratory therapy
0977 = Professional fees — physical therapy
0978 = Professional fees — occupational therapy
0979 = Professional fees — speech pathology (NOTE: 098X is an extension of 096X and 097X)
0981 = Professional fees — emergency room
0982 = Professional fees — outpatient services
0983 = Professional fees — clinic
0984 = Professional fees — medical social services
0985 = Professional fees — EKG
0986 = Professional fees — EEG
0987 = Professional fees — hospital visit
0988 = Professional fees — consultation
0989 = Professional fees — private duty nurse
0990 = Patient convenience items — general classification
0991 = Patient convenience items — cafeteria/guest tray
0992 = Patient convenience items — private linen service
0993 = Patient convenience items — telephone/telegraph
0994 = Patient convenience items —tv/radio
0995 = Patient convenience items — nonpatient room rentals
0996 = Patient convenience items — late discharge charge
0997 = Patient convenience items — admission kits
0998 = Patient convenience items — beauty shop/barber
0999 = Patient convenience items — other
1000 = Behavioral health Accommodations — general
1001 = Behavioral health Accommodations — residential treatment psychiatric
1002 = Behavioral health Accommodations — residential treatment chemical dependency
2101 = Alternative Therapy Services — Acupuncture
2103 = Alternative Therapy Services — Massage
3101 = Adult Day Care — Medical and Social (hourly)
3103 = Adult Day Care — Medical and Social (daily)
3104 = Adult Day Care — Social (daily)
3109 = Adult Day Care — other
Null/missing = source value is missing or unknown

COMMENT: Revenue code is a data set that health care providers or insurers usually pay for to use. These values may change annually but are typically very stable.

https://www.cms.gov/Regulations-and- Guidance/Guidance/Transmittals/downloads/r167cp.pdf

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REV_CNTR_CHRG_AMT

LABEL: Revenue Center Charge Amount

DESCRIPTION: The total charge for the revenue center code for the billing period. Total charges include both covered and non-covered charges (as defined by UB-04 Billing Manual)

SHORT NAME: REV_CNTR_CHRG_AMT

LONG NAME: REV_CNTR_CHRG_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Line
LT Line

VALUES: Dollar amount with two decimal places (e.g., 98.76)
Null/missing = source value is missing or unknown

COMMENT: Not available for managed care claims. CMS has required redaction of some payment fields for managed care claims due to the proprietary and confidential nature of this information. The managed care records are identified as those where the claim type code (CLM_TYPE_CD) = 3, C, or W.

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RFRG_PRVDR_ID

LABEL: Referring Provider Identification Number

DESCRIPTION: A unique identification number assigned to a provider which identifies the physician or other provider who referred the patient.

For physicians, this must be the individual's ID number, not a group identification number.

SHORT NAME: RFRG_PRVDR_ID

LONG NAME: RFRG_PRVDR_ID

TYPE: CHAR

LENGTH: 30

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header

VALUES: State Assigned Identifier
Null/missing = source value is missing or unknown

COMMENT: —

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RFRG_PRVDR_NPI

LABEL: Referring Provider NPI

DESCRIPTION: The National Provider Identifier (NPI) assigned to a provider which identifies the physician or other provider who referred the patient.

SHORT NAME: RFRG_PRVDR_NPI

LONG NAME: RFRG_PRVDR_NPI

TYPE: CHAR

LENGTH: 10

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header

VALUES: https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/

Null/missing = source value is missing or unknown

COMMENT: Values and websites referenced may change over time.

To search CMS's NPI registry, you may use the following link: https://npiregistry.cms.hhs.gov/.

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RFRG_PRVDR_SPCLTY_CD

LABEL: Referring Provider Specialty Code

DESCRIPTION: This code indicates the area of specialty of the referring provider.

SHORT NAME: RFRG_PRVDR_SPCLTY_CD

LONG NAME: RFRG_PRVDR_SPCLTY_CD

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header

VALUES:
01 = General Practice
02 = General Surgery
03 = Allergy/Immunology
04 = Otolaryngology
05 = Anesthesiology
06 = Cardiology
07 = Dermatology
08 = Family Practice
09 = Interventional Pain Management
10 = Gastroenterology
11 = Internal Medicine
12 = Osteopathic Manipulative Therapy
13 = Neurology
14 = Neurosurgery
15 = Speech Language Pathologist
16 = Obstetrics/Gynecology
17 = Hospice and Palliative Care
18 = Ophthalmology
19 = Oral Surgery (dentists only)
20 = Orthopedic Surgery
21 = Cardiac Electrophysiology
22 = Pathology
23 = Sports Medicine
24 = Plastic and Reconstructive Surgery
25 = Physical Medicine and Rehabilitation
26 = Psychiatry
27 = Geriatric Psychiatry
28 = Colorectal Surgery (formerly proctology)
29 = Pulmonary Disease
30 = Diagnostic Radiology

31 = Cardiac Rehabilitation and Intensive Cardiac Rehabilitation
32 = Anesthesiologist Assistant
33 = Thoracic Surgery
34 = Urology
35 = Chiropractic
36 = Nuclear Medicine
37 = Pediatric Medicine
38 = Geriatric Medicine
39 = Nephrology
40 = Hand Surgery
41 = Optometry
42 = Certified Nurse Midwife
43 = Certified Registered Nurse Anesthetist (CRNA)
44 = Infectious Disease
45 = Mammography Center
46 = Endocrinology
47 = Independent Diagnostic Testing Facility (IDTF)
48 = Podiatry
49 = Ambulatory Surgical Center
50 = Nurse Practitioner
51 = Medical Supply Company with Orthotist
52 = Medical Supply Company with Prosthetist
53 = Medical Supply Company with Orthotist-Prosthetist
54 = Other Medical Supply Company
55 = Individual Certified Orthotist
56 = Individual Certified Prosthetist
57 = Individual Certified Orthotist-Prosthetist
58 = Medical Supply Company with Pharmacist
59 = Ambulance Service Provider
60 = Public Health or Welfare Agency
61 = Voluntary Health or Charitable Agency
62 = Psychologist, Clinical
63 = Portable X-Ray Supplier
64 = Audiologist
65 = Physical Therapist in Private Practice
66 = Rheumatology
67 = Occupational Therapist in Private Practice
68 = Psychologist, Clinical
69 = Clinical Laboratory
70 = Single or Multispecialty Clinic or Group Practice
71 = Registered Dietitian or Nutrition Professional
72 = Pain Management
73 = Mass Immunization Roster Biller
74 = Radiation Therapy Center
75 = Slide Preparation Facility
76 = Peripheral Vascular Disease
77 = Vascular Surgery
78 = Cardiac Surgery

79 = Addiction Medicine
80 = Licensed Clinical Social Worker
81 = Critical Care (Intensivists)
82 = Hematology
83 = Hematology/Oncology
84 = Preventive Medicine
85 = Maxillofacial Surgery
86 = Neuropsychiatry
87 = All Other Suppliers
88 = Unknown Supplier/Provider Specialty
89 = Certified Clinical Nurse Specialist
90 = Medical Oncology
91 = Surgical Oncology
92 = Radiation Oncology
93 = Emergency Medicine
94 = Interventional Radiology
95 = Advance Diagnostic Imaging
96 = Optician
97 = Physician Assistant
98 = Gynecological/Oncology
99 = Undefined physician type (provider is an MD)
A0 = Hospital-General
A1 = Skilled Nursing Facility
A2 = Intermediate Care Nursing Facility
A3 = Other Nursing Facility
A4 = Home Health Agency
A5 = Pharmacy
A6 = Medical Supply Company with Respiratory Therapist
A7 = Department Store
A8 = Grocery Store
A9 = Indian Health Service facility
B1 = Oxygen supplier
B2 = Pedorthic personnel
B3 = Medical supply company with pedorthic personnel
B4 = Rehabilitation Agency
B5 = Ocularist
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

RFRG_PRVDR_TXNMY_CD

LABEL: Referring Provider Taxonomy Code

DESCRIPTION: The taxonomy code for the provider who referred the beneficiary for treatment.

SHORT NAME: RFRG_PRVDR_TXNMY_CD

LONG NAME: RFRG_PRVDR_TXNMY_CD

TYPE: CHAR

LENGTH: 12

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Header

VALUES: http://www.wpc-edi.com/reference/

Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

RFRG_PRVDR_TYPE_CD

LABEL: Referring Provider Type Code

DESCRIPTION: A code describing the type of provider (i.e. doctor) who referred the patient.

SHORT NAME: RFRG_PRVDR_TYPE_CD

LONG NAME: RFRG_PRVDR_TYPE_CD

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header

VALUES:
01 = Physician
02 = Speech Language Pathologist
03 = Oral Surgery (Dentist only)
04 = Cardiac Rehabilitation and Intensive Cardiac Rehabilitation
05 = Anesthesiology Assistant
06 = Chiropractic
07 = Optometry
08 = Certified Nurse Midwife
09 = Certified Registered Nurse Anesthetist (CRNA)
10 = Mammography Center
11 = Independent Diagnostic Testing Facility (IDTF)
12 = Podiatry
13 = Ambulatory Surgical Center
14 = Nurse Practitioner
15 = Medical Supply Company with Orthotist
16 = Medical Supply Company with Prosthetist
17 = Medical Supply Company with Orthotist-Prosthetist
18 = Other Medical Supply Company
19 = Individual Certified Orthotist
20 = Individual Certified Prosthetist
21 = Individual Certified Prosthetist-Orthotist
22 = Medical Supply Company with Pharmacist
23 = Ambulance Service Provider
24 = Public Health or Welfare Agency
25 = Voluntary Health or Charitable Agency
26 = Psychologist, Clinical
27 = Portable X-Ray Supplier
28 = Audiologist
29 = Physical Therapist in Private Practice
30 = Occupational Therapist in Private Practice

31 = Clinical Laboratory
32 = Clinic or Group Practice
33 = Registered Dietitian or Nutrition Professional
34 = Mass Immunizer Roster Biller
35 = Radiation Therapy Center
36 = Slide Preparation Facility
37 = Licensed Clinical Social Worker
38 = Certified Clinical Nurse Specialist
39 = Advance Diagnostic Imaging
40 = Optician
41 = Physician Assistant
42 = Hospital-General
43 = Skilled Nursing Facility
44 = Intermediate Care Nursing Facility
45 = Other Nursing Facility
46 = Home Health Agency
47 = Pharmacy
48 = Medical Supply Company with Respiratory Therapist
49 = Department Store
50 = Grocery Store
51 = Indian Health Service Facility
52 = Oxygen supplier
53 = Pedorthic personnel
54 = Medical supply company with pedorthic personnel
55 = Rehabilitation Agency
56 = Ocularist
57 = All Other
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

RSLT_SRVC_CD

LABEL: Result of Service Code

DESCRIPTION: Describes the action the pharmacist took in response to a conflict or the result of a pharmacist's professional service.

This is the value reported in the Result of Service Code field of the NCPDP claim form.

SHORT NAME: RSLT_SRVC_CD

LONG NAME: RSLT_SRVC_CD

TYPE: CHAR

LENGTH: 6

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): RX Line

VALUES:
00 = Not Specified
1A = Filled As Is, False Positive
1B = Filled Prescription As Is
1C = Filled, With Different Dose
1D = Filled, With Different Directions
1E = Filled, With Different Drug
1F = Filled, With Different Quantity
1G = Filled, With Prescriber Approval
1H = Brand-to-Generic Change
1J = Rx-to-OTC Change
1K = Filled with Different Dosage Form
2A = Prescription Not Filled
2B = Not Filled, Directions Clarified
3A = Recommendation Accepted
3B = Recommendation Not Accepted
3C = Discontinued Drug
3D = Regimen Changed
3E = Therapy Changed
3F = Therapy Changed — cost increased acknowledged
3G = Drug Therapy Unchanged
3H = Follow-Up/Report
3J = Patient Referral
3K = Instructions Understood
3M = Compliance Aid Provided
3N = Medication Administered
Null/missing = source value is missing or unknown

COMMENT: This Result of Service Code is data element 441-E6 of the NCPDP data dictionary. It is one of three fields concatenated into the drug utilization code field (DRUG_UTLZTN_CD) in this file.

^ Back to TOC ^

RSN_SRVC_CD

LABEL: Reason for Service Code

DESCRIPTION: Explains whether the pharmacist filled the prescription, filled part of the prescription, etc.

This is the value reported in the Reason for Service Code field of the NCPDP claim form.

SHORT NAME: RSN_SRVC_CD

LONG NAME: RSN_SRVC_CD

TYPE: CHAR

LENGTH: 6

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): RX Line

VALUES:

AD = Additional Drug Needed
AN = Prescription Authentication
AR = Adverse Drug Reaction
AT = Additive Toxicity
CD = Chronic Disease Management
CH = Call Help Desk
CS = Patient Complaint/Symptom
DA = Drug-Allergy
DC = Drug-Disease (Inferred)
DD = Drug-Drug Interaction
DF = Drug-Food interaction
DI = Drug Incompatibility
DL = Drug-Lab Conflict
DM = Apparent Drug Misuse
DS = Tobacco Use
ED = Patient Education/Instruction
ER = Overuse
EX = Excessive Quantity
HD = High Dose
IC = Iatrogenic Condition
ID = Ingredient Duplication
LD = Low Dose
LK = Lock In Recipient
LR = Underuse
MC = Drug-Disease (Reported)
MN = Insufficient Duration
MS = Missing Information/Clarification
MX = Excessive Duration
NA = Drug Not Available
NF = Non-Formulary Drug

NN = Unnecessary Drug
NP = New Patient Processing
NR = Lactation/Nursing Interaction
NS = Insufficient Quantity
OH = Alcohol Conflict
PA = Drug-Age
PC = Patient Question/Concern
PG = Drug-Pregnancy
PH = Preventive Health Care
PN = Prescriber Consultation
PP = Plan Protocol
PR = Prior Adverse Reaction
PS = Product Selection Opportunity
RF = Health Provider Referral
SC = Suboptimal Compliance
SD = Suboptimal Drug/Indication
SE = Side Effect
SF = Suboptimal Dosage Form
SR = Suboptimal Regimen
SX = Drug-Gender
TD = Therapeutic
TN = Laboratory Test Needed
TP = Payer/Processor Question
Null/missing = source value is missing or unknown

COMMENT: The Reason for Service Code field is data element 439-E4 of the NCPDP data dictionary. It is one of three fields concatenated into the drug utilization code field (DRUG_UTLZTN_CD) in this file.

^ Back to TOC ^

RX_FIL_DT

LABEL: RX File Date — Represents the Year and Month of the Reporting Period

DESCRIPTION: This field represents the year and month of the reporting period.

SHORT NAME: RX_FIL_DT

LONG NAME: RX_FIL_DT

TYPE: DATE

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): RX Header

VALUES: YYYYMM (e.g., 201507 is the date for the July 2015 file)

COMMENT: Claims for this time period are in the file.

^ Back to TOC ^

RX_FILL_DT

LABEL: Prescription Fill Date

DESCRIPTION: Date the drug, device, or supply was dispensed by the provider.

SHORT NAME: RX_FILL_DT

LONG NAME: RX_FILL_DT

TYPE: DATE

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): RX Header
RX Line

VALUES: Date (numeric, system dependent)
Null/missing = source value is missing or unknown

COMMENT: CCW copies the RX_FILL_DT from the RX Header and includes in the RX Line File.

^ Back to TOC ^

RX_VRSN

LABEL: Rx Version Representing the Iteration of the File

DESCRIPTION: Indicator representing the iteration of the file.

SHORT NAME: RX_VRSN

LONG NAME: RX_VRSN

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims (derived)

FILE(S): RX Header

VALUES: Two-digit values from 01–XX

COMMENT: A version number where the value 01 is assigned to the original monthly file, and the version number is increased by one for each subsequent month in which one or more replacement files are generated after the original month in which the file was generated. The higher the number, the more time has elapsed following the dates of service in the file.

This variable will never contain NULL values.

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SECT_1115A_DEMO_IND

LABEL: 1115(A) Demonstration Participation Indicator

DESCRIPTION: Indicates that the claim or encounter was covered under the authority of an 1115(A) demonstration. 1115(A) is a Center for Medicare and Medicaid Innovation (CMMI) demonstration.

SHORT NAME: SECT_1115A_DEMO_IND

LONG NAME: SECT_1115A_DEMO_IND

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: 0 = No
1 = Yes

COMMENT: —

^ Back to TOC ^

SELF_DRCTN_TYPE_CD

LABEL: Beneficiary Service Self-Direction Type Code

DESCRIPTION: A data element to identify how the beneficiary self-directed the service, i.e. Hiring Authority (the beneficiary has decision-making authority to recruit, hire, train and supervise the individuals who furnish his/her services), Budget Authority (The beneficiary has decision-making authority over how the Medicaid funds in a budget are spent), or both Hiring and Budget Authority.

SHORT NAME: SELF_DRCTN_TYPE_CD

LONG NAME: SELF_DRCTN_TYPE_CD

TYPE: CHAR

LENGTH: 3

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Line

VALUES:
000 = Not Applicable
001 = Hiring Authority
002 = Budget Authority
003 = Hiring and Budget Authority
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

SPLIT_CLM_IND

LABEL: Split Claim Indicator

DESCRIPTION: An indicator that denotes that claims in excess of a pre-determined number of claim lines (threshold determined by the individual state) were split during processing.

SHORT NAME: SPLIT_CLM_IND

LONG NAME: SPLIT_CLM_IND

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header

VALUES: 0 = No
1 = Yes

COMMENT: —

^ Back to TOC ^

SPRVSNG_PRVDR_NPI

LABEL: Supervising Provider NPI

DESCRIPTION: The National Provider ID (NPI) of the provider who supervised another provider.

SHORT NAME: SPRVSNG_PRVDR_NPI

LONG NAME: SPRVSNG_PRVDR_NPI

TYPE: CHAR

LENGTH: 10

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Header

VALUES: https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/

Null/missing = source value is missing or unknown

COMMENT: Values and websites referenced may change over time.

To search CMS's NPI registry, you may use the following link: https://npiregistry.cms.hhs.gov/

^ Back to TOC ^

SPRVSNG_PRVDR_TXNMY_CD

LABEL: Supervising Provider Taxonomy Code

DESCRIPTION: The Provider Taxonomy of the provider who supervised another provider.

SHORT NAME: SPRVSNG_PRVDR_TXNMY_CD

LONG NAME: SPRVSNG_PRVDR_TXNMY_CD

TYPE: CHAR

LENGTH: 12

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Header

VALUES: http://www.wpc-edi.com/reference/

Null/missing = source value is missing or unknown

COMMENT: Values and websites referenced may change over time.

^ Back to TOC ^

SRVC_BGN_DT

LABEL: Claim Beginning Date of Service

DESCRIPTION: The date the service covered by this claim began. For capitation premium payments, the date on which the period of coverage related to this payment began.

SHORT NAME: SRVC_BGN_DT

LONG NAME: SRVC_BGN_DT

TYPE: DATE

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header

VALUES: Date (numeric, system dependent)
Null/missing = source value is missing or unknown

COMMENT: For services involving multiple encounters on different days, or periods of care extending over two or more days, this would be the date on which the service covered by this claim began.

^ Back to TOC ^

SRVC_END_DT

LABEL: Claim Ending Date of Service

DESCRIPTION: The date the service covered by this claim ended. For capitation premium payments, the date on which the period of coverage related to this payment ends/ended.

SHORT NAME: SRVC_END_DT

LONG NAME: SRVC_END_DT

TYPE: DATE

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header

VALUES: Date (numeric, system dependent)

COMMENT: For services involving multiple encounters on different days, or periods of care extending over two or more days, the date on which the service covered by this claim ended.

The Service End Date (SRVC_END_DT) is a key partitioning field for the CCW data files. To be included in a RIF, each claim must have a SRVC_END_DT, therefore this value is never missing. If this date is missing from the source files, we derive the value. We include a variable (called the service end date code - SRVC_END_DT_CD) to identify when and how the date was imputed.

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SRVC_END_DT_CD

LABEL: Identifies the Date Field Used to Populate SRVC_END_DT

DESCRIPTION: The Service End Date (SRVC_END_DT) is a key partitioning field for the CCW data files. This derived variable indicates where on the claim the service end date was located.

SHORT NAME: SRVC_END_DT_CD

LONG NAME: SRVC_END_DT_CD

TYPE: CHAR

LENGTH: 1

SOURCE: CCW Derived

FILE(S): IP Header
LT Header
OT Header

VALUES: 1 = IP Header file, discharge date
2 = LT or OT Header file, service end date
3 = LT or OT Header file, service begin date
4 = IP or OT Line file, service end date (most recent date on any claim line)
5 = IP Line file, service begin date (most recent date on any claim line)

COMMENT: To be included in a RIF, each claim must have a SRVC_END_DT. For RX claims, we use the prescription fill date (variable called RX_FILL_DT).

^ Back to TOC ^

SRVC_PRVDR_ID

LABEL: Servicing Provider Identification Number

DESCRIPTION: A state-assigned unique number to identify the provider who treated the recipient.

SHORT NAME: SRVC_PRVDR_ID

LONG NAME: SRVC_PRVDR_ID

TYPE: CHAR

LENGTH: 30

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Line
LT Line
OT Line

VALUES: State Assigned Identifier
Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

SRVC_PRVDR_NPI

LABEL: Servicing Provider NPI

DESCRIPTION: The National Provider Identifier (NPI) of the health care professional who delivers or completes a particular medical service or non-surgical procedure.

SHORT NAME: SRVC_PRVDR_NPI

LONG NAME: SRVC_PRVDR_NPI

TYPE: CHAR

LENGTH: 10

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Line
LT Line
OT Line

VALUES: https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/index

Null/missing = source value is missing or unknown

COMMENT: This field is required when rendering provider is different than the attending provider and state or federal regulatory requirements call for a "combined claim" (i.e., a claim that includes both facility and professional components). Examples are Medicaid clinic bills or critical access hospital claims.

To search CMS's NPI registry, you may use the following link: https://npiregistry.cms.hhs.gov/

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SRVC_PRVDR_NPPES_TXNMY_CD

LABEL: Servicing Provider NPPES Taxonomy Code

DESCRIPTION: The taxonomy code for the provider who treated the recipient.

SHORT NAME: SRVC_PRVDR_NPPES_TXNMY_CD

LONG NAME: SRVC_PRVDR_NPPES_TXNMY_CD

TYPE: CHAR

LENGTH: 10

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Line

VALUES: Alphanumeric string
Ex: 207KA0200X = Allergy Physician
Null/missing = source value is missing or unknown

COMMENT: Values and websites referenced may change over time.

The Provider Taxonomy Codes valid values can be found in the following link:
https://x12.org/codes/provider-taxonomy-codes

This variable is not sourced from T-MSIS data as reported by states. Rather, the value is derived by CMS through mapping the servicing provider NPI to the National Plan and Provider Enumeration System (NPPES) to obtain the NPPES taxonomy code.

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SRVC_PRVDR_SPCLTY_CD

LABEL: Servicing Provider Specialty Code

DESCRIPTION: This code indicates the area of specialty for the servicing provider.

SHORT NAME: SRVC_PRVDR_SPCLTY_CD

LONG NAME: SRVC_PRVDR_SPCLTY_CD

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Line
LT Line
OT Line

VALUES:
01 = General Practice
02 = General Surgery
03 = Allergy/Immunology
04 = Otolaryngology
05 = Anesthesiology
06 = Cardiology
07 = Dermatology
08 = Family Practice
09 = Interventional Pain Management
10 = Gastroenterology
11 = Internal Medicine
12 = Osteopathic Manipulative Therapy
13 = Neurology
14 = Neurosurgery
15 = Speech Language Pathologist
16 = Obstetrics/Gynecology
17 = Hospice and Palliative Care
18 = Ophthalmology
19 = Oral Surgery (dentists only)
20 = Orthopedic Surgery
21 = Cardiac Electrophysiology
22 = Pathology
23 = Sports Medicine
24 = Plastic and Reconstructive Surgery
25 = Physical Medicine and Rehabilitation
26 = Psychiatry
27 = Geriatric Psychiatry
28 = Colorectal Surgery (formerly proctology)
29 = Pulmonary Disease
30 = Diagnostic Radiology

31 = Cardiac Rehabilitation and Intensive Cardiac Rehabilitation
32 = Anesthesiologist Assistant
33 = Thoracic Surgery
34 = Urology
35 = Chiropractic
36 = Nuclear Medicine
37 = Pediatric Medicine
38 = Geriatric Medicine
39 = Nephrology
40 = Hand Surgery
41 = Optometry
42 = Certified Nurse Midwife
43 = Certified Registered Nurse Anesthetist (CRNA)
44 = Infectious Disease
45 = Mammography Center
46 = Endocrinology
47 = Independent Diagnostic Testing Facility (IDTF)
48 = Podiatry
49 = Ambulatory Surgical Center
50 = Nurse Practitioner
51 = Medical Supply Company with Orthotist
52 = Medical Supply Company with Prosthetist
53 = Medical Supply Company with Orthotist-Prosthetist
54 = Other Medical Supply Company
55 = Individual Certified Orthotist
56 = Individual Certified Prosthetist
57 = Individual Certified Orthotist-Prosthetist
58 = Medical Supply Company with Pharmacist
59 = Ambulance Service Provider
60 = Public Health or Welfare Agency
61 = Voluntary Health or Charitable Agency
62 = Psychologist, Clinical
63 = Portable X-Ray Supplier
64 = Audiologist
65 = Physical Therapist in Private Practice
66 = Rheumatology
67 = Occupational Therapist in Private Practice
68 = Psychologist, Clinical
69 = Clinical Laboratory
70 = Single or Multispecialty Clinic or Group Practice
71 = Registered Dietitian or Nutrition Professional
72 = Pain Management
73 = Mass Immunization Roster Biller
74 = Radiation Therapy Center
75 = Slide Preparation Facility
76 = Peripheral Vascular Disease
77 = Vascular Surgery
78 = Cardiac Surgery

79 = Addiction Medicine
80 = Licensed Clinical Social Worker
81 = Critical Care (Intensivists)
82 = Hematology
83 = Hematology/Oncology
84 = Preventive Medicine
85 = Maxillofacial Surgery
86 = Neuropsychiatry
87 = All Other Suppliers
88 = Unknown Supplier/Provider Specialty
89 = Certified Clinical Nurse Specialist
90 = Medical Oncology
91 = Surgical Oncology
92 = Radiation Oncology
93 = Emergency Medicine
94 = Interventional Radiology
95 = Advance Diagnostic Imaging
96 = Optician
97 = Physician Assistant
98 = Gynecological/Oncology
99 = Undefined physician type (provider is an MD)
A0 = Hospital-General
A1 = Skilled Nursing Facility
A2 = Intermediate Care Nursing Facility
A3 = Other Nursing Facility
A4 = Home Health Agency
A5 = Pharmacy
A6 = Medical Supply Company with Respiratory Therapist
A7 = Department Store
A8 = Grocery Store
A9 = Indian Health Service facility
B1 = Oxygen supplier
B2 = Pedorthic personnel
B3 = Medical supply company with pedorthic personnel
B4 = Rehabilitation Agency
B5 = Ocularist
Null/missing = source value is missing or unknown

COMMENT: —

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SRVC_PRVDR_TXNMY_CD

LABEL: Servicing Provider Taxonomy Code

DESCRIPTION: The taxonomy code for the institution billing/caring for the beneficiary.

SHORT NAME: SRVC_PRVDR_TXNMY_CD

LONG NAME: SRVC_PRVDR_TXNMY_CD

TYPE: CHAR

LENGTH: 12

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Line
LT Line
OT Line

VALUES: http://www.wpc-edi.com/reference/

Null/missing = source value is missing or unknown

COMMENT: —

^ Back to TOC ^

SRVC_PRVDR_TYPE_CD

LABEL: Servicing Provider Type Code

DESCRIPTION: A code describing the type of provider (i.e. doctor or facility) responsible for treating a patient. This represents the attending physician if available.

SHORT NAME: SRVC_PRVDR_TYPE_CD

LONG NAME: SRVC_PRVDR_TYPE_CD

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Line
LT Line
OT Line

VALUES:
01 = Physician
02 = Speech Language Pathologist
03 = Oral Surgery (Dentist only)
04 = Cardiac Rehabilitation and Intensive Cardiac Rehabilitation
05 = Anesthesiology Assistant
06 = Chiropractic
07 = Optometry
08 = Certified Nurse Midwife
09 = Certified Registered Nurse Anesthetist (CRNA)
10 = Mammography Center
11 = Independent Diagnostic Testing Facility (IDTF)
12 = Podiatry
13 = Ambulatory Surgical Center
14 = Nurse Practitioner
15 = Medical Supply Company with Orthotist
16 = Medical Supply Company with Prosthetist
17 = Medical Supply Company with Orthotist-Prosthetist
18 = Other Medical Supply Company
19 = Individual Certified Orthotist
20 = Individual Certified Prosthetist
21 = Individual Certified Prosthetist-Orthotist
22 = Medical Supply Company with Pharmacist
23 = Ambulance Service Provider
24 = Public Health or Welfare Agency
25 = Voluntary Health or Charitable Agency
26 = Psychologist, Clinical
27 = Portable X-Ray Supplier
28 = Audiologist
29 = Physical Therapist in Private Practice

30 = Occupational Therapist in Private Practice
31 = Clinical Laboratory
32 = Clinic or Group Practice
33 = Registered Dietitian or Nutrition Professional
34 = Mass Immunizer Roster Biller
35 = Radiation Therapy Center
36 = Slide Preparation Facility
37 = Licensed Clinical Social Worker
38 = Certified Clinical Nurse Specialist
39 = Advance Diagnostic Imaging
40 = Optician
41 = Physician Assistant
42 = Hospital-General
43 = Skilled Nursing Facility
44 = Intermediate Care Nursing Facility
45 = Other Nursing Facility
46 = Home Health Agency
47 = Pharmacy
48 = Medical Supply Company with Respiratory Therapist
49 = Department Store
50 = Grocery Store
51 = Indian Health Service Facility
52 = Oxygen supplier
53 = Pedorthic personnel
54 = Medical supply company with pedorthic personnel
55 = Rehabilitation Agency
56 = Ocularist
57 = All Other
Null/missing = source value is missing or unknown

COMMENT: If the state uses state-specific codes, they should map their internal codes to the CMS standard list provided.

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SRVC_TRKNG_PYMT_AMT

LABEL: Service Tracking Payment Amount

DESCRIPTION: On service tracking claims, the lump sum amount paid to the provider.

SHORT NAME: SRVC_TRKNG_PYMT_AMT

LONG NAME: SRVC_TRKNG_PYMT_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: Dollar amount with two decimal places (e.g., 98.76 or -2322.23); may be negative.

COMMENT: Service tracking claims (identified by claim types [CLM_TYPE_CD] 4, D, X) are not included in the TAF RIFs, but this variable is populated for non-service tracking claims as well.

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SRVC_TRKNG_TYPE_CD

LABEL: Service Tracking Type Code

DESCRIPTION: A code to categorize service tracking claims. A service tracking claim is used to report lump sum payments that cannot be attributed to a single enrollee.

SHORT NAME: SRVC_TRKNG_TYPE_CD

LONG NAME: SRVC_TRKNG_TYPE_CD

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: 00 = Not a Service Tracking Claim
01 = Drug Rebate
02 = Disproportionate Share Hospital (DSH) Payment
03 = Lump Sum Payment
04 = Cost Settlement
05 = Supplemental
06 = Other
Null/missing = source value is missing or unknown

COMMENT: States are to use an encounter record to report services provided under a capitated payment arrangement, rather than this field.

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STATE_CD

LABEL: Submitting State Alpha Abbreviation

DESCRIPTION: Submitting State (postal abbreviation)

SHORT NAME: STATE_CD

LONG NAME: STATE_CD

TYPE: CHAR

LENGTH: 2

SOURCE: CCW and CMS/Census Bureau crosswalk (derived)

FILE(S): All Header Claim, Line, and Occurrence Code Files

VALUES: Two-character postal state code

AK = Alaska
AL = Alabama
AR = Arkansas
AZ = Arizona
CA = California
CO = Colorado
CT = Connecticut
DC = District of Columbia
DE = Delaware
FL = Florida
GA = Georgia
HI = Hawaii
IA = Iowa
ID = Idaho
IL = Illinois
IN = Indiana
KS = Kansas
KY = Kentucky
LA = Louisiana
MA = Massachusetts
MD = Maryland ME = Maine
MI = Michigan
MN = Minnesota
MO = Missouri
MS = Mississippi
MT = Montana
NC =North Carolina
ND = North Dakota
NE = Nebraska
NH = New Hampshire
NJ = New Jersey
NM = New Mexico
NV = Nevada
NY = New York
OH = Ohio
OK = Oklahoma
OR = Oregon
PA = Pennsylvania
PR = Puerto Rico
RI = Rhode Island
SC = South Carolina
SD = South Dakota
TN = Tennessee
TX = Texas
UT = Utah
VA = Virginia
VI = Virgin Islands
VT = Vermont
WA = Washington
WI = Wisconsin
WV = West Virginia
WY = Wyoming
Null = Unknown

COMMENT: This variable is the two-letter postal abbreviation for the state that submitted the TAF.

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SUBMTG_STATE_CD

LABEL: Submitting State Entity Code

DESCRIPTION: The numeric state code for the U.S. state, territory, or the District of Columbia that has submitted the data.

SHORT NAME: SUBMTG_STATE_CD

LONG NAME: SUBMTG_STATE_CD

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): All Header Claim, Line, and Occurrence Code Files

VALUES: https://www.census.gov/library/reference/code-lists/ansi.html

2-digit value (with leading zeros)

01 = Alabama
02 = Alaska
04 = Arizona
05 = Arkansas
06 = California
08 = Colorado
09 = Connecticut
10 = Delaware
11 = District of Columbia
12 = Florida
13 = Georgia
15 = Hawaii
16 = Idaho
17 = Illinois
18 = Indiana
19 = Iowa
20 = Kansas
21 = Kentucky
22 = Louisiana
23 = Maine
24 = Maryland
25 = Massachusetts
26 = Michigan
27 = Minnesota
28 = Mississippi
29 = Missouri
30 = Montana
31 = Nebraska
32 = Nevada
33 = New Hampshire
34 = New Jersey
35 = New Mexico
36 = New York
37 = North Carolina
38 = North Dakota
39 = Ohio
40 = Oklahoma
41 = Oregon
42 = Pennsylvania
44 = Rhode Island
45 = South Carolina
46 = South Dakota
47 = Tennessee
48 = Texas
49 = Utah
50 = Vermont
51 = Virginia
53 = Washington
54 = West Virginia
55 = Wisconsin
56 = Wyoming
72 = Puerto Rico
78 = U.S. Virgin Islands
93 = Wyoming CHIP
94 = Montana Third-Party Administrator (TPA)
97 = Pennsylvania CHIP

COMMENT: Codes represent FIPS state codes with the exception of '93,' '94,' and '97,' which represent non-Medicaid entities from states that submit CHIP or TPA separately from Medicaid. For those states with multiple reporting entities, all values of SUBMTG_STATE_CD should be used ('56' and '93' for Wyoming; '30' and '94' for Montana; '; '42' and '97' for Pennsylvania).

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SUD_DGNS_IND

LABEL: Substance Use Disorder Diagnosis Indicator

DESCRIPTION: Indicator that identifies if diagnosis code on the claim is related to substance use disorders (SUD)

SHORT NAME: SUD_DGNS_IND

LONG NAME: SUD_DGNS_IND

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS Analytic File (TAF) Claims (derived)

FILE(S): LT Header

OT Header

VALUES: 0 = Not substance use diagnosis (SUD) claim
1 = SUD Claim
Null/missing = source value is missing or unknown

COMMENT: This variable is derived in the TAF using ICD-9 diagnosis codes 303-305 and ICD-10 diagnosis codes F10-F19 to identify substance use-related claims.

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SUD_TXNMY_IND

LABEL: Substance Use Disorder Provider Taxonomy Indicator

DESCRIPTION: Indicator that Indicator that identifies whether the billing and/or servicing provider are substance use disorders (SUD) providers. Taxonomies for substance use treatment providers and facilities are used to identify substance use-related claims.

SHORT NAME: SUD_TXNMY_IND

LONG NAME: SUD_TXNMY_IND

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS Analytic File (TAF) Claims (derived)

FILE(S): LT Header
OT Header

VALUES: 0 = Neither billing provider nor servicing provider(s) on claim are substance use disorders (SUD) providers
1 = Both SUD billing provider and servicing provider(s) on claim
2 = Only SUD billing provider on claim
3 = Only SUD servicing provider(s) on claim
Null/missing = source value is missing or unknown

COMMENT: This variable is derived in the TAF using Taxonomy codes for SUD. A provider will be considered a SUD provider if either the T-MSIS taxonomy code or the NPPES taxonomy code (based on provider NPI) indicates a SUD provider:

Codes	Classification and area of specialization
(a) Individual or Groups of Individuals	
101YA0400X	Behavioral Health and Social Service Providers: Counselor, Addiction (Substance Use Disorder)
103TA0400X	Behavioral Health and Social Service Providers: Psychologist, Addiction (Substance Use Disorder)
163WA0400X	Nursing Service Providers: Registered Nurse, Addiction (Substance Use Disorder)
207LA0401X	Allopathic and Osteopathic Physicians: Anesthesiology, Addiction Medicine
207QA0401X	Allopathic and Osteopathic Physicians: Family Medicine, Addiction Medicine
207RA0401X	Allopathic and Osteopathic Physicians: Internal Medicine, Addiction Medicine
2084A0401X	Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Addiction Medicine
2084P0802X	Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Addiction Psychiatry
2083A0300X	Preventive Medicine - Addiction Medicine
(b) Non-Individual	
261QM2800X	Ambulatory Health Care Facilities: Clinic/Center, Methadone
261QR0405X	Ambulatory Health Care Facilities: Clinic/Center, Rehabilitation, Substance Use Disorder

276400000X	Hospital Units: Rehabilitation, Substance Use Disorder Unit
324500000X	Residential Treatment Facilities: Substance Abuse Rehabilitation Facility
3245S0500X	Residential Treatment Facilities: Substance Abuse Rehabilitation Facility, Substance Abuse Treatment, Children

For Substance Use Disorder Taxonomy Codes, please visit http://www.wpc-edi.com/reference/

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TMSIS_RUN_ID

LABEL: TMSIS State Data Processing Run Identifier

DESCRIPTION: Identifier for the processing run that produced the T-MSIS source data.

SHORT NAME: TMSIS_RUN_ID

LONG NAME: TMSIS_RUN_ID

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): All Header Claim and Line Files

VALUES: XXXX

COMMENT: Higher numbers indicate later run dates.

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TOOTH_DSGNTN_SYS

LABEL: Tooth Designation System/Nomenclature

DESCRIPTION: A code to identify which tooth numbering system is being used.

SHORT NAME: TOOTH_DSGNTN_SYS

LONG NAME: TOOTH_DSGNTN_SYS

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Line

VALUES: JO = ANSI/ADA/ISO Specification No. 3950
JP = ADA's Universal/National Tooth Designation system
Null/missing = source value is missing, unknown, or not on the valid value list or within the range of valid values

COMMENT: —

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TOOTH_NUM

LABEL: Tooth Number

DESCRIPTION: The tooth number serviced based on the tooth numbering system identified in the Tooth Designation System/Nomenclature (TOOTH_DSGNTN_SYS) field.

SHORT NAME: TOOTH_NUM

LONG NAME: TOOTH_NUM

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Line

VALUES: Upper Arch (commencing in the upper right quadrant and rotating counterclockwise): Tooth # 1–16 or "Super#" 51–66.

Lower Arch: Tooth # 32-17 or "Super #" 82-67.

Primary Dentition: Upper Arch (commencing in the upper right quadrant and rotating counterclockwise): Tooth # A–J or "Super #" AS–JS"

Primary Dentition: Lower Arch: Tooth # T–K or "Super #" TS–KS

COMMENT: —

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TOOTH_ORAL_CVTY_AREA_DSGNTD_CD

LABEL: Tooth Oral Cavity Area Designated Code

DESCRIPTION: The area of the oral cavity on which the service was performed.

SHORT NAME: TOOTH_ORAL_CVTY_AREA_DSGNTD_CD

LONG NAME: TOOTH_ORAL_CVTY_AREA_DSGNTD_CD

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Line

VALUES:
00 = Entire Oral Cavity
01 = Maxillary Area
02 = Mandibular Area
03 = Upper Right Sextant
04 = Upper Anterior Sextant
05 = Upper Left Sextant
06 = Lower Left Sextant
07 = Lower Anterior Sextant
08 = Lower Right Sextant
09 = Other Area of Oral Cavity (An area specified in an annexed document or further explanation available.)
10 = Upper Right Quadrant (Right Refers to the oral and skeletal structures on the right side.)
20 = Upper Left Quadrant (Left Refers to the oral and skeletal structures on the left side.)
30 = Lower Left Quadrant
40 = Lower Right Quadrant
Null/missing = source value is missing, unknown, or not on the valid value list or within the range of valid values

COMMENT: —

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TOOTH_SRFC_CD

LABEL: Tooth Surface Code

DESCRIPTION: A code to identify the tooth's surface on which the service was performed.

SHORT NAME: TOOTH_SRFC_CD

LONG NAME: TOOTH_SRFC_CD

TYPE: CHAR

LENGTH: 1

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Line

VALUES:
B = Buccal — the surface of the tooth which is closest to the cheek.
D = Distal — the surface of the tooth facing away from an invisible line drawn vertically through the center of the face.
F = Facial — the surface of a tooth that is directed towards the face.
I = Incisal — the cutting edges of the anterior teeth.
L = Lingual — the surface of the tooth that is directed towards the tongue.
M = Mesial — the surface of a tooth which faces toward an invisible line drawn vertically through the center of the face.
O = Occlusal — the surfaces of the posterior (back) teeth which provides the chewing function.
Null/missing = source value is missing, unknown, or not on the valid value list or within the range of valid values

COMMENT: —

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TOS_CD

LABEL: Type of Service Code

DESCRIPTION: A code to categorize the services provided to a Medicaid or CHIP enrollee. A TOS code value may appear in more than one file type.

SHORT NAME: TOS_CD

LONG NAME: TOS_CD

TYPE: CHAR

LENGTH: 3

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): All Line Files

VALUES: Three-digit value; may have leading zeros; are displayed by file type, according to the source:

TOS code	TOS description	IP	LT	OT	RX
001	Inpatient hospital services, other than services in an institution for mental diseases	X			
002	Outpatient hospital services			X	
003	Rural health clinic services			X	
004	Other ambulatory services furnished by a rural health clinic			X	
005	Professional laboratory services, technical laboratory services			X	
006	Technical laboratory services			X	
007	Professional radiological services			X	
008	Technical radiological services			X	
009	Nursing facility services for individuals age 21 or older (other than services in an institution for mental disease)		X		
010	Early and periodic screening and diagnosis and treatment (EPSDT) services			X	
011	Family planning services and supplies for individuals of child-bearing age			X	X
012	Physicians' services			X	
013	Medical and surgical services of a dentist			X	
014	Outpatient substance abuse treatment services			X	
015	Medical or other remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under State law			X	
016	Home health services — Nursing services			X	
017	Home health services — Home health aide services			X	
018	Home health services — Medical supplies, equipment, and appliances suitable for use in the home			X	X
019	Home health services — Physical therapy provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services			X	
020	Home health services — Occupational therapy provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services			X	

TOS code	TOS description	IP	LT	OT	RX
021	Home health services — Speech pathology and audiology services provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services			X	
022	Private duty nursing services			X	
023	Advanced practice nurse services			X	
024	Pediatric nurse			X	
025	Nurse-midwife service			X	
026	Nurse practitioner services			X	
027	Respiratory care for ventilator-dependent individuals			X	
028	Clinic services			X	
029	Dental services			X	
030	Physical therapy services (when not provided under home health services)			X	
031	Occupational therapy services (when not provided under home health services)			X	
032	Speech, hearing, and language disorders services (when not provided under home health services)			X	
033	Prescribed drugs				X
034	Over-the-counter medications				X
035	Dentures			X	
036	Medical equipment/prosthetic devices			X	X
037	Eyeglasses			X	
038	Hearing Aids			X	
039	Diagnostic services			X	
040	Screening services			X	
041	Preventive services			X	
042	Well-baby and well-childcare services as defined by the State.			X	
043	Rehabilitative services			X	
044	Inpatient hospital services for individuals age 65 or older in institutions for mental diseases		X		
045	Nursing facility services for individuals age 65 or older in institutions for mental diseases		X		
046	Intermediate care facility (ICF)/Intermediate Care Facilities for individuals with Intellectual Disabilities (IIDICF)/Individuals with Intellectual Disabilities (IID) services		X		
047	Nursing facility services, other than in institutions for mental diseases		X		
048	Inpatient psychiatric services for individuals under age 21		X		
049	Outpatient mental health services, other than Outpatient substance abuse treatment services. This TOS includes services furnished in a State-operated mental hospital and including community-based services.			X	
050	Inpatient substance abuse treatment services and residential substance abuse treatment services.		X	X	
051	Personal care services			X	
052	Primary care case management services			X	

TOS code	TOS description	IP	LT	OT	RX
053	Targeted case management services			X	
054	Case Management services other than those that meet the definition of primary care case management services or targeted case management services			X	
055	Care coordination services			X	
056	Transportation services			X	
057	Enabling services			X	
058	Services furnished in a religious nonmedical health care institution	X			
059	Skilled nursing facility services for individuals under age 21		X		
060	Emergency hospital services	X		X	
061	Critical access hospital services — OT			X	
062	HCBS — Case management services			X	
063	HCBS — Homemaker services			X	
064	HCBS — Home health aide services			X	
065	HCBS — Personal care services			X	
066	HCBS — Adult day health services			X	
067	HCBS — Habilitation services			X	
068	HCBS — Respite care services			X	
069	HCBS — Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness			X	
070	HCBS — Day Care			X	
071	HCBS — Training for family members			X	
072	HCBS — Minor modification to the home			X	
073	HCBS — Other services requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization			X	
074	HCBS — Expanded habilitation services — Prevocational services			X	
075	HCBS — Expanded habilitation services — Educational services			X	
076	HCBS — Expanded habilitation services — Supported employment services, which facilitate paid employment			X	
077	HCBS65-plus — Case management services			X	
078	HCBS-65-plus — Homemaker services			X	
079	HCBS-65-plus — Home health aide services			X	
080	HCBS-65-plus — Personal care services			X	
081	HCBS-65-plus — Adult day health services			X	
082	HCBS-65-plus — Respite care services			X	
083	HCBS-65-plus — Other medical and social services			X	
084	Sterilizations	X		X	
085	Prenatal care and pre-pregnancy family planning services and supplies			X	X
086	Other Pregnancy-related Procedures	X		X	
087	Hospice services			X	
088	Any other health care services or items specified by the Secretary and not excluded under regulations			X	
089	Disposable medical supplies			X	X
090	Critical access hospital services — IP	X			
091	Skilled care — hospital residing	X			

TOS code	TOS description	IP	LT	OT	RX
092	Exceptional care — hospital residing	X			
093	Non-acute care — hospital residing	X			
115	Residential care			X	
119	Capitated payments to HMOs, HIOs, or PACE plans			X	
120	Capitated payments for primary care case management (PCCM)			X	
121	Premium payments for private health insurance			X	
122	Capitated payments to prepaid health plans (PHPs)			X	
123	Disproportionate share hospital (DSH) payments	X		X	
127	Indian Health Service (IHS) — Family Plan			X	X
131	Drug Rebates			X	X
132	Supplemental payment — inpatient	X			
133	Supplemental payment — nursing		X		
134	Supplemental payment — outpatient			X	
135	Electronic health record (EHR) payments to provider	X		X	
136	In vitro diagnostic products administered during any portion of the emergency period for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19, and the administration of such in vitro diagnostic products	X	X	X	X
137	COVID–19 testing-related services	X	X	X	X
138	Per member per month (PMPM) payments for health home services			X	
139	Per member per month (PMPM) payments for Medicare Part A premiums			X	
140	Per member per month (PMPM) payments for Medicare Part B premiums			X	
141	Per member per month (PMPM) payments for Medicare Advantage Dual Special Needs Plans (D-SNP) – Medicare Part C			X	
142	Per member per month (PMPM) payments for Medicare Part D premiums			X	
143	Per member per month (PMPM) payments for other payments			X	
144	Payments to individuals for personal assistance services under 1915(j)			X	
145	Medication Assisted Treatment (MAT) services and drugs for evidenced-based treatment of Opioid Use Disorder (OUD) in accordance with section 1905(a)(29) of the Social Security Act	X	X	X	X
146	Inpatient Psychiatric Services for beneficiaries between the ages of 22 and 64 who receive services in an institution for mental disease (IMD)	X	X	X	X
147	Residential Pediatric Recovery Center (RPRC): A center or facility that furnishes items and services for which medical assistance is available under the State plan to infants with the diagnosis of neonatal abstinence syndrome without any other significant medical risk factors.	X	X	X	X

Null/missing = source value is missing or unknown

COMMENT: For additional information regarding the TOS_CDs in the data files, refer to DQ Atlas ("Data Quality and Analytic Resource Downloads. Service Use Information." Type of service — IP, LT, OT, and RX https://www.medicaid.gov/dq-atlas/landing/resources).

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TP_COINSRNC_PD_AMT

LABEL: Third Party Coinsurance Paid Amount

DESCRIPTION: The amount of money paid by a third-party on behalf of the beneficiary towards coinsurance for the claim.

SHORT NAME: TP_COINSRNC_PD_AMT

LONG NAME: TP_COINSRNC_PD_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: Dollar amount with two decimal places (e.g., 98.76)

COMMENT: —

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TP_COPAY_PD_AMT

LABEL: Third Party Copayment Paid Amount

DESCRIPTION: The amount the third-party paid toward the copayment amount.

SHORT NAME: TP_COPAY_PD_AMT

LONG NAME: TP_COPAY_PD_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: Dollar amount with two decimal places (e.g., 98.76)
Null/missing = source value is missing or unknown

COMMENT: —

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TP_PD_AMT

LABEL: Total Third-Party Liability Paid Amount

DESCRIPTION: Third-Party Liability (TPL) refers to the legal obligation of third parties (i.e., certain individuals, entities, or programs), to pay all or part of the expenditures for medical assistance furnished under a state plan.

SHORT NAME: TP_PD_AMT

LONG NAME: TP_PD_AMT

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: Dollar amount with two decimal places (e.g., 98.76); may be negative.
Null/missing = source value is missing or unknown

COMMENT: This is the total amount denoted at the header claim level paid by the third party.

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WVR_ID

LABEL: Waiver Identification Number

DESCRIPTION: Field specifying the waiver or demonstration which authorized payment for a claim.

SHORT NAME: WVR_ID

LONG NAME: WVR_ID

TYPE: CHAR

LENGTH: 20

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES: Waiver ID, maximum 20 letters and numbers
Null/missing = source value is missing or unknown

COMMENT: These IDs must be the approved, full federal waiver ID number assigned during the state submission and CMS approval process. The categories of demonstration and waiver programs include:

- 1915(b)(1);
- 1915(b)(2);
- 1915(b)(3), and 1915(b)(4) managed care waivers;
- 1915(c) home and community-based services waivers;
- combined 1915(b) and 1915(c) managed home and community-based services waivers and 1115 demonstrations.

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WVR_TYPE_CD

LABEL: Waiver Type Code

DESCRIPTION: Code for specifying waiver type under which the eligible beneficiary is covered during the month and receiving services/under which claim is submitted.

SHORT NAME: WVR_TYPE_CD

LONG NAME: WVR_TYPE_CD

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Header
LT Header
OT Header
RX Header

VALUES:
01 = Other 1115(a) Medicaid research and evaluation demonstrations.
02 = 1915(b)(1) – These waivers permit freedom-of-choice or mandatory managed care with some voluntary managed care.
03 = 1915(b)(2) – These waivers allow states to use enrollment brokers.
04 = 1915(b)(3) – These waivers allow states to use savings to provide additional services that are not in the State Plan.
05 = 1915(b)(4) – These waivers allow fee for service selective contracting.
06 = 1915(c) – Aged and Disabled
07 = 1915(c) – Aged
08 = 1915(c) – Physical Disabilities
09 = 1915(c) – Intellectual Disabilities
10 = 1915(c) – Intellectual and Developmental Disabilities
11 = 1915(c) – Brain Injury
12 = 1915(c) – HIV/AIDS
13 = 1915(c) – Technology Dependent or Medically Fragile
14 = 1915(c) – Disabled (other)
15 = 1915(c) – Enrolled in 1915(c) waiver for unspecified or unknown populations
16 = 1915(c) – Autism/Autism Spectrum Disorder
17 = 1915(c) – Developmental Disabilities
18 = 1915(c) – Mental Illness – Age 18 or Older
19 = 1915(c) – Mental Illness – Under Age 18
20 = 1915(c) waiver concurrent with an 1115 or 1915(b) managed care authority
21 = 1115 Health Insurance Flexibility and Accountability (HIFA) demonstration
22 = 1115 Pharmacy demonstration
23 = 1115 Disaster-related demonstration
24 = 1115 Family planning demonstration.
25 = 1115 Substance use demonstration
26 = 1115 Premium Assistance demonstration

27 = 1115 Beneficiary engagement demonstration
28 = 1115 Former foster care youth from another state
29 = 1115 Managed long term services and support
30 = 1115 Delivery system reform
31 = 1332 Demonstration
32 = 1915(b) waiver
33 = 1915(c) waiver
Null/missing = source value is missing or unknown

COMMENT: —

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XIX_SRVC_CTGRY_CD

LABEL: CMS-64 Form Category of Service for the Paid Claim

DESCRIPTION: A code indicating the category of service for the paid claim. The category of service is the line item from the CMS-64 form that states use to report their expenditures and request federal financial participation.

SHORT NAME: XIX_SRVC_CTGRY_CD

LONG NAME: XIX_SRVC_CTGRY_CD

TYPE: CHAR

LENGTH: 4

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): All Line Files

VALUES:
001A = Inpatient Hospital — Reg. Payments
001B = Inpatient Hospital — DSH
001C = Inpatient Hospital — Sup. Payments
001D = Inpatient Hospital — GME Payments
002A = Mental Health Facility Services — Reg. Payments
002B = Mental Health Facility – DSH
002C = Certified Community Behavior Health Clinic Payments
003A = Nursing Facility Services — Reg. Payments
003B = Nursing Facility Services — Sup. Payments
004A = Intermediate Care Facility Services — Individuals with Intellectual Disabilities: Public Providers
004B = Intermediate Care Facility Services — Individuals with Intellectual Disabilities: Private Providers
005A = Physician and Surgical Services — Reg. Payments
005B = Physician and Surgical Services — Sup. Payments
005C = Physician and Surgical Services — Evaluation and Management
006A = Outpatient Hospital Services — Reg. Payments
006B = Outpatient Hospital Services — Sup. Payments
0007 = Prescribed Drugs
0008 = Dental Services
009A = Other Practitioners Services — Reg. Payments
009B = Other Practitioners Services — Sup. Payments
0010 = Clinic Services
0011 = Laboratory/Radiological
0012 = Home Health Services
0013 = Sterilizations
0014 = Other Pregnancy-related Procedures
0015 = EPSDT Screening
0016 = Rural Health
017A = Medicare — Part A
017B = Medicare — Part B

17C1 = 120% — 134% of Poverty
017D = Coinsurance
018A = Medicaid — MCO
18A5 = Medicaid MCO - Certified Community Behavior Health Clinic Payments
18B1 = Prepaid Ambulatory Health Plan
18B2 = Prepaid Inpatient Health Plan
018C = Medicaid — Group Health
018D = Medicaid — Coinsurance
018E = Medicaid — Other
019A = Home and Community-Based Services — Reg. Pay. (Waiv)
019B = Home and Community-Based Services — St. Plan 1915(i) Only Pay
019C = Home and Community-Based Services — St. Plan 1915(j) Only Pay
019D = Home and Community Based Services State Plan 1915(k) Community First Choice
0022 = All-Inclusive Care Elderly
023A = Personal Care Services — Reg. Payments
023B = Personal Care Services — SDS 1915(j)
024A = Targeted Case Management Services — Com. Case-Man.
024B = Case Management — Statewide
0025 = Primary Care Case Management
0026 = Hospice Benefits
0027 = Emergency Services for Undocumented Aliens
0028 = Federally Qualified Health Center
0029 = Non-Emergency Medical Transportation
0030 = Physical Therapy
0031 = Occupational Therapy
0032 = Services for Speech, Hearing and Language
0033 = Prosthetic Devices, Dentures, Eyeglasses
0034 = Diagnostic Screening and Preventive Services
034A = Preventive Services Grade A OR B, ACIP Vaccines and their Admin
0035 = Nurse Mid-Wife
0036 = Emergency Hospital Services
0037 = Critical Access Hospitals
0038 = Nurse Practitioner Services
0039 = School Based Services
0040 = Rehabilitative Services (non- school-based)
0041 = Private Duty Nursing
0042 = Freestanding Birth Center
0043 = Health Home for Enrollees w Chronic Conditions
0044 = Tobacco Cessation for Pregnant Women
0045 = Health Homes for Substance-Use-Disorder Enrollees per section 1006 of the SUPPORT for Patients and Communities Act
0046 = Opioid Use Disorder (OUD) Medicaid Assisted Treatment – Drugs
046B = OUD Medicaid Assisted Treatment Services
0047 = American Rescue Plan Act of 2021 (ARP) Section 9811 COVID Vaccine/Vaccine Administration
0049 = Other Care Services
Null/missing = source value is missing or unknown

COMMENT: —

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XXI_SRVC_CTGRY_CD

LABEL: CMS-21 Form Category of Service for the Paid Claim

DESCRIPTION: A code indicating the category of service for the paid claim. The category of service is the line item from the CMS-21 form that states use to report their expenditures and request federal financial participation.

SHORT NAME: XXI_SRVC_CTGRY_CD

LONG NAME: XXI_SRVC_CTGRY_CD

TYPE: CHAR

LENGTH: 3

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): All Line Files

VALUES:
01A = Premiums — Up To 150%: Gross Premiums Paid
01C = Premiums — Over 150%: Gross Premiums Paid
01D = Premiums — Over 150%: Cost Sharing Offset
002 = Inpatient Hospital
02A = Inpatient Hospital Services — DSH
003 = Inpatient Mental Health
03A = Inpatient Mental Health — DSH
03B = Certified Community Behavior Health Clinic Payments
004 = Nursing Care Services
005 = Physician/Surgical
006 = Outpatient Hospital
007 = Outpatient Mental Health
008 = Prescribed Drugs
08A = Drug Rebate
8A2 = Drug Rebate — State
8A3 = MCO — National Agreement
8A4 = MCO — State Sidebar Agreement
8A5 = Increased ACA OFFSET — Fee for Service — 100%
8A6 = Increased ACA OFFSET — MCO — 100%
009 = Dental Services
010 = Vision Services
011 = Other Practitioners
012 = Clinic Services
013 = Therapy Services
014 = Laboratory/Radiological
015 = Medical Equipment
016 = Family Planning
017 = Other Pregnancy-related Procedures
018 = Screening Services
019 = Home Health

020 = Health Services Initiatives
021 = Home and Community
21A = Home and Community-Based Services — Regular Payment (WAIVER)
022 = Hospice
023 = Medical Transportation
024 = Case Management
025 = Translation and Interpretation
026 = American Rescue Plan Act of 2021 (ARP) Section 9821 COVID Vaccine/Vaccine Administration
031 = Other Services
032 = Outreach
033 = Administration (costs incurred by State to administer plan)
034 = PERM Administration
035 = Citizenship Verification Technology CHIPRA
048 = Balance
049 = Less: Collections; total computable amount of refunds or collections attributable to the CHIP program
050 = Total
Null/missing = source value is missing or unknown

COMMENT: —

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