Chronic Conditions Warehouse
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CODEBOOK:
T-MSIS Analytic Files (TAF) Claims
Research Identifiable Files (RIFs)

NOVEMBER 2021 | VERSION 1.4
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## Revision Log

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<td>November 2021</td>
<td>K. Schneider</td>
<td>Added new valid values for TOS_CD and XIX_SRVC_CTGRY_CD.</td>
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<td>September 2021</td>
<td>K. Schneider</td>
<td>Added new valid values for XIX_SRVC_CTGRY_CD and XXI_SRVC_CTGRY_CD.</td>
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<td>September 2021</td>
<td>K. Schneider</td>
<td>Added new valid values for XIX_SRVC_CTGRY_CD and XXI_SRVC_CTGRY_CD; added new valid values related to COVID-19: PGM_TYPE_CD, BNFT_TYPE_CD, and TOS_CD.</td>
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<td>August 2020</td>
<td>K. Schneider</td>
<td>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</td>
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<td>November 2019</td>
<td>K. Schneider</td>
<td>Initial release of codebook for T-MSIS Analytic Files (TAF) Claims files</td>
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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 claims1 (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)


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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<tr>
<td>SRVC_END_DT</td>
<td>Service End Date</td>
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<tr>
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<tr>
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<td>TOOTH_ORAL_CVTY_AREA_DSGNTD_CD</td>
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<td>TOOTH_SRFC_CD</td>
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<td>TOS_CD</td>
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<td>TP_COINSRNC_PD_AMT</td>
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<td>TP_COPAY_PD_AMT</td>
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<td>WVR_ID</td>
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<tr>
<td>WVR_TYPE_CD</td>
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<tr>
<td>XIX_SRVC_CTGRY_CD</td>
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<tr>
<td>XXI_SRVC_CTGRY_CD</td>
<td>285</td>
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</table>
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:** —
**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:** —
**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:** —
**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 026 and 027.
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.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>091</td>
<td>Dispensing fee adjustment</td>
</tr>
<tr>
<td>092</td>
<td>Claim Paid in full</td>
</tr>
<tr>
<td>093</td>
<td>No Claim level Adjustments. Notes: As of 004010, CAS at the claim level is optional.</td>
</tr>
<tr>
<td>094</td>
<td>Processed in Excess of charges</td>
</tr>
<tr>
<td>095</td>
<td>Plan procedures not followed</td>
</tr>
<tr>
<td>096</td>
<td>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).</td>
</tr>
<tr>
<td>097</td>
<td>The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.</td>
</tr>
<tr>
<td>098</td>
<td>The hospital must file the Medicare claim for this inpatient non-physician service</td>
</tr>
<tr>
<td>099</td>
<td>Medicare Secondary Payer Adjustment Amount</td>
</tr>
<tr>
<td>100</td>
<td>Payment made to patient/insured/responsible party</td>
</tr>
<tr>
<td>101</td>
<td>Predetermination: anticipated payment upon completion of services or claim adjudication</td>
</tr>
<tr>
<td>102</td>
<td>Major Medical Adjustment</td>
</tr>
<tr>
<td>103</td>
<td>Provider promotional discount (e.g., Senior citizen discount).</td>
</tr>
<tr>
<td>104</td>
<td>Managed care withholding</td>
</tr>
<tr>
<td>105</td>
<td>Tax withholding</td>
</tr>
<tr>
<td>106</td>
<td>Patient payment option/election not in effect.</td>
</tr>
<tr>
<td>107</td>
<td>The related or qualifying claim/service was not identified on this claim.</td>
</tr>
<tr>
<td>108</td>
<td>Rent/purchase guidelines were not met</td>
</tr>
<tr>
<td>109</td>
<td>Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor</td>
</tr>
<tr>
<td>110</td>
<td>Billing date predates service date</td>
</tr>
<tr>
<td>112</td>
<td>Service not furnished directly to the patient and/or not documented</td>
</tr>
<tr>
<td>117</td>
<td>Transportation is only covered to the closest facility that can provide the necessary care</td>
</tr>
<tr>
<td>118</td>
<td>ESRD network support adjustment</td>
</tr>
<tr>
<td>119</td>
<td>Benefit maximum for this time period or occurrence has been reached</td>
</tr>
<tr>
<td>121</td>
<td>Indemnification adjustment — compensation for outstanding member responsibility</td>
</tr>
<tr>
<td>123</td>
<td>Payer refund due to overpayment</td>
</tr>
</tbody>
</table>
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/](http://www.x12.org/codes/claim-adjustment-reason-codes/)
**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:** —
**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).
**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:** —
**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](http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html)


**COMMENT:** —
**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

**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:** —
**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:** —
### 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  

**VALUES:** 

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/](https://npiregistry.cms.hhs.gov/)

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

**COMMENT:** Null/missing = source value is missing or unknown
**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


Null/missing = source value is missing or unknown

**COMMENT:** —
**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: —
ALLOWD_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: ALLOWD_SRVC_QTY

LONG NAME: ALLOWD_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.
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
**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:** —
**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: 011x 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
### Variable Details

**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
**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.
**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:** —
**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

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Variable Details

**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:** —
**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


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/](https://npiregistry.cms.hhs.gov/)

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**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
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56 = Individual Certified Prosthetist
57 = Individual Certified Orthotist-Prosthetist
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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: —
**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


Null/missing = source value is missing or unknown

**COMMENT:** —
**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: —
**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:** —
### 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
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>021</td>
<td>Medical care and any type of remedial care recognized under State law — Other Practitioners' Services within scope of practice as defined by state law</td>
</tr>
<tr>
<td>022</td>
<td>Home Health Services — Physical therapy; occupational therapy; speech pathology; audiology provided by a home health agency</td>
</tr>
<tr>
<td>023</td>
<td>Private Duty Nursing</td>
</tr>
<tr>
<td>024</td>
<td>Clinic Services</td>
</tr>
<tr>
<td>025</td>
<td>Dental Services</td>
</tr>
<tr>
<td>026</td>
<td>Physical Therapy and Related Services — Physical Therapy</td>
</tr>
<tr>
<td>027</td>
<td>Physical Therapy and Related Services — Occupational Therapy</td>
</tr>
<tr>
<td>028</td>
<td>Physical Therapy and Related Services — Services for individuals with speech, hearing and language disorders</td>
</tr>
<tr>
<td>029</td>
<td>Prescription drugs, dentures, and prosthetic devices; and eyeglasses — Prescribed Drugs</td>
</tr>
<tr>
<td>030</td>
<td>Prescription drugs, dentures, and prosthetic devices; and eyeglasses — Dentures</td>
</tr>
<tr>
<td>031</td>
<td>Prescription drugs, dentures, and prosthetic devices; and eyeglasses — Prosthetic Devices</td>
</tr>
<tr>
<td>032</td>
<td>Prescription drugs, dentures, and prosthetic devices; and eyeglasses — Eyeglasses</td>
</tr>
<tr>
<td>033</td>
<td>Other diagnostic, screening, preventive, and rehabilitative services — Diagnostic Services</td>
</tr>
<tr>
<td>034</td>
<td>Other diagnostic, screening, preventive, and rehabilitative services — Screening Services</td>
</tr>
<tr>
<td>035</td>
<td>Other diagnostic, screening, preventive, and rehabilitative services — Preventive Services</td>
</tr>
<tr>
<td>036</td>
<td>Other diagnostic, screening, preventive, and rehabilitative services — Rehabilitative Services</td>
</tr>
<tr>
<td>037</td>
<td>Services for individuals over age 65 in IMDs — Inpatient hospital services</td>
</tr>
<tr>
<td>038</td>
<td>Services for individuals over age 65 in IMDs — Nursing facility services</td>
</tr>
<tr>
<td>039</td>
<td>Intermediate Care Facility Services for individuals with intellectual disabilities or persons with related conditions</td>
</tr>
<tr>
<td>040</td>
<td>Inpatient psychiatric facility services for under 21</td>
</tr>
<tr>
<td>041</td>
<td>Hospice Care</td>
</tr>
<tr>
<td>042</td>
<td>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)</td>
</tr>
<tr>
<td>043</td>
<td>Case Management Services and TB related services — Special TB related services under section 1902(z)(2)</td>
</tr>
<tr>
<td>044</td>
<td>Respiratory care services under 1902(e9)(A) through (C)</td>
</tr>
<tr>
<td>045</td>
<td>Personal care services</td>
</tr>
<tr>
<td>046</td>
<td>Primary care case management services</td>
</tr>
<tr>
<td>047</td>
<td>Special sickle-cell anemia-related services</td>
</tr>
<tr>
<td>048</td>
<td>Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary — Transportation</td>
</tr>
<tr>
<td>049</td>
<td>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</td>
</tr>
<tr>
<td>050</td>
<td>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</td>
</tr>
<tr>
<td>051</td>
<td>Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary — Emergency hospital services</td>
</tr>
<tr>
<td>052</td>
<td>Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary — Critical Access Hospitals</td>
</tr>
<tr>
<td>053</td>
<td>Extended services for pregnant women — Additional Services for any other medical conditions that may complicate pregnancy</td>
</tr>
<tr>
<td>054</td>
<td>Community First Choice</td>
</tr>
<tr>
<td>055</td>
<td>Health Home Services</td>
</tr>
</tbody>
</table>
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
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>090</td>
<td>Non-Medical Transportation</td>
</tr>
<tr>
<td>091</td>
<td>Special Medical Equipment (minor assistive Devices)</td>
</tr>
<tr>
<td>092</td>
<td>Home Delivered meals</td>
</tr>
<tr>
<td>093</td>
<td>Assistive Technology (i.e., communication devices)</td>
</tr>
<tr>
<td>094</td>
<td>Personal Emergency Response (PERS)</td>
</tr>
<tr>
<td>095</td>
<td>Nursing Services</td>
</tr>
<tr>
<td>096</td>
<td>Community Transition Services</td>
</tr>
<tr>
<td>097</td>
<td>Adult Foster Care</td>
</tr>
<tr>
<td>098</td>
<td>Day Supports (non-habilitative)</td>
</tr>
<tr>
<td>099</td>
<td>Supported Employment</td>
</tr>
<tr>
<td>100</td>
<td>Supported Living Arrangements</td>
</tr>
<tr>
<td>101</td>
<td>Supports for Consumer Direction (Supports Facilitation)</td>
</tr>
<tr>
<td>102</td>
<td>Participant Directed Goods and Services</td>
</tr>
<tr>
<td>103</td>
<td>Senior Companion (Adult Companion Services)</td>
</tr>
<tr>
<td>104</td>
<td>Assisted Living</td>
</tr>
</tbody>
</table>

**Other**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>105</td>
<td>Program for All-inclusive Care for the Elderly (PACE) Services</td>
</tr>
<tr>
<td>106</td>
<td>Self-directed Personal Assistance Services under 1915(j)</td>
</tr>
<tr>
<td>107</td>
<td>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</td>
</tr>
<tr>
<td>108</td>
<td>COVID–19 testing-related services</td>
</tr>
</tbody>
</table>

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.
**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:** —
**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:** —
**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.
**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.
**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.
**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:** —
**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:** —
**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:**

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1 = A Fee-For-Service (FFS) Medicaid or Medicaid-expansion Claim</td>
</tr>
<tr>
<td>2</td>
<td>2 = Medicaid or Medicaid-expansion Capitated Payment</td>
</tr>
<tr>
<td>3</td>
<td>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.</td>
</tr>
<tr>
<td>4</td>
<td>4 = Medicaid or Medicaid-expansion CHIP Service Tracking Claim</td>
</tr>
<tr>
<td>5</td>
<td>5 = Medicaid or Medicaid-expansion Supplemental Payment (above capitation fee or above negotiated rate) (e.g., FQHC additional reimbursement)</td>
</tr>
<tr>
<td>A</td>
<td>A = Separate CHIP (Title XXI) claim: A Fee-for-Service (FFS) Claim</td>
</tr>
<tr>
<td>B</td>
<td>B = Separate CHIP (Title XXI) claim: Capitated Payment</td>
</tr>
<tr>
<td>C</td>
<td>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</td>
</tr>
<tr>
<td>D</td>
<td>D = Separate CHIP (Title XXI) Service Tracking Claim</td>
</tr>
<tr>
<td>E</td>
<td>E = Separate CHIP (Title XXI) claim for a supplemental payment (above capitation fee or above negotiated rate) (e.g., FQHC additional reimbursement)</td>
</tr>
<tr>
<td>U</td>
<td>U = Other FFS claim</td>
</tr>
<tr>
<td>V</td>
<td>V = Other Capitated Payment</td>
</tr>
</tbody>
</table>
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.
**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:** —
**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:** —
**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:** —
**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:** —
**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:** —
**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:**  —
<table>
<thead>
<tr>
<th>Variable Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COPAY_WVD_IND</strong></td>
</tr>
<tr>
<td><strong>LABEL:</strong> Indicator Signifying Copay was Waived by Provider</td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong> An indicator signifying that the copay was waived by the provider.</td>
</tr>
<tr>
<td><strong>SHORT NAME:</strong> COPAY_WVD_IND</td>
</tr>
<tr>
<td><strong>LONG NAME:</strong> COPAY_WVD_IND</td>
</tr>
<tr>
<td><strong>TYPE:</strong> CHAR</td>
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<tr>
<td><strong>LENGTH:</strong> 1</td>
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<tr>
<td><strong>SOURCE:</strong> T-MSIS Analytic File (TAF) Claims</td>
</tr>
<tr>
<td><strong>FILE(S):</strong> IP Header LT Header OT Header RX Header</td>
</tr>
<tr>
<td><strong>VALUES:</strong> 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</td>
</tr>
<tr>
<td><strong>COMMENT:</strong> —</td>
</tr>
</tbody>
</table>
**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:** —
**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:** —
**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:** —
**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–XXXXXXXX; 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.
**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:** —
**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:** —
**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–XXXXX; 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.
**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.
**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:** —
<table>
<thead>
<tr>
<th><strong>DA_RUN_ID</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>LABEL:</strong> TAF Production Run Identifier (unique for each TAF run)</td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong> A unique identifier that identifies the TAF production run that produced the TAF file</td>
</tr>
<tr>
<td><strong>SHORT NAME:</strong> DA_RUN_ID</td>
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<tr>
<td><strong>LONG NAME:</strong> DA_RUN_ID</td>
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<tr>
<td><strong>TYPE:</strong> NUM</td>
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<tr>
<td><strong>LENGTH:</strong> 8</td>
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<tr>
<td><strong>SOURCE:</strong> T-MSIS Analytic File (TAF) Claims</td>
</tr>
<tr>
<td><strong>FILE(S):</strong> All Header Claim and Line Files</td>
</tr>
<tr>
<td><strong>VALUES:</strong> —</td>
</tr>
<tr>
<td><strong>COMMENT:</strong> —</td>
</tr>
</tbody>
</table>
### 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:** —
**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.).
<table>
<thead>
<tr>
<th>Variable</th>
<th>Label</th>
<th>Description</th>
<th>Short Name</th>
<th>Long Name</th>
<th>Type</th>
<th>Length</th>
<th>Source</th>
<th>Files</th>
<th>Values</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>DDCTBL_AMT</td>
<td>Beneficiary Deductible Amount</td>
<td>The amount of money the beneficiary paid towards an annual deductible.</td>
<td>DDCTBL_AMT</td>
<td>DDCTBL_AMT</td>
<td>NUM</td>
<td>8</td>
<td>T-MSIS Analytic File (TAF) Claims</td>
<td>IP Header, LT Header, OT Header, RX Header</td>
<td>Dollar amount with two decimal places (e.g., 98.76)</td>
<td>—</td>
</tr>
</tbody>
</table>

^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:** —
### Variable Details

<table>
<thead>
<tr>
<th>Variable</th>
<th>Label</th>
<th>Description</th>
<th>Short Name</th>
<th>Long Name</th>
<th>Type</th>
<th>Length</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>DGNS_CD_1</td>
<td>Diagnosis Code (1–12)</td>
<td>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).</td>
<td>DGNS_CD_1, DGNS_CD_7</td>
<td>DGNS_CD_1, DGNS_CD_7</td>
<td>CHAR</td>
<td>7</td>
<td>T-MSIS Analytic File (TAF) Claims</td>
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<tr>
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<td>DGNS_CD_4, DGNS_CD_10</td>
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<tr>
<td>DGNS_CD_5</td>
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<td>DGNS_CD_5, DGNS_CD_11</td>
<td>DGNS_CD_5, DGNS_CD_11</td>
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</tr>
<tr>
<td>DGNS_CD_6</td>
<td></td>
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<td>DGNS_CD_6, DGNS_CD_12</td>
<td>DGNS_CD_6, DGNS_CD_12</td>
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<td></td>
</tr>
</tbody>
</table>
FILE(S): IP Header
     LT Header
     OT Header

VALUES: —

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).
**Variable Details**

**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_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

**LONG NAME:**
- 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

**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
Null/miissing = 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).
Variable Details

**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:**

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<thead>
<tr>
<th>SHORT_NAME_1</th>
<th>SHORT_NAME_2</th>
<th>SHORT_NAME_3</th>
<th>SHORT_NAME_4</th>
<th>SHORT_NAME_5</th>
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<th>SHORT_NAME_7</th>
<th>SHORT_NAME_8</th>
<th>SHORT_NAME_9</th>
<th>SHORT_NAME_10</th>
<th>SHORT_NAME_11</th>
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<tbody>
<tr>
<td>DGNS_VRSN_CD_1</td>
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<td>DGNS_VRSN_CD_12</td>
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</tbody>
</table>

**TYPE:** CHAR

**LENGTH:** 1

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

**FILE(S):** IP Header
Variable Details

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.
**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.
**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


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/](https://npiregistry.cms.hhs.gov/)
**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


Null/missing = source value is missing or unknown

**COMMENT:** Values and websites referenced may change over time.
**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](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software.html)
**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:** —
**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.
**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.
**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).
**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 (1\textsuperscript{st} and 2\textsuperscript{nd} 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
Variable Details

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
PO = 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
3I = Patient Referral
3J = Instructions Understood
3K = Instructions Understood
3L = 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.
**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:** —

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**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).
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: —
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:** —
**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)


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/
**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.
**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:** —
**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:** —
**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:** —
**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:** —

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### 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
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<td>09011</td>
<td>Respite, Out-Of-Home</td>
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<td>09012</td>
<td>Respite, In-Home</td>
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<tr>
<td>09020</td>
<td>Caregiver Counseling and/or Training</td>
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<td>10010</td>
<td>Mental Health Assessment</td>
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<td>Assertive Community Treatment</td>
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<td>Housing Consultation</td>
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<tr>
<td>17990</td>
<td>Other</td>
</tr>
</tbody>
</table>

**Null/missing** = source value is missing or unknown

**COMMENT:** Values containing digits will include leading zeros.

Values and websites referenced may change over time.
**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.
**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:** —
**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


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/](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:** —
**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).
**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.
**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.
**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:

<table>
<thead>
<tr>
<th>Codes</th>
<th>Classification and area of specialization</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Individual or Groups of Individuals</td>
<td></td>
</tr>
<tr>
<td>101Y00000X</td>
<td>Behavioral Health and Social Service Providers: Counselor</td>
</tr>
<tr>
<td>101YM8000X</td>
<td>Behavioral Health and Social Service Providers: Counselor, Mental Health</td>
</tr>
<tr>
<td>101YP1600X</td>
<td>Behavioral Health and Social Service Providers: Counselor, Pastoral</td>
</tr>
<tr>
<td>101YP2500X</td>
<td>Behavioral Health and Social Service Providers: Counselor, Professional</td>
</tr>
<tr>
<td>101YS0200X</td>
<td>Behavioral Health and Social Service Providers: Counselor, School</td>
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<tr>
<td>102L00000X</td>
<td>Behavioral Health and Social Service Providers: Psychoanalyst</td>
</tr>
<tr>
<td>102X00000X</td>
<td>Behavioral Health and Social Service Providers: Poetry Therapist</td>
</tr>
<tr>
<td>103G00000X</td>
<td>Behavioral Health and Social Service Providers: Clinical Neuropsychologist</td>
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<tr>
<td>103GC0700X</td>
<td>Behavioral Health and Social Service Providers: Clinical Neuropsychologist, Clinical</td>
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<tr>
<td>103K00000X</td>
<td>Behavioral Health and Social Service Providers: Behavior Analyst</td>
</tr>
<tr>
<td>103T00000X</td>
<td>Behavioral Health and Social Service Providers: Psychologist</td>
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<tr>
<td>103TA0700X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Adult Development and Aging</td>
</tr>
<tr>
<td>103TB0200X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Cognitive and Behavioral</td>
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<tr>
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<td>Behavioral Health and Social Service Providers: Psychologist, Clinical</td>
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<tr>
<td>103TC1900X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Counseling</td>
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<td>103TC2200X</td>
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<tr>
<td>103TE1000X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Educational</td>
</tr>
<tr>
<td>103TE1100X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Exercise and Sports</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
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<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>103TF0000X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Family</td>
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<tr>
<td>103TF0200X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Forensic</td>
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<tr>
<td>103TH0004X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Health</td>
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<td>103TH0100X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Health Service</td>
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<td>103TM1700X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Men and Masculinity</td>
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<td>103TM1800X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Mental Retardation and Developmental Disabilities</td>
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<td>103TP0016X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Prescribing (Medical)</td>
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<td>103TP0814X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Psychoanalysis</td>
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<td>103TP2700X</td>
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<tr>
<td>103TP2701X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Group Psychotherapy</td>
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<td>103TR0400X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Rehabilitation</td>
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<td>103TS0200X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, School</td>
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<tr>
<td>103TW0100X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Women</td>
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<td>104100000X</td>
<td>Behavioral Health and Social Service Providers: Social Worker</td>
</tr>
<tr>
<td>1041C0700X</td>
<td>Behavioral Health and Social Service Providers: Social Worker, Clinical</td>
</tr>
<tr>
<td>1041S0200X</td>
<td>Behavioral Health and Social Service Providers: Social Worker, School</td>
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<tr>
<td>106E00000X</td>
<td>Behavioral Health and Social Service Providers: Assistant Behavior Analyst</td>
</tr>
<tr>
<td>106H00000X</td>
<td>Behavioral Health and Social Service Providers: Marriage and Family Therapist</td>
</tr>
<tr>
<td>106S00000X</td>
<td>Behavioral Health and Social Service Providers: Behavior Technician</td>
</tr>
<tr>
<td>163WP0807X</td>
<td>Nursing Service Providers: Registered Nurse, Psychiatric/Mental Health, Child and Adolescent</td>
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<tr>
<td>163WP0808X</td>
<td>Nursing Service Providers: Registered Nurse, Psychiatric/Mental Health</td>
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<tr>
<td>163WP0809X</td>
<td>Nursing Service Providers: Registered Nurse, Psychiatric/Mental Health, Adult</td>
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<tr>
<td>167G00000X</td>
<td>Nursing Service Providers: Licensed Psychiatric Technician</td>
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<td>1835P1300X</td>
<td>Pharmacy Service Providers: Pharmacist, Psychiatric</td>
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<tr>
<td>2080P0006X</td>
<td>Allopathic and Osteopathic Physicians: Pediatrics, Developmental — Behavioral Pediatrics</td>
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<tr>
<td>2080P0008X</td>
<td>Allopathic and Osteopathic Physicians: Pediatrics, Neurodevelopmental Disabilities</td>
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<tr>
<td>2084B0040X</td>
<td>Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Behavioral Neurology and Neuropsychiatry</td>
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<tr>
<td>2084F0202X</td>
<td>Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Forensic Psychiatry</td>
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<tr>
<td>2084P0005X</td>
<td>Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Neurodevelopmental Disabilities</td>
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<td>2084P0015X</td>
<td>Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Psychosomatic Medicine</td>
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<td>Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Psychiatry</td>
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<td>Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Child and Adolescent Psychiatry</td>
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<td>2084P0805X</td>
<td>Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Geriatric Psychiatry</td>
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<td>225XM0800X</td>
<td>Respiratory, Developmental, Rehabilitative and Restorative Service Providers: Occupational Therapist, Mental Health</td>
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<tr>
<td>363LP0808X</td>
<td>Physician Assistants and Advanced Practice Nursing Providers: Nurse Practitioner, Psychiatric/Mental Health</td>
</tr>
<tr>
<td>364SP0807X</td>
<td>Physician Assistants and Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health, Child and Adolescent</td>
</tr>
<tr>
<td>364SP0808X</td>
<td>Physician Assistants and Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health</td>
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<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>364SP0809X</td>
<td>Physician Assistants and Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health, Adult</td>
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<td>364SP0810X</td>
<td>Physician Assistants and Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health, Child and Family</td>
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<td>364SP0811X</td>
<td>Physician Assistants and Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health, Chronically Ill</td>
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<td>364SP0812X</td>
<td>Physician Assistants and Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health, Community</td>
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<tr>
<td>364SP0813X</td>
<td>Physician Assistants and Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health, Geropsychiatric</td>
</tr>
</tbody>
</table>

(b) Non-Individual

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

**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.
**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:

<table>
<thead>
<tr>
<th>Codes</th>
<th>Classification and area of specialization</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Individual or Groups of Individuals</td>
<td></td>
</tr>
<tr>
<td>101YA0400X</td>
<td>Behavioral Health and Social Service Providers: Counselor, Addiction (Substance Use Disorder)</td>
</tr>
<tr>
<td>103TA0400X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Addiction (Substance Use Disorder)</td>
</tr>
<tr>
<td>163WA0400X</td>
<td>Nursing Service Providers: Registered Nurse, Addiction (Substance Use Disorder)</td>
</tr>
<tr>
<td>207LA0401X</td>
<td>Allopathic and Osteopathic Physicians: Anesthesiology, Addiction Medicine</td>
</tr>
<tr>
<td>207QA0401X</td>
<td>Allopathic and Osteopathic Physicians: Family Medicine, Addiction Medicine</td>
</tr>
<tr>
<td>207RA0401X</td>
<td>Allopathic and Osteopathic Physicians: Internal Medicine, Addiction Medicine</td>
</tr>
<tr>
<td>2084A0401X</td>
<td>Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Addiction Medicine</td>
</tr>
<tr>
<td>2084P0802X</td>
<td>Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Addiction Psychiatry</td>
</tr>
<tr>
<td>2083A0300X</td>
<td>Preventive Medicine — Addiction Medicine</td>
</tr>
<tr>
<td>(b) Non-Individual</td>
<td></td>
</tr>
<tr>
<td>261QM2800X</td>
<td>Ambulatory Health Care Facilities: Clinic/Center, Methadone</td>
</tr>
<tr>
<td>261QR0405X</td>
<td>Ambulatory Health Care Facilities: Clinic/Center, Rehabilitation, Substance Use Disorder</td>
</tr>
<tr>
<td>276400000X</td>
<td>Hospital Units: Rehabilitation, Substance Use Disorder Unit</td>
</tr>
<tr>
<td>324500000X</td>
<td>Residential Treatment Facilities: Substance Abuse Rehabilitation Facility</td>
</tr>
</tbody>
</table>
3245S0500X Residential Treatment Facilities: Substance Abuse Rehabilitation Facility, Substance Abuse Treatment, Children


[^ Back to TOC ^]
**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
**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:** —
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: —
**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


Null/missing = source value is missing or unknown

**COMMENT:** Values will include leading zeros.

Values and websites referenced may change over time.

\[^{Back to TOC}\]
**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.
**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](https://x12.org/codes/claim-status-codes)

Null/missing = source value is missing or unknown

**COMMENT:** Values and websites referenced may change over time.
**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:** —
<table>
<thead>
<tr>
<th>Variable Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LINE_MDCD_ALOWD_AMT</strong></td>
</tr>
<tr>
<td><strong>LABEL:</strong></td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong></td>
</tr>
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<td><strong>TYPE:</strong></td>
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<td><strong>FILE(S):</strong></td>
</tr>
<tr>
<td><strong>VALUES:</strong></td>
</tr>
<tr>
<td><strong>COMMENT:</strong></td>
</tr>
</tbody>
</table>
**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:** —
**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.
**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.
**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:** —
**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.
**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.
**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:** —
**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:** —
**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.
**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.
**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)
- 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:** —
**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

**LONG NAME:** LINE_PRCDR_MDFR_CD_1 LINE_PRCDR_MDFR_CD_3

**TYPE:** CHAR

**LENGTH:** 2

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

**FILE(S):** OT Line

**VALUES:** 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.
**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:** —
**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:** —
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: —
**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).
**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.
**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
**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:** —
**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](https://www.cms.gov/Medicare/coding/ICD10/Downloads/ICD-10-MS-DRG-v31R-Definitions-Manual-Text.zip)
**MDCD_ACMODTN_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_ACMODTN_PD_AMT

**LONG NAME:** MDCD_ACMODTN_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.
**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.
### 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.
**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:** —
**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:** —
**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.
**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:** —
**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:** —
**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.

[^Back to TOC^]
**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.
**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:** —
**MDCR_REIMBRSMNT_TYPE_CD**

**LABEL:** Medicare Reimbursement Type Code

**DESCRIPTION:** This code indicates the type of Medicare reimbursement.

**SHORT NAME:** MDCR_REIMBRSMNT_TYPE_CD

**LONG NAME:** MDCR_REIMBRSMNT_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 = OPSS — 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:** —
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 using ICD-9 diagnosis codes 290–302 and 306–319 and ICD-10 diagnosis codes F01–F09 and F20–F99 to identify mental health-related claims.
**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:

<table>
<thead>
<tr>
<th>Code</th>
<th>Classification and area of specialization</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Individual or Groups of Individuals</td>
<td></td>
</tr>
<tr>
<td>101Y00000X</td>
<td>Behavioral Health and Social Service Providers: Counselor</td>
</tr>
<tr>
<td>101YM0800X</td>
<td>Behavioral Health and Social Service Providers: Counselor, Mental Health</td>
</tr>
<tr>
<td>101YP1600X</td>
<td>Behavioral Health and Social Service Providers: Counselor, Pastoral</td>
</tr>
<tr>
<td>101YP2500X</td>
<td>Behavioral Health and Social Service Providers: Counselor, Professional</td>
</tr>
<tr>
<td>101YS0200X</td>
<td>Behavioral Health and Social Service Providers: Counselor, School</td>
</tr>
<tr>
<td>102L00000X</td>
<td>Behavioral Health and Social Service Providers: Psychoanalyst</td>
</tr>
<tr>
<td>102X00000X</td>
<td>Behavioral Health and Social Service Providers: Poetry Therapist</td>
</tr>
<tr>
<td>103G00000X</td>
<td>Behavioral Health and Social Service Providers: Clinical Neuropsychologist</td>
</tr>
<tr>
<td>103GC0700X</td>
<td>Behavioral Health and Social Service Providers: Clinical Neuropsychologist, Clinical</td>
</tr>
<tr>
<td>103K00000X</td>
<td>Behavioral Health and Social Service Providers: Behavior Analyst</td>
</tr>
<tr>
<td>103T00000X</td>
<td>Behavioral Health and Social Service Providers: Psychologist</td>
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<tr>
<td>103TA0700X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Adult Development and Aging</td>
</tr>
<tr>
<td>103TB0200X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Cognitive and Behavioral</td>
</tr>
<tr>
<td>103TC0700X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Clinical</td>
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<td>103TC1900X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Counseling</td>
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<tr>
<td>103TC2200X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Clinical Child and Adolescent</td>
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<td>Variable Code</td>
<td>Description</td>
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<tr>
<td>103TE1000X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Educational</td>
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<tr>
<td>103TE1100X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Exercise and Sports</td>
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<tr>
<td>103TF0000X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Family</td>
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<td>103TF0200X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Forensic</td>
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<td>103TH0004X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Health</td>
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<td>103TH0100X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Health Service</td>
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<tr>
<td>103TM1700X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Men and Masculinity</td>
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<tr>
<td>103TM1800X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Mental Retardation and Developmental Disabilities</td>
</tr>
<tr>
<td>103TP0016X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Prescribing (Medical)</td>
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<tr>
<td>103TP0814X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Psychoanalysis</td>
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<tr>
<td>103TP2700X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Psychotherapy</td>
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<tr>
<td>103TP2701X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Group Psychotherapy</td>
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<tr>
<td>103TR0400X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Rehabilitation</td>
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<tr>
<td>103TS0200X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, School</td>
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<tr>
<td>103TW0100X</td>
<td>Behavioral Health and Social Service Providers: Psychologist, Women</td>
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<td>104100000X</td>
<td>Behavioral Health and Social Service Providers: Social Worker</td>
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<tr>
<td>1041C0700X</td>
<td>Behavioral Health and Social Service Providers: Social Worker, Clinical</td>
</tr>
<tr>
<td>1041S0200X</td>
<td>Behavioral Health and Social Service Providers: Social Worker, School</td>
</tr>
<tr>
<td>106E00000X</td>
<td>Behavioral Health and Social Service Providers: Assistant Behavior Analyst</td>
</tr>
<tr>
<td>106H00000X</td>
<td>Behavioral Health and Social Service Providers: Marriage and Family Therapist</td>
</tr>
<tr>
<td>106S00000X</td>
<td>Behavioral Health and Social Service Providers: Behavior Technician</td>
</tr>
<tr>
<td>163WP0807X</td>
<td>Nursing Service Providers: Registered Nurse, Psychiatric/Mental Health, Child and Adolescent</td>
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<tr>
<td>163WP0808X</td>
<td>Nursing Service Providers: Registered Nurse, Psychiatric/Mental Health</td>
</tr>
<tr>
<td>163WP0809X</td>
<td>Nursing Service Providers: Registered Nurse, Psychiatric/Mental Health, Adult</td>
</tr>
<tr>
<td>167G00000X</td>
<td>Nursing Service Providers: Licensed Psychiatric Technician</td>
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<tr>
<td>1835P1300X</td>
<td>Pharmacy Service Providers: Pharmacist, Psychiatric</td>
</tr>
<tr>
<td>2080P0006X</td>
<td>Allopathic and Osteopathic Physicians: Pediatrics, Developmental — Behavioral Pediatrics</td>
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<tr>
<td>2080P0008X</td>
<td>Allopathic and Osteopathic Physicians: Pediatrics, Neurodevelopmental Disabilities</td>
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<tr>
<td>2084B0040X</td>
<td>Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Behavioral Neurology and Neuropsychiatry</td>
</tr>
<tr>
<td>2084F0202X</td>
<td>Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Forensic Psychiatry</td>
</tr>
<tr>
<td>2084P0005X</td>
<td>Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Neurodevelopmental Disabilities</td>
</tr>
<tr>
<td>2084P0015X</td>
<td>Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Psychosomatic Medicine</td>
</tr>
<tr>
<td>2084P0800X</td>
<td>Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Psychiatry</td>
</tr>
<tr>
<td>2084P0804X</td>
<td>Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Child and Adolescent Psychiatry</td>
</tr>
<tr>
<td>2084P0805X</td>
<td>Allopathic and Osteopathic Physicians: Psychiatry and Neurology, Geriatric Psychiatry</td>
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<tr>
<td>225XM0800X</td>
<td>Respiratory, Developmental, Rehabilitative and Restorative Service Providers: Occupational Therapist, Mental Health</td>
</tr>
<tr>
<td>363LP0808X</td>
<td>Physician Assistants and Advanced Practice Nursing Providers: Nurse Practitioner, Psychiatric/Mental Health</td>
</tr>
<tr>
<td>364SP0807X</td>
<td>Physician Assistants and Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health, Child and Adolescent</td>
</tr>
</tbody>
</table>
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/
**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](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.
**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.
**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

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

**COMMENT:** —
**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:** —
**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](https://www.fda.gov/Drugs/InformationOnDrugs/ucm142438.htm)
**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:**  —
**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.
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: —
**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:** —
**OCRNC_CD**

**LABEL:** Occurrence Code

**DESCRIPTION:** A code 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.
Variable Details

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.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>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.</td>
</tr>
<tr>
<td>28</td>
<td>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.</td>
</tr>
<tr>
<td>29</td>
<td>Date OPT plan established or last reviewed — the date a plan of treatment was established for outpatient physical therapy.</td>
</tr>
<tr>
<td>30</td>
<td>Date speech pathology plan treatment established or last reviewed — The date a speech pathology plan of treatment was established or last reviewed.</td>
</tr>
<tr>
<td>31</td>
<td>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.</td>
</tr>
<tr>
<td>32</td>
<td>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.</td>
</tr>
<tr>
<td>33</td>
<td>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.</td>
</tr>
<tr>
<td>34</td>
<td>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).</td>
</tr>
<tr>
<td>35</td>
<td>Date treatment started for physical therapy — The date services were initiated by the billing provider for physical therapy.</td>
</tr>
<tr>
<td>36</td>
<td>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.</td>
</tr>
<tr>
<td>37</td>
<td>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 non-covered transplant procedure. Entered on bills for which the hospital is billing for immunosuppressive drugs. Hospital is billing for immunosuppressive drugs.</td>
</tr>
<tr>
<td>38</td>
<td>Date treatment started for home IV therapy — Date the patient was first treated in his home for IV therapy.</td>
</tr>
<tr>
<td>39</td>
<td>Date discharged on a continuous course of IV therapy — Date the patient was discharged from the hospital on a continuous course of IV therapy.</td>
</tr>
<tr>
<td>40</td>
<td>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.)</td>
</tr>
</tbody>
</table>
Variable Details

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).

**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).
<table>
<thead>
<tr>
<th><strong>OCRNC_CD_SEQ</strong></th>
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<tbody>
<tr>
<td><strong>LABEL:</strong></td>
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<td><strong>DESCRIPTION:</strong></td>
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<td><strong>SHORT NAME:</strong></td>
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<td><strong>VALUES:</strong></td>
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<td><strong>COMMENT:</strong></td>
</tr>
</tbody>
</table>
**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).
**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:**


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/
**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](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.
**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.
**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.
**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:** —
**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:** —
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: —
**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–XXXXX; may be negative

Null/missing = source value is missing or unknown

**COMMENT:** —
**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:** —
**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:** —
### 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](https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html)

Values and websites referenced may change over time.
**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:**

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<td>PRCDR_CD_3</td>
<td>PRCDR_CD_6</td>
</tr>
</tbody>
</table>

**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.
**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_2
- PRCDR_CD_DT_3
- PRCDR_CD_DT_4
- PRCDR_CD_DT_5
- PRCDR_CD_DT_6

**LONG NAME:**
- PRCDR_CD_DT_1
- PRCDR_CD_DT_2
- PRCDR_CD_DT_3
- PRCDR_CD_DT_4
- PRCDR_CD_DT_5
- 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.
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 (Was 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:** —
**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.
**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 ^]
**PRSRBNG_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:** PRSRBNG_PRVDR_ID

**LONG NAME:** PRSRBNG_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:** —
**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)


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/
**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:** —
**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:** —
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 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: —
**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:** —
**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:**     —
**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:** —
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
Variable Details

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
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0259</td>
<td>Pharmacy — other pharmacy</td>
</tr>
<tr>
<td>0260</td>
<td>IV therapy — general classification</td>
</tr>
<tr>
<td>0261</td>
<td>IV therapy — infusion pump</td>
</tr>
<tr>
<td>0262</td>
<td>IV therapy — pharmacy services</td>
</tr>
<tr>
<td>0263</td>
<td>IV therapy — drug supply/delivery</td>
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<tr>
<td>0264</td>
<td>IV therapy — supplies</td>
</tr>
<tr>
<td>0269</td>
<td>IV therapy — other IV therapy</td>
</tr>
<tr>
<td>0270</td>
<td>Medical/surgical supplies — general classification (also refer to 062X)</td>
</tr>
<tr>
<td>0271</td>
<td>Medical/surgical supplies — nonsterile supply</td>
</tr>
<tr>
<td>0272</td>
<td>Medical/surgical supplies — sterile supply</td>
</tr>
<tr>
<td>0273</td>
<td>Medical/surgical supplies — take home supplies</td>
</tr>
<tr>
<td>0274</td>
<td>Medical/surgical supplies — prosthetic/orthotic devices</td>
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<tr>
<td>0275</td>
<td>Medical/surgical supplies — pacemaker</td>
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<tr>
<td>0276</td>
<td>Medical/surgical supplies — intraocular lens</td>
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<td>0277</td>
<td>Medical/surgical supplies — oxygen-take home</td>
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<td>0278</td>
<td>Medical/surgical supplies — other implants</td>
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<td>0279</td>
<td>Medical/surgical supplies — other devices</td>
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<tr>
<td>0280</td>
<td>Oncology — general classification</td>
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<tr>
<td>0289</td>
<td>Oncology — other oncology</td>
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<td>0290</td>
<td>DME (other than renal) — general classification</td>
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<tr>
<td>0291</td>
<td>DME (other than renal) — rental</td>
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<tr>
<td>0292</td>
<td>DME (other than renal) — purchase of new DME</td>
</tr>
<tr>
<td>0293</td>
<td>DME (other than renal) — purchase of used DME</td>
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<tr>
<td>0294</td>
<td>DME (other than renal) — related to and listed as DME</td>
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<tr>
<td>0299</td>
<td>DME (other than renal) — other</td>
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<tr>
<td>0300</td>
<td>Laboratory — general classification</td>
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<tr>
<td>0301</td>
<td>Laboratory — chemistry</td>
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<tr>
<td>0302</td>
<td>Laboratory — immunology</td>
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<tr>
<td>0303</td>
<td>Laboratory — renal patient (home)</td>
</tr>
<tr>
<td>0304</td>
<td>Laboratory — non-routine dialysis</td>
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<td>0305</td>
<td>Laboratory — hematology</td>
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<tr>
<td>0306</td>
<td>Laboratory — bacteriology and microbiology</td>
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<td>0307</td>
<td>Laboratory — urology</td>
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<td>0309</td>
<td>Laboratory — other laboratory</td>
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<td>0310</td>
<td>Laboratory pathological — general classification</td>
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<td>0311</td>
<td>Laboratory pathological — cytology</td>
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<td>0312</td>
<td>Laboratory pathological — histology</td>
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<td>Laboratory pathological — biopsy</td>
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<tr>
<td>0319</td>
<td>Laboratory pathological — other</td>
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<tr>
<td>0320</td>
<td>Radiology diagnostic — general classification</td>
</tr>
<tr>
<td>0321</td>
<td>Radiology diagnostic — angiocardiography</td>
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<tr>
<td>0322</td>
<td>Radiology diagnostic — arthrography</td>
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<td>0323</td>
<td>Radiology diagnostic — arteriography</td>
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<td>0324</td>
<td>Radiology diagnostic — chest X-ray</td>
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<td>0329</td>
<td>Radiology diagnostic — other</td>
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<td>0330</td>
<td>Radiology therapeutic — general classification</td>
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<tr>
<td>0331</td>
<td>Radiology therapeutic — chemotherapy injected</td>
</tr>
<tr>
<td>0332</td>
<td>Radiology therapeutic — chemotherapy oral</td>
</tr>
</tbody>
</table>
Variable Details

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
<table>
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<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>0700</td>
<td>Cast room — general classification</td>
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<tr>
<td>0709</td>
<td>Cast room — other</td>
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<tr>
<td>0710</td>
<td>Recovery room — general classification</td>
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<tr>
<td>0719</td>
<td>Recovery room — other</td>
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<tr>
<td>0720</td>
<td>Labor room/delivery — general classification</td>
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<tr>
<td>0721</td>
<td>Labor room/delivery — labor</td>
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<td>0722</td>
<td>Labor room/delivery — delivery</td>
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<td>0723</td>
<td>Labor room/delivery — circumcision</td>
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<tr>
<td>0724</td>
<td>Labor room/delivery — birthing center</td>
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<td>Labor room/delivery — other</td>
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<td>0730</td>
<td>EKG/ECG — general classification</td>
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<td>0731</td>
<td>EKG/ECG — Holter monitor</td>
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<td>EKG/ECG — telemetry</td>
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<td>0739</td>
<td>EKG/ECG — other</td>
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<td>EEG — general classification</td>
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<td>0749</td>
<td>EEG (electroencephalogram) — other</td>
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<td>Gastro-intestinal services — general classification</td>
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<td>Gastro-intestinal services — other</td>
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<td>0760</td>
<td>Treatment or observation room — general classification</td>
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<td>0761</td>
<td>Treatment or observation room — treatment room</td>
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<td>0762</td>
<td>Treatment or observation room — observation room</td>
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<td>0769</td>
<td>Treatment or observation room — other</td>
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<td>0770</td>
<td>Preventative care services — general classification</td>
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<td>0771</td>
<td>Preventative care services — vaccine administration</td>
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<td>Preventative care services — other</td>
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<td>Telemedicine — general classification</td>
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<td>Telemedicine — telemedicine</td>
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<td>Lithotripsy — other</td>
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<td>Inpatient renal dialysis — general classification</td>
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<td>0801</td>
<td>Inpatient renal dialysis — inpatient hemodialysis</td>
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<td>0802</td>
<td>Inpatient renal dialysis — inpatient peritoneal (non-CAPD)</td>
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<td>Inpatient renal dialysis — inpatient CAPD</td>
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<td>0804</td>
<td>Inpatient renal dialysis — inpatient CCPD</td>
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<tr>
<td>0809</td>
<td>Inpatient renal dialysis — other inpatient dialysis</td>
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<td>0810</td>
<td>Organ acquisition — general classification</td>
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<tr>
<td>0811</td>
<td>Organ acquisition — living donor</td>
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<td>0812</td>
<td>Organ acquisition — cadaver donor</td>
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<td>0813</td>
<td>Organ acquisition — unknown donor</td>
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<td>0814</td>
<td>Organ acquisition — unsuccessful organ search-donor bank charges</td>
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<td>0815</td>
<td>Allogeneic Stem Cell Acquisition/Donor Services</td>
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<td>Organ acquisition — other donor</td>
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<td>0820</td>
<td>Hemodialysis OP or home dialysis — general classification</td>
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<td>0821</td>
<td>Hemodialysis OP or home dialysis — hemodialysis-composite or other rate</td>
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<td>0822</td>
<td>Hemodialysis OP or home dialysis — home supplies</td>
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<td>0823</td>
<td>Hemodialysis OP or home dialysis — home equipment</td>
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<td>0824</td>
<td>Hemodialysis OP or home dialysis — maintenance/100%</td>
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<tr>
<td>0825</td>
<td>Hemodialysis OP or home dialysis — support services</td>
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</tbody>
</table>
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)
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<th>Description</th>
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<td>Reserved for National Use (effective 10/2004); prior to 10/2004 defined as</td>
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<td>Psychiatric/psychological treatments-other</td>
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<td>Behavioral Health Treatment/Services — Reserved for National Assignment (effective 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-general classification</td>
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<td>0911</td>
<td>Behavioral Health Treatment/Services — rehabilitation (effective 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-rehabilitation</td>
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<td>0912</td>
<td>Behavioral Health Treatment/Services — partial hospitalization-less intensive (effective 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-less intensive</td>
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<td>Behavioral Health Treatment/Services — partial hospitalization-intensive (effective 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-intensive</td>
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<td>0914</td>
<td>Behavioral Health Treatment/Services — individual therapy (effective 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-individual therapy</td>
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<td>0915</td>
<td>Behavioral Health Treatment/Services — group therapy (effective 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-group therapy</td>
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<td>0916</td>
<td>Behavioral Health Treatment/Services — family therapy (effective 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-family therapy</td>
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<td>Behavioral Health Treatment/Services — biofeedback (effective 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-biofeedback</td>
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<td>Behavioral Health Treatment/Services — testing (effective 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-testing</td>
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<td>Behavioral Health Treatment/Services — other (effective 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-other</td>
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<td>0920</td>
<td>Other diagnostic services — general classification</td>
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<tr>
<td>0921</td>
<td>Other diagnostic services — peripheral vascular lab</td>
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<td>0922</td>
<td>Other diagnostic services — electro myelogram</td>
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<td>0923</td>
<td>Other diagnostic services — pap smear</td>
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<td>0924</td>
<td>Other diagnostic services — allergy test</td>
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<td>Other diagnostic services — pregnancy test</td>
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<td>0929</td>
<td>Other diagnostic services — other</td>
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<tr>
<td>0931</td>
<td>Medical Rehabilitation Day Program — Half Day</td>
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<td>0932</td>
<td>Medical Rehabilitation Day Program — Full Day</td>
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<td>0940</td>
<td>Other therapeutic services — general classification</td>
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<tr>
<td>0941</td>
<td>Other therapeutic services — recreational therapy</td>
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<tr>
<td>0942</td>
<td>Other therapeutic services — education/training (include diabetes diet training)</td>
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<td>0943</td>
<td>Other therapeutic services — cardiac rehabilitation</td>
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<td>0944</td>
<td>Other therapeutic services — drug rehabilitation</td>
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<td>Other therapeutic services — alcohol rehabilitation</td>
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<td>0946</td>
<td>Other therapeutic services — routine complex medical equipment</td>
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<td>0947</td>
<td>Other therapeutic services — ancillary complex medical equipment</td>
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<td>Other therapeutic services — other</td>
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<tr>
<td>0951</td>
<td>Professional Fees — athletic training (extension of 094X)</td>
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<td>0952</td>
<td>Professional Fees — kinesiotherapy (extension of 094X)</td>
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<td>Professional fees — general classification</td>
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<td>0961</td>
<td>Professional fees — psychiatric</td>
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<td>0962</td>
<td>Professional fees — ophthalmology</td>
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<tr>
<td>0963</td>
<td>Professional fees — anesthesiologist (MD)</td>
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<td>0964</td>
<td>Professional fees — anesthetist (CRNA)</td>
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<tr>
<td>0969</td>
<td>Professional fees — other (NOTE: 097X is an extension of 096X)</td>
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<td>Code</td>
<td>Description</td>
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<tr>
<td>0971</td>
<td>Professional fees — laboratory</td>
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<tr>
<td>0972</td>
<td>Professional fees — radiology diagnostic</td>
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<td>0973</td>
<td>Professional fees — radiology therapeutic</td>
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<td>0974</td>
<td>Professional fees — nuclear medicine</td>
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<td>Professional fees — operating room</td>
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<td>Professional fees — respiratory therapy</td>
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<td>Professional fees — physical therapy</td>
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<td>0978</td>
<td>Professional fees — occupational therapy</td>
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<td>0979</td>
<td>Professional fees — speech pathology (NOTE: 098X is an extension of 096X and 097X)</td>
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<td>0981</td>
<td>Professional fees — emergency room</td>
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<td>0982</td>
<td>Professional fees — outpatient services</td>
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<td>Professional fees — clinic</td>
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<td>Professional fees — medical social services</td>
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<td>Professional fees — EKG</td>
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<td>Professional fees — EEG</td>
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<td>0987</td>
<td>Professional fees — hospital visit</td>
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<td>Professional fees — consultation</td>
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<td>Professional fees — private duty nurse</td>
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<td>0990</td>
<td>Patient convenience items — general classification</td>
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<tr>
<td>0991</td>
<td>Patient convenience items — cafeteria/guest tray</td>
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<td>0992</td>
<td>Patient convenience items — private linen service</td>
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<td>0993</td>
<td>Patient convenience items — telephone/telegraph</td>
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<td>Patient convenience items — tv/radio</td>
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<td>0995</td>
<td>Patient convenience items — nonpatient room rentals</td>
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<td>0996</td>
<td>Patient convenience items — late discharge charge</td>
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<td>0997</td>
<td>Patient convenience items — admission kits</td>
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<td>Patient convenience items — beauty shop/barber</td>
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<td>Patient convenience items — other</td>
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<td>Behavioral health Accommodations — general</td>
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<td>Behavioral health Accommodations — residential treatment psychiatric</td>
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<td>1002</td>
<td>Behavioral health Accommodations — residential treatment chemical dependency</td>
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<td>2101</td>
<td>Alternative Therapy Services — Acupuncture</td>
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<td>2103</td>
<td>Alternative Therapy Services — Massage</td>
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<tr>
<td>3101</td>
<td>Adult Day Care — Medical and Social (hourly)</td>
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<td>3103</td>
<td>Adult Day Care — Medical and Social (daily)</td>
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<td>Adult Day Care — Social (daily)</td>
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<td>Adult Day Care — other</td>
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</tbody>
</table>

 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.

**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.
**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:** —
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

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/.
**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: —
**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


Null/missing = source value is missing or unknown

**COMMENT:** —
**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: —
**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.
**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
Variable Details

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.
**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.
**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.
**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.
**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:** —
**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:** —
**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:** —
<table>
<thead>
<tr>
<th>Variable</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPRVSNG_PRVDR_NPI</td>
<td>The National Provider ID (NPI) of the provider who supervised another provider.</td>
</tr>
</tbody>
</table>

**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:**  
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/
<table>
<thead>
<tr>
<th><strong>SPRSNG_PRVDR_TXNMY_CD</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LABEL:</strong></td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong></td>
</tr>
<tr>
<td><strong>SHORT NAME:</strong></td>
</tr>
<tr>
<td><strong>LONG NAME:</strong></td>
</tr>
<tr>
<td><strong>TYPE:</strong></td>
</tr>
<tr>
<td><strong>LENGTH:</strong></td>
</tr>
<tr>
<td><strong>SOURCE:</strong></td>
</tr>
<tr>
<td><strong>FILE(S):</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>COMMENT:</strong></td>
</tr>
</tbody>
</table>
**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.
**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.
**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).
**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:** —
Variable Details

**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


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/](https://npiregistry.cms.hhs.gov/)
**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
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>Cardiac Rehabilitation and Intensive Cardiac Rehabilitation</td>
</tr>
<tr>
<td>32</td>
<td>Anesthesiologist Assistant</td>
</tr>
<tr>
<td>33</td>
<td>Thoracic Surgery</td>
</tr>
<tr>
<td>34</td>
<td>Urology</td>
</tr>
<tr>
<td>35</td>
<td>Chiropractic</td>
</tr>
<tr>
<td>36</td>
<td>Nuclear Medicine</td>
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<td>37</td>
<td>Pediatric Medicine</td>
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<td>Geriatric Medicine</td>
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<td>39</td>
<td>Nephrology</td>
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<tr>
<td>40</td>
<td>Hand Surgery</td>
</tr>
<tr>
<td>41</td>
<td>Optometry</td>
</tr>
<tr>
<td>42</td>
<td>Certified Nurse Midwife</td>
</tr>
<tr>
<td>43</td>
<td>Certified Registered Nurse Anesthetist (CRNA)</td>
</tr>
<tr>
<td>44</td>
<td>Infectious Disease</td>
</tr>
<tr>
<td>45</td>
<td>Mammography Center</td>
</tr>
<tr>
<td>46</td>
<td>Endocrinology</td>
</tr>
<tr>
<td>47</td>
<td>Independent Diagnostic Testing Facility (IDTF)</td>
</tr>
<tr>
<td>48</td>
<td>Podiatry</td>
</tr>
<tr>
<td>49</td>
<td>Ambulatory Surgical Center</td>
</tr>
<tr>
<td>50</td>
<td>Nurse Practitioner</td>
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<tr>
<td>51</td>
<td>Medical Supply Company with Orthotist</td>
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<td>52</td>
<td>Medical Supply Company with Prosthetist</td>
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<td>Individual Certified Orthotist</td>
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<td>Individual Certified Prosthetist</td>
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<td>57</td>
<td>Individual Certified Orthotist-Prosthetist</td>
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<td>58</td>
<td>Medical Supply Company with Pharmacist</td>
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<td>59</td>
<td>Ambulance Service Provider</td>
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<tr>
<td>60</td>
<td>Public Health or Welfare Agency</td>
</tr>
<tr>
<td>61</td>
<td>Voluntary Health or Charitable Agency</td>
</tr>
<tr>
<td>62</td>
<td>Psychologist, Clinical</td>
</tr>
<tr>
<td>63</td>
<td>Portable X-Ray Supplier</td>
</tr>
<tr>
<td>64</td>
<td>Audiologist</td>
</tr>
<tr>
<td>65</td>
<td>Physical Therapist in Private Practice</td>
</tr>
<tr>
<td>66</td>
<td>Rheumatology</td>
</tr>
<tr>
<td>67</td>
<td>Occupational Therapist in Private Practice</td>
</tr>
<tr>
<td>68</td>
<td>Psychologist, Clinical</td>
</tr>
<tr>
<td>69</td>
<td>Clinical Laboratory</td>
</tr>
<tr>
<td>70</td>
<td>Single or Multispecialty Clinic or Group Practice</td>
</tr>
<tr>
<td>71</td>
<td>Registered Dietitian or Nutrition Professional</td>
</tr>
<tr>
<td>72</td>
<td>Pain Management</td>
</tr>
<tr>
<td>73</td>
<td>Mass Immunization Roster Biller</td>
</tr>
<tr>
<td>74</td>
<td>Radiation Therapy Center</td>
</tr>
<tr>
<td>75</td>
<td>Slide Preparation Facility</td>
</tr>
<tr>
<td>76</td>
<td>Peripheral Vascular Disease</td>
</tr>
<tr>
<td>77</td>
<td>Vascular Surgery</td>
</tr>
<tr>
<td>78</td>
<td>Cardiac Surgery</td>
</tr>
</tbody>
</table>
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: —
**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:** —
**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
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20 = Individual Certified Prosthetist
21 = Individual Certified Prosthetist-Orthotist
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36 = Slide Preparation Facility
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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.
**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.
### 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.
**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

<table>
<thead>
<tr>
<th>State Abbreviation</th>
<th>State Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>AK</td>
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**COMMENT:** This variable is the two-letter postal abbreviation for the state that submitted the TAF.
Variable Details

**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](https://www.census.gov/library/reference/code-lists/ansi.html)

2-digit value (with leading zeros)

<table>
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<td>Third-Party Administrator (TPA)</td>
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</table>

**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).
**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.
**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:** 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) **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 Psychiatry
- 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


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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.
**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:** —
**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:** —
**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

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

[^ Back to TOC ^]
**TOS_CD**

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<thead>
<tr>
<th>VALUE</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
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<td>Inpatient hospital services, other than services in an institution for mental diseases</td>
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<tr>
<td>002</td>
<td>Outpatient hospital services</td>
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<tr>
<td>003</td>
<td>Rural health clinic services</td>
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<td>Other ambulatory services furnished by a rural health clinic</td>
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<td>005</td>
<td>Professional laboratory services, Technical laboratory services</td>
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<td>Professional radiological services</td>
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<tr>
<td>008</td>
<td>Technical radiological services</td>
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<td>Nursing facility services for individuals aged 21 or older (other than services in an institution for mental disease)</td>
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<td>010</td>
<td>Early and periodic screening and diagnosis and treatment (EPSDT) services</td>
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<td>Family planning services and supplies for individuals of child-bearing age</td>
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<td>Physicians' services</td>
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<td>013</td>
<td>Medical and surgical services of a dentist</td>
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<tr>
<td>014</td>
<td>Outpatient substance abuse treatment services.</td>
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<tr>
<td>015</td>
<td>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</td>
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<td>Home health services — Nursing services</td>
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<td>017</td>
<td>Home health services — Home health aide services</td>
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<td>018</td>
<td>Home health services — Medical supplies, equipment, and appliances suitable for use in the home</td>
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<tr>
<td>019</td>
<td>Home health services — Physical therapy provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services</td>
</tr>
<tr>
<td>020</td>
<td>Home health services — Occupational therapy provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services</td>
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</tbody>
</table>
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
022 = Private duty nursing services
023 = Advanced practice nurse services
024 = Pediatric nurse
025 = Nurse-midwife service
026 = Nurse practitioner services
027 = Respiratory care for ventilator — dependent individuals
028 = Clinic services
029 = Dental services
030 = Physical therapy services (when not provided under home health services)
031 = Occupational therapy services (when not provided under home health services)
032 = Speech, hearing, and language disorders services (when not provided under home health services)
033 = Prescribed drugs
034 = Over-the-counter medications
035 = Dentures
036 = Medical equipment/prosthetic devices
037 = Eyeglasses
038 = Hearing Aids
039 = Diagnostic services
040 = Screening services
041 = Preventive services
042 = Well-baby and well-childcare services as defined by the State
043 = Rehabilitative services
044 = Inpatient hospital services for individuals aged 65 or older in institutions for mental diseases
045 = Nursing facility services for individuals aged 65 or older in institutions for mental diseases
046 = Intermediate care facility (ICF)/ Intermediate Care Facilities for individuals with Intellectual Disabilities (IIDICF)/ Individuals with Intellectual Disabilities (IID) services
047 = Nursing facility services, other than in institutions for mental diseases
048 = Inpatient psychiatric services for individuals underage 21
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.
050 = Inpatient substance abuse treatment services and residential substance abuse treatment services.
051 = Personal care services
052 = Primary care case management services (PCCM)
053 = Targeted case management services
054 = Case Management services other than those that meet the definition of primary care case management services or targeted case management services
055 = Care coordination services
056 = Transportation services
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<td>HCBS — Home health aide services</td>
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<td>HCBS — Personal care services</td>
</tr>
<tr>
<td>066</td>
<td>HCBS — Adult day health services</td>
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<td>067</td>
<td>HCBS — Habilitation services</td>
</tr>
<tr>
<td>068</td>
<td>HCBS — Respite care services</td>
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<tr>
<td>069</td>
<td>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</td>
</tr>
<tr>
<td>070</td>
<td>HCBS — Day Care</td>
</tr>
<tr>
<td>071</td>
<td>HCBS — Training for family members</td>
</tr>
<tr>
<td>072</td>
<td>HCBS — Minor modification to the home</td>
</tr>
<tr>
<td>073</td>
<td>HCBS — Other services requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization</td>
</tr>
<tr>
<td>074</td>
<td>HCBS — Expanded habilitation services — Prevocational services</td>
</tr>
<tr>
<td>075</td>
<td>HCBS — Expanded habilitation services — Educational services</td>
</tr>
<tr>
<td>076</td>
<td>HCBS — Expanded habilitation services — Supported employment services, which facilitate paid employment</td>
</tr>
<tr>
<td>077</td>
<td>HCBS-65-plus — Case management services</td>
</tr>
<tr>
<td>078</td>
<td>HCBS-65-plus — Homemaker services</td>
</tr>
<tr>
<td>079</td>
<td>HCBS-65-plus — Home health aide services</td>
</tr>
<tr>
<td>080</td>
<td>HCBS-65-plus — Personal care services</td>
</tr>
<tr>
<td>081</td>
<td>HCBS-65-plus — Adult day health services</td>
</tr>
<tr>
<td>082</td>
<td>HCBS-65-plus — Respite care services</td>
</tr>
<tr>
<td>083</td>
<td>HCBS-65-plus — Other medical and social services</td>
</tr>
<tr>
<td>084</td>
<td>Sterilizations</td>
</tr>
<tr>
<td>085</td>
<td>Prenatal care and pre-pregnancy family planning services and supplies.</td>
</tr>
<tr>
<td>086</td>
<td>Other Pregnancy-related Procedures</td>
</tr>
<tr>
<td>087</td>
<td>Hospice services</td>
</tr>
<tr>
<td>088</td>
<td>Any other health care services or items specified by the Secretary and not excluded under regulations.</td>
</tr>
<tr>
<td>089</td>
<td>Disposable medical supplies.</td>
</tr>
<tr>
<td>090</td>
<td>Critical access hospital services — IP</td>
</tr>
<tr>
<td>091</td>
<td>Skilled care — hospital residing</td>
</tr>
<tr>
<td>092</td>
<td>Exceptional care — hospital residing</td>
</tr>
<tr>
<td>093</td>
<td>Non-acute care — hospital residing</td>
</tr>
<tr>
<td>115</td>
<td>Residential care</td>
</tr>
<tr>
<td>119</td>
<td>Capitated payments to HMOs, HIOs, or PACE plans</td>
</tr>
<tr>
<td>120</td>
<td>Capitated payments for primary care case management (PCCM)</td>
</tr>
<tr>
<td>121</td>
<td>Premium payments for private health insurance</td>
</tr>
<tr>
<td>122</td>
<td>Capitated payments to prepaid health plans (PHPs)</td>
</tr>
<tr>
<td>Value</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
</tr>
<tr>
<td>123</td>
<td>Disproportionate share hospital (DSH) payments</td>
</tr>
<tr>
<td>127</td>
<td>Indian Health Service (IHS) - Family Plan</td>
</tr>
<tr>
<td>131</td>
<td>Drug Rebates</td>
</tr>
<tr>
<td>132</td>
<td>Supplemental payment — inpatient</td>
</tr>
<tr>
<td>133</td>
<td>Supplemental payment — nursing</td>
</tr>
<tr>
<td>134</td>
<td>Supplemental payment — outpatient</td>
</tr>
<tr>
<td>135</td>
<td>EHR payments to provider</td>
</tr>
<tr>
<td>136</td>
<td>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</td>
</tr>
<tr>
<td>137</td>
<td>COVID–19 testing-related services</td>
</tr>
<tr>
<td>138</td>
<td>Per member per month (PMPM) payments for health home services</td>
</tr>
<tr>
<td>139</td>
<td>Per member per month (PMPM) payments for Medicare Part A premiums</td>
</tr>
<tr>
<td>140</td>
<td>Per member per month (PMPM) payments for Medicare Part B premiums</td>
</tr>
<tr>
<td>141</td>
<td>Per member per month (PMPM) payments for Medicare Advantage Dual Special Needs Plans (O-SNP) – Medicare Part C</td>
</tr>
<tr>
<td>142</td>
<td>Per member per month (PMPM) payments for Medicare Part D premiums</td>
</tr>
<tr>
<td>143</td>
<td>Per member per month (PMPM) payments for other payments</td>
</tr>
<tr>
<td>144</td>
<td>Payments to individuals for personal assistance services under 1915(j)</td>
</tr>
<tr>
<td>145</td>
<td>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</td>
</tr>
<tr>
<td>146</td>
<td>Inpatient Psychiatric Services for beneficiaries between the ages of 22 and 64 who receive services in an institution for mental disease</td>
</tr>
</tbody>
</table>

Null/missing = source value is missing or unknown

**COMMENT:** —
**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:** —
**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:** —
**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.
**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.

^ Back to TOC ^
### 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: —
**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
- 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
- 0009 = Other Practitioners Services — Reg. Payments
- 0009B = 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
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)
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
046B = OUD Medicaid Assisted Treatment Services
0049 = Other Care Services
Null/missing = source value is missing or unknown

COMMENT: —
**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
- 003 = Inpatient Mental Health
- 004 = Nursing Care Services
- 005 = Physician/Surgical
- 006 = Outpatient Hospital
- 007 = Outpatient Mental Health
- 008 = Prescribed Drugs
- 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
- 022 = Hospice
- 023 = Medical Transportation
- 024 = Case Management
- 025 = Translation and Interpretation
- 031 = Other Services
- 032 = Outreach
- 033 = Administration (costs incurred by State to administer plan)
034 = PERM Administration
035 = Citizenship Verification Technology CHIPRA
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: —