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## Revision Log

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<tr>
<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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<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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**Tips on Navigating the Codebook**

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

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

For more information about the TAF claims files, please see the TAF User Guide, available at [https://www2.ccwdata.org/web/guest/user-documentation](https://www2.ccwdata.org/web/guest/user-documentation).

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

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

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

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

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\(^1\) “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/](https://www.resdac.org/)
# Table of Contents

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

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Variable Details

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

ACTL_SRVC_QTY

LABEL: Actual Service Quantity

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

SHORT NAME: ACTL_SRVC_QTY

LONG NAME: ACTL_SRVC_QTY

TYPE: NUM

LENGTH: 8

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Line
         LT Line
         OT Line

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

COMMENT: —
**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&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.
091 = Dispensing fee adjustment
092 = Claim Paid in full
093 = No Claim level Adjustments. Notes: As of 004010, CAS at the claim level is optional.
094 = Processed in Excess of charges
095 = Plan procedures not followed
096 = Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
097 = The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
098 = The hospital must file the Medicare claim for this inpatient non-physician service
099 = Medicare Secondary Payer Adjustment Amount
100 = Payment made to patient/insured/responsible party
101 = Predetermination: anticipated payment upon completion of services or claim adjudication
102 = Major Medical Adjustment
103 = Provider promotional discount (e.g., Senior citizen discount).
104 = Managed care withholding
105 = Tax withholding
106 = Patient payment option/election not in effect.
107 = The related or qualifying claim/service was not identified on this claim.
108 = Rent/purchase guidelines were not met
109 = Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor
110 = Billing date predates service date
112 = Service not furnished directly to the patient and/or not documented
117 = Transportation is only covered to the closest facility that can provide the necessary care
118 = ESRD network support adjustment
119 = Benefit maximum for this time period or occurrence has been reached
121 = Indemnification adjustment — compensation for outstanding member responsibility
123 = Payer refund due to overpayment
125 = Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

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

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

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

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

130 = Claim submission fee

131 = Claim specific negotiated discount

132 = Prearranged demonstration project adjustment

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

135 = Interim bills cannot be processed

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

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

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

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

141 = Claim spans eligible and ineligible periods of coverage

142 = Monthly Medicaid patient liability amount

143 = Portion of payment deferred

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

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

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

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

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

149 = Lifetime benefit maximum has been reached for this service/benefit category
150 = Payer deems the information submitted does not support this level of service
151 = Payment adjusted because the payer deems the information submitted does not support this many/frequency of services
152 = Payer deems the information submitted does not support this length of service
153 = Payer deems the information submitted does not support this dosage
154 = Payer deems the information submitted does not support this day's supply
159 = Service/procedure was provided as a result of terrorism
163 = Attachment/other documentation referenced on the claim was not received
164 = Attachment/other documentation referenced on the claim was not received in a timely fashion
165 = Referral absent or exceeded
166 = These services were submitted after this payers responsibility for processing claims under this plan ended
167 = This (these) diagnosis(es) is (are) not covered
168 = Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan
169 = Alternate benefit has been provided
170 = Payment is denied when performed/billed by this type of provider
171 = Payment is denied when performed/billed by this type of provider in this type of facility.
172 = Payment is adjusted when performed/billed by a provider of this specialty
173 = Service/equipment was not prescribed by a physician
174 = Service was not prescribed prior to delivery
176 = Prescription is not current
177 = Patient has not met the required eligibility requirements
178 = Patient has not met the required spend down requirements
179 = Patient has not met the required waiting requirements.
180 = Patient has not met the required residency requirements
181 = Procedure code was invalid on the date of service
182 = Procedure modifier was invalid on the date of service
183 = The referring provider is not eligible to refer the service billed
184 = The prescribing/ordering provider is not eligible to prescribe/order the service billed
185 = The rendering provider is not eligible to perform the service billed
186 = Level of care change adjustment
187 = Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.)
189 = 'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service
190 = Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay
192 = Non standard 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/authorization/notification/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 see 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/
**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
                LT Header

**VALUES:**    1 = ICD-9

2 = ICD-10

3 = Other

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

**COMMENT:**    —
**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/)
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 & 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: —
**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
**ALOWD_SRVC_QTY**

**LABEL:** Maximum Allowed Service Quantity

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

**SHORT NAME:** ALOWD_SRVC_QTY

**LONG NAME:** ALOWD_SRVC_QTY

**TYPE:** NUM

**LENGTH:** 8

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

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

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

**COMMENT:** When HCPCS codes are required for services, the units are equal to the number of times the procedure/service being reported was performed.
**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](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
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)
   7–8 = Reserved for National Assignment
   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
   6–8 = Reserved for National Assignment
   9 = Other

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

COMMENT: —
**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.

**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
**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

**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/)
**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 & Intensive Cardiac Rehabilitation
32 = Anesthesiologist Assistant
33 = Thoracic Surgery
34 = Urology
35 = Chiropractic
36 = Nuclear Medicine
37 = Pediatric Medicine
38 = Geriatric Medicine
39 = Nephrology
40 = Hand Surgery
41 = Optometry
42 = Certified Nurse Midwife
43 = Certified Registered Nurse Anesthetist (CRNA)
44 = Infectious Disease
45 = Mammography Center
46 = Endocrinology
47 = Independent Diagnostic Testing Facility (IDTF)
48 = Podiatry
49 = Ambulatory Surgical Center
50 = Nurse Practitioner
51 = Medical Supply Company with Orthotist
52 = Medical Supply Company with Prosthetist
53 = Medical Supply Company with Orthotist-Prosthetist
54 = Other Medical Supply Company
55 = Individual Certified Orthotist
56 = Individual Certified Prosthetist
57 = Individual Certified Orthotist-Prosthetist
58 = Medical Supply Company with Pharmacist
59 = Ambulance Service Provider
60 = Public Health or Welfare Agency
61 = Voluntary Health or Charitable Agency
62 = Psychologist, Clinical
63 = Portable X-Ray Supplier
64 = Audiologist
65 = Physical Therapist in Private Practice
66 = Rheumatology
67 = Occupational Therapist in Private Practice
68 = Psychologist, Clinical
69 = Clinical Laboratory
70 = Single or Multispecialty Clinic or Group Practice
71 = Registered Dietitian or Nutrition Professional
72 = Pain Management
73 = Mass Immunization Roster Biller
74 = Radiation Therapy Center
75 = Slide Preparation Facility
76 = Peripheral Vascular Disease
77 = Vascular Surgery
78 = Cardiac Surgery
79 = Addiction Medicine
80 = Licensed Clinical Social Worker
81 = Critical Care (Intensivists)
82 = Hematology
83 = Hematology/Oncology
84 = Preventive Medicine
85 = Maxillofacial Surgery
86 = Neuropsychiatry
87 = All Other Suppliers
88 = Unknown Supplier/Provider Specialty (T-MSIS DD v2.1)
89 = Certified Clinical Nurse Specialist
90 = Medical Oncology
91 = Surgical Oncology
92 = Radiation Oncology
93 = Emergency Medicine
94 = Interventional Radiology
95 = Advance Diagnostic Imaging
96 = Optician
97 = Physician Assistant
98 = Gynecological/Oncology
99 = Undefined physician type (provider is an MD) (T-MSIS DD v2.1)
A0 = Hospital-General
A1 = Skilled Nursing Facility
A2 = Intermediate Care Nursing Facility
A3 = Other Nursing Facility
A4 = Home Health Agency
A5 = Pharmacy
A6 = Medical Supply Company with Respiratory Therapist
A7 = Department Store
A8 = Grocery Store
A9 = Indian Health Service facility
B1 = Oxygen supplier
B2 = Pedorthic personnel
B3 = Medical supply company with pedorthic personnel
B4 = Rehabilitation Agency
B5 = Ocularist

Null/missing = source value is missing or unknown
Variable Details

**BLG_PRVDR_TXNMY_CD**

**LABEL:** Billing Provider Taxonomy Code

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

**SHORT NAME:** BLG_PRVDR_TXNMY_CD

**LONG NAME:** BLG_PRVDR_TXNMY_CD

**TYPE:** CHAR

**LENGTH:** 12

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

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

**VALUES:**

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

Null/missing = source value is missing or unknown

**COMMENT:** —
Variable Details

**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

021 = Medical care and any type of remedial care recognized under State law — Other Practitioners' Services within scope of practice as defined by state law

022 = Home Health Services — Physical therapy; occupational therapy; speech pathology; audiology provided by a home health agency

023 = Private Duty Nursing

024 = Clinic Services

025 = Dental Services

026 = Physical Therapy and Related Services — Physical Therapy

027 = Physical Therapy and Related Services — Occupational Therapy

028 = Physical Therapy and Related Services — Services for individuals with speech, hearing and language disorders

029 = Prescription drugs, dentures, and prosthetic devices; and eyeglasses — Prescribed Drugs

030 = Prescription drugs, dentures, and prosthetic devices; and eyeglasses — Dentures

031 = Prescription drugs, dentures, and prosthetic devices; and eyeglasses — Prosthetic Devices

032 = Prescription drugs, dentures, and prosthetic devices; and eyeglasses — Eyeglasses

033 = Other diagnostic, screening, preventive, and rehabilitative services — Diagnostic Services

034 = Other diagnostic, screening, preventive, and rehabilitative services — Screening Services

035 = Other diagnostic, screening, preventive, and rehabilitative services — Preventive Services

036 = Other diagnostic, screening, preventive, and rehabilitative services — Rehabilitative Services

037 = Services for individuals over age 65 in IMDs — Inpatient hospital services

038 = Services for individuals over age 65 in IMDs — Nursing facility services
039 = Intermediate Care Facility Services for individuals with intellectual disabilities or persons with related conditions

040 = Inpatient psychiatric facility services for under 21

041 = Hospice Care

042 = Case Management Services and TB related services — Case management services as defined in the State Plan in accordance with section 1905(a)(19) or 1915(g)

043 = Case Management Services and TB related services — Special TB related services under section 1902(z)(2)

044 = Respiratory care services under 1902(e)(9)(A) through (C)

045 = Personal care services

046 = Primary care case management services

047 = Special sickle-cell anemia-related services

048 = Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary — Transportation

049 = Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary — Services provided in religious non-medical health care facilities

050 = Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary — Nursing facility services for patients under 21

051 = Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary — Emergency hospital services

052 = Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary — Critical Access Hospitals

053 = Extended services for pregnant women — Additional Services for any other medical conditions that may complicate pregnancy

054 = Community First Choice

055 = Health Home Services

**Special Benefit Provisions**

056 = Limited Pregnancy-Related Services for Pregnant Women with Income Above the Applicable Income Limit

057 = Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period

058 = Benefits for Families Receiving Transitional Medical Assistance

059 = Standards for Coverage of Transplant Services
Variable Details

060 = School-Based Services Payment Methodologies
061 = Indian Health Services and Tribal Health Facilities
062 = Methods and Standards to Assure High Quality Care

**Coordination of Medicaid with Medicare and Other Insurance**

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

**Special Benefit Programs**

066 = Programs for Distribution of Pediatric Vaccines

**Home and Community-Based Services**

067 = Laboratory and X-Ray services
068 = Home Health Services — Home health aide services provided by a home health agency
069 = Private duty nursing services
070 = Physical Therapy and Related Services — Audiology services
071 = Extended services for pregnant women — Additional Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.
072 = Home and Community Care for Functionally Disabled Elderly individuals as defined and described in the State Plan
073 = Emergency services for certain legalized aliens and undocumented aliens
074 = Licensed or Otherwise State-Approved Free-Standing Birthing Center and other ambulatory services that are offered by a freestanding birth center
075 = Homemaker
076 = Home Health Aide
077 = Adult Day Health services
078 = Habilitation
079 = Habilitation: Residential Habilitation
080 = Habilitation: Supported Employment
081 = Habilitation: Education (non-IDEA available)
082 = Habilitation: Day Habilitation
083 = Habilitation: Pre-Vocational
084 = Habilitation: Other Habilitative Services
085 = Respite
086 = Day Treatment (mental health service)
087 = Psychosocial rehabilitation
088 = Environmental Modifications (Home Accessibility Adaptations)
089 = Vehicle Modifications
090 = Non-Medical Transportation
091 = Special Medical Equipment (minor assistive Devices)
092 = Home Delivered meals
093 = Assistive Technology (i.e., communication devices)
094 = Personal Emergency Response (PERS)
095 = Nursing Services
096 = Community Transition Services
097 = Adult Foster Care
098 = Day Supports (non-habilitative)
099 = Supported Employment
100 = Supported Living Arrangements
101 = Supports for Consumer Direction (Supports Facilitation)
102 = Participant Directed Goods and Services
103 = Senior Companion (Adult Companion Services)
104 = Assisted Living

Other
105 = Program for All-inclusive Care for the Elderly (PACE) Services
106 = Self-directed Personal Assistance Services under 1915(j)

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:** —
<table>
<thead>
<tr>
<th><strong>Variable Details</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CCW_LD_DT</strong></td>
</tr>
<tr>
<td><strong>LABEL:</strong> CCW Load Date</td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong> The Date Source File was loaded to the CCW</td>
</tr>
<tr>
<td><strong>SHORT NAME:</strong> CCW_LD_DT</td>
</tr>
<tr>
<td><strong>LONG NAME:</strong> CCW_LD_DT</td>
</tr>
<tr>
<td><strong>TYPE:</strong> DATE</td>
</tr>
<tr>
<td><strong>LENGTH:</strong> 8</td>
</tr>
<tr>
<td><strong>SOURCE:</strong> CCW (derived)</td>
</tr>
<tr>
<td><strong>FILE(S):</strong> IP Header LT Header OT Header RX Header</td>
</tr>
<tr>
<td><strong>VALUES:</strong> Date (numeric, system dependent)</td>
</tr>
<tr>
<td><strong>COMMENT:</strong> 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.</td>
</tr>
</tbody>
</table>
**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. See also 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.
CHRONIC CONDITION WAREHOUSE

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:**

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

2 = Medicaid or Medicaid-expansion Capitated Payment

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

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

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

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

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

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

U = Other FFS claim

V = Other Capitated Payment

W = Other Managed Care Encounter

Y = Other Supplemental Payment
Null/missing = source value is missing or unknown

**COMMENT:** Note that service tracking records (i.e., those where CLM_TYPE_CD = 4, D or X) are not included in the claims RIFs.
**CMPND_DRUG_IND**

**LABEL:** Compound Drug Indicator  
**DESCRIPTION:** Indicator to specify if 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:** —
**COPAY_WVD_IND**

**LABEL:** Indicator Signifying Copay was Waived by Provider

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

**SHORT NAME:** COPAY_WVD_IND

**LONG NAME:** COPAY_WVD_IND

**TYPE:** CHAR

**LENGTH:** 1

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

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

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

**COMMENT:** —
### 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 a portion is paid by Medicare.  

**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–XXXXXX; may be negative

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

Null/missing = source value is missing or unknown

**COMMENT:** If type of service code (TOS_CD) = 044 (Inpatient hospital services for individuals age 65 or older in institutions for mental diseases) or 045 (Nursing facility services for individuals age 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.

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**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:** —
**DA_RUN_ID**

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

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

**SHORT NAME:** DA_RUN_ID

**LONG NAME:** DA_RUN_ID

**TYPE:** NUM

**LENGTH:** 8

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

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

**VALUES:** —

**COMMENT:** —
**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>Description</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>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>
**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:** —
DGNS_CD_1
DGNS_CD_2
DGNS_CD_3
DGNS_CD_4
DGNS_CD_5
DGNS_CD_6
DGNS_CD_7
DGNS_CD_8
DGNS_CD_9
DGNS_CD_10
DGNS_CD_11
DGNS_CD_12

LABEL: Diagnosis Code (1–12)

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

SHORT NAME:

<table>
<thead>
<tr>
<th>SHORT NAME</th>
<th>SHORT NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>DGNS_CD_1</td>
<td>DGNS_CD_7</td>
</tr>
<tr>
<td>DGNS_CD_2</td>
<td>DGNS_CD_8</td>
</tr>
<tr>
<td>DGNS_CD_3</td>
<td>DGNS_CD_9</td>
</tr>
<tr>
<td>DGNS_CD_4</td>
<td>DGNS_CD_10</td>
</tr>
<tr>
<td>DGNS_CD_5</td>
<td>DGNS_CD_11</td>
</tr>
<tr>
<td>DGNS_CD_6</td>
<td>DGNS_CD_12</td>
</tr>
</tbody>
</table>

LONG NAME:

<table>
<thead>
<tr>
<th>LONG NAME</th>
<th>LONG NAME</th>
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</thead>
<tbody>
<tr>
<td>DGNS_CD_1</td>
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<td>DGNS_CD_2</td>
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<tr>
<td>DGNS_CD_5</td>
<td>DGNS_CD_11</td>
</tr>
<tr>
<td>DGNS_CD_6</td>
<td>DGNS_CD_12</td>
</tr>
</tbody>
</table>

TYPE: CHAR

LENGTH: 7
SOURCE: T-MSIS Analytic File (TAF) Claims

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. In 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

<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>
</tr>
</thead>
<tbody>
<tr>
<td>DGNS_POA_IND_1</td>
<td>Diagnosis Present on Admission Indicator (1–12)</td>
<td>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.</td>
<td>DGNS_POA_IND_1, DGNS_POA_IND_7</td>
<td>DGNS_POA_IND_1, DGNS_POA_IND_7</td>
<td>CHAR</td>
<td>1</td>
</tr>
<tr>
<td>DGNS_POA_IND_2</td>
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<td>DGNS_POA_IND_2, DGNS_POA_IND_8</td>
<td>DGNS_POA_IND_2, DGNS_POA_IND_8</td>
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<tr>
<td>DGNS_POA_IND_3</td>
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<td>DGNS_POA_IND_3, DGNS_POA_IND_9</td>
<td>DGNS_POA_IND_3, DGNS_POA_IND_9</td>
<td></td>
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</tr>
<tr>
<td>DGNS_POA_IND_4</td>
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<td>DGNS_POA_IND_4, DGNS_POA_IND_10</td>
<td>DGNS_POA_IND_4, DGNS_POA_IND_10</td>
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</tr>
<tr>
<td>DGNS_POA_IND_5</td>
<td></td>
<td></td>
<td>DGNS_POA_IND_5, DGNS_POA_IND_11</td>
<td>DGNS_POA_IND_5, DGNS_POA_IND_11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DGNS_POA_IND_6</td>
<td></td>
<td></td>
<td>DGNS_POA_IND_6, DGNS_POA_IND_12</td>
<td>DGNS_POA_IND_6, DGNS_POA_IND_12</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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/missing = source value is missing, unknown, or not on the valid value list or within the range of valid values

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

(a) high cost or high volume or both,

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

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

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

There is a POA indicator code associated with each diagnosis code (principal and secondary).
<table>
<thead>
<tr>
<th>Variable</th>
<th>Label</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>DGNS_VRSN_CD_1</td>
<td>Diagnosis Version Code (1–12) (ICD-9 or ICD-10)</td>
<td>This variable identifies the coding system (ICD-9 or ICD-10) used for the Diagnosis Codes 1 through 12 (DGNS_CD_1–12 fields).</td>
</tr>
</tbody>
</table>

**Short Name:**
- 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

**Long Name:**
- 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

**Type:** CHAR

**Length:** 1
**SOURCE:** T-MSIS Analytic File (TAF) Claims

**FILE(S):**
- IP Header
- LT Header
- OT Header

**VALUES:**
1 = ICD-9
2 = ICD-10
3 = Other/invalid code

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

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

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**DRCTNG_PRVDR_TXNMY_CD**

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

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

**SHORT NAME:** DRCTNG_PRVDR_TXNMY_CD

**LONG NAME:** DRCTNG_PRVDR_TXNMY_CD

**TYPE:** CHAR

**LENGTH:** 12

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

**FILE(S):** OT Header


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 see HG33; also see 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 (1st and 2nd characters) are the Reason for Service Code:

- **AD** = Additional Drug Needed
- **AN** = Prescription Authentication
- **AR** = Adverse Drug Reaction
- **AT** = Additive Toxicity
- **CD** = Chronic Disease Management
- **CH** = Call Help Desk
- **CS** = Patient Complaint/Symptom
- **DA** = Drug — Allergy
- **DC** = Drug — Disease (Inferred)
- **DD** = Drug — Drug Interaction
- **DF** = Drug — Food interaction
- **DI** = Drug Incompatibility
- **DL** = Drug — Lab Conflict
- **DM** = Apparent Drug Misuse
- **DS** = Tobacco Use
- **ED** = Patient Education/Instruction
- **ER** = Overuse
EX = Excessive Quantity
HD = High Dose
IC = Iatrogenic Condition
ID = Ingredient Duplication
LD = Low Dose
LK = Lock In Recipient
LR = Underuse
MC = Drug — Disease (Reported)
MN = Insufficient Duration
MS = Missing Information/Clarification
MX = Excessive Duration
NA = Drug Not Available
NC = Non-covered Drug Purchase
ND = New Disease/Diagnosis
NF = Non-Formulary Drug
NN = Unnecessary Drug
NP = New Patient Processing
NR = Lactation/Nursing Interaction
NS = Insufficient Quantity
OH = Alcohol Conflict
PA = Drug — Age
PC = Patient Question/Concern
PG = Drug — Pregnancy
PH = Preventive Health Care
PN = Prescriber Consultation
PP = Plan Protocol
PR = Prior Adverse Reaction
PS = Product Selection Opportunity
RE = Suspected Environmental Risk  
RF = Health Provider Referral  
SC = Suboptimal Compliance  
SD = Suboptimal Drug/Indication  
SE = Side Effect  
SF = Suboptimal Dosage Form  
SR = Suboptimal Regimen  
SX = Drug — Gender  
TD = Therapeutic  
TN = Laboratory Test Needed  
TP = Payer/Processor Question  

The 3rd and 4th digits are the Professional Service Code:  

00 = No intervention  
AS = Patient assessment  
CC = Coordination of care  
DE = Dosing evaluation/determination  
FE = Formulary enforcement  
GP = Generic product selection  
MA = Medication administration  
M0 = Prescriber consulted  
MR = Medication review  
PE = Patient education/instruction  
PH = Patient medication history  
PM = Patient monitoring  
P0 = Patient consulted  
PT = Perform laboratory test  
R0 = Pharmacist consulted other source  
RT = Recommend laboratory test
Variable Details

SC = Self-care consultation
SW = Literature search/review
TC = Payer/processor consulted
TH = Therapeutic product interchange

The two rightmost digits (5th and 6th characters) are the Result of Service Code:

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

**COMMENT:**

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

1. The NCPDP "Reason of Service Code" (bytes 1 & 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 & 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 & 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:** —
**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.
### FUNDING_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:** —
HCBS_TXNMY_CD

LABEL: Home- and Community-Based Services Taxonomy Code

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

SHORT NAME: HCBS_TXNMY_CD

LONG NAME: HCBS_TXNMY_CD

TYPE: CHAR

LENGTH: 5

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): OT Line

VALUES:

01010 = Case Management
02011 = Group Living, Residential Habilitation
02012 = Group Living, Mental Health Services
02013 = Group Living, Other
02021 = Shared Living, Residential Habilitation
02022 = Shared Living, Mental Health Services
02023 = Shared Living, Other
02031 = In-e Residential Habilitation
02032 = In-Home Round-The-Clock Mental Health Services
02033 = In-Home Round-The-Clock Services, Other
03010 = Job Development
03021 = Ongoing Supported Employment, Individual
03022 = Ongoing Supported Employment, Group
03030 = Career Planning
04010 = Prevocational Services
04020 = Day Habilitation
04030 = Education Services
04040 = Day Treatment/Partial Hospitalization
04050 = Adult Day Health
04060 = Adult Day Services (Social Model)
04070 = Community Integration
04080 = Medical Day Care for Children
05010 = Private Duty Nursing
05020 = Skilled Nursing
06010 = Home Delivered Meals
07010 = Rent and Food Expenses For Live-In Caregiver
08010 = Home-Based Habilitation
08020 = Home Health Aide
08030 = Personal Care
08040 = Companion
08050 = Homemaker
08060 = Chore
09011 = Respite, Out-Of-Home
09012 = Respite, In-Home
09020 = Caregiver Counseling and/or Training
10010 = Mental Health Assessment
10020 = Assertive Community Treatment
10030 = Crisis Intervention
10040 = Behavior Support
10050 = Peer Specialist
10060 = Counseling
10070 = Psychosocial Rehabilitation
10080 = Clinic Services
10090 = Other Mental Health and Behavioral Services
11010 = Health Monitoring
11020 = Health Assessment
11030 = Medication Assessment and/or Management
11040 = Nutrition Consultation
11050 = Physician Services
11060 = Prescription Drugs
11070 = Dental Services
11080 = Occupational Therapy
11090 = Physical Therapy
11100 = Speech, Hearing, And Language Therapy
11110 = Respiratory Therapy
11120 = Cognitive Rehabilitative Therapy
11130 = Other Therapies
12010 = Financial Management Services In Support Of Participant Direction
12020 = Information and Assistance In Support Of Participant Direction
13010 = Participant Training
14010 = Personal Emergency Response System (Pers)
14020 = Home and/or Vehicle Accessibility Adaptations
14031 = Equipment and Technology
14032 = Supplies
15010 = Non-Medical Transportation
16010 = Community Transition Services
17010 = Goods and Services
17020 = Interpreter
17030 = Housing Consultation
17990 = Other

Null/missing = source value is missing or unknown

COMMENT: Values containing digits will include leading zeros.
Values and websites referenced may change over time.
**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

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

Null/missing = source value is missing or unknown

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

To search CMS’s NPI registry, you may use the following link: https://npiregistry.cms.hhs.gov/
**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: —
**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 &amp; Social Service Providers: Counselor</td>
</tr>
<tr>
<td>101YM0800X</td>
<td>Behavioral Health &amp; Social Service Providers: Counselor, Mental Health</td>
</tr>
<tr>
<td>101YP1600X</td>
<td>Behavioral Health &amp; Social Service Providers: Counselor, Pastoral</td>
</tr>
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<td>101YP2500X</td>
<td>Behavioral Health &amp; Social Service Providers: Counselor, Professional</td>
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<td>Behavioral Health &amp; Social Service Providers: Counselor, School</td>
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<td>Behavioral Health &amp; Social Service Providers: Psychoanalyst</td>
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<td>Behavioral Health &amp; Social Service Providers: Poetry Therapist</td>
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<td>103G00000X</td>
<td>Behavioral Health &amp; Social Service Providers: Clinical Neuropsychologist</td>
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<td>Behavioral Health &amp; Social Service Providers: Behavior Analyst</td>
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<td>Behavioral Health &amp; Social Service Providers: Psychologist</td>
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<td>Behavioral Health &amp; Social Service Providers: Psychologist, Family</td>
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<td>Behavioral Health &amp; Social Service Providers: Psychologist, Women</td>
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<td>Behavioral Health &amp; Social Service Providers: Social Worker</td>
</tr>
<tr>
<td>1041C0700X</td>
<td>Behavioral Health &amp; Social Service Providers: Social Worker, Clinical</td>
</tr>
<tr>
<td>1041S0200X</td>
<td>Behavioral Health &amp; Social Service Providers: Social Worker, School</td>
</tr>
<tr>
<td>106E00000X</td>
<td>Behavioral Health &amp; Social Service Providers: Assistant Behavior Analyst</td>
</tr>
<tr>
<td>106H00000X</td>
<td>Behavioral Health &amp; Social Service Providers: Marriage &amp; Family Therapist</td>
</tr>
<tr>
<td>106S00000X</td>
<td>Behavioral Health &amp; Social Service Providers: Behavior Technician</td>
</tr>
<tr>
<td>163WP0807X</td>
<td>Nursing Service Providers: Registered Nurse, Psychiatric/Mental Health, Child &amp; Adolescent</td>
</tr>
<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>
</tr>
<tr>
<td>183SP1300X</td>
<td>Pharmacy Service Providers: Pharmacist, Psychiatric</td>
</tr>
<tr>
<td>2080P0006X</td>
<td>Allopathic &amp; Osteopathic Physicians: Pediatrics, Developmental — Behavioral Pediatrics</td>
</tr>
<tr>
<td>2080P0008X</td>
<td>Allopathic &amp; Osteopathic Physicians: Pediatrics, Neurodevelopmental Disabilities</td>
</tr>
<tr>
<td>2084B0040X</td>
<td>Allopathic &amp; Osteopathic Physicians: Psychiatry &amp; Neurology, Behavioral Neurology &amp; Neuropsychiatry</td>
</tr>
<tr>
<td>2084F0202X</td>
<td>Allopathic &amp; Osteopathic Physicians: Psychiatry &amp; Neurology, Forensic Psychiatry</td>
</tr>
<tr>
<td>2084P0005X</td>
<td>Allopathic &amp; Osteopathic Physicians: Psychiatry &amp; Neurology, Neurodevelopmental Disabilities</td>
</tr>
<tr>
<td>2084P0015X</td>
<td>Allopathic &amp; Osteopathic Physicians: Psychiatry &amp; Neurology, Psychosomatic Medicine</td>
</tr>
<tr>
<td>2084P0800X</td>
<td>Allopathic &amp; Osteopathic Physicians: Psychiatry &amp; Neurology, Psychiatry</td>
</tr>
<tr>
<td>2084P0804X</td>
<td>Allopathic &amp; Osteopathic Physicians: Psychiatry &amp; Neurology, Child &amp; Adolescent Psychiatry</td>
</tr>
<tr>
<td>2084P0805X</td>
<td>Allopathic &amp; Osteopathic Physicians: Psychiatry &amp; Neurology, Geriatric Psychiatry</td>
</tr>
<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 &amp; Advanced Practice Nursing Providers: Nurse Practitioner, Psychiatric/Mental Health</td>
</tr>
<tr>
<td>364SP0807X</td>
<td>Physician Assistants &amp; Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health, Child &amp; Adolescent</td>
</tr>
<tr>
<td>364SP0808X</td>
<td>Physician Assistants &amp; Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health</td>
</tr>
<tr>
<td>364SP0809X</td>
<td>Physician Assistants &amp; Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health, Adult</td>
</tr>
<tr>
<td>364SP0810X</td>
<td>Physician Assistants &amp; Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health, Child &amp; Family</td>
</tr>
<tr>
<td>364SP0811X</td>
<td>Physician Assistants &amp; Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health, Chronically Ill</td>
</tr>
<tr>
<td>364SP0812X</td>
<td>Physician Assistants &amp; Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health, Community</td>
</tr>
<tr>
<td>364SP0813X</td>
<td>Physician Assistants &amp; 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 &amp; Custodial Care Facilities: Assisted Living Facility, Assisted Living, Mental Illness</td>
</tr>
<tr>
<td>3104A0630X</td>
<td>Nursing &amp; Custodial Care Facilities: Assisted Living Facility, Assisted Living, Behavioral Disturbances</td>
</tr>
<tr>
<td>310500000X</td>
<td>Nursing &amp; Custodial Care Facilities: Intermediate Care Facility, Mental Illness</td>
</tr>
<tr>
<td>311500000X</td>
<td>Nursing &amp; Custodial Care Facilities: Alzheimer Center (Dementia Center)</td>
</tr>
<tr>
<td>315P00000X</td>
<td>Nursing &amp; 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>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>101YA0400X</td>
<td>Behavioral Health &amp; Social Service Providers: Counselor, Addiction (Substance Use Disorder)</td>
</tr>
<tr>
<td>103TA0400X</td>
<td>Behavioral Health &amp; 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 &amp; Osteopathic Physicians: Anesthesiology, Addiction Medicine</td>
</tr>
<tr>
<td>207QA0401X</td>
<td>Allopathic &amp; Osteopathic Physicians: Family Medicine, Addiction Medicine</td>
</tr>
<tr>
<td>207RA0401X</td>
<td>Allopathic &amp; Osteopathic Physicians: Internal Medicine, Addiction Medicine</td>
</tr>
<tr>
<td>2084A0401X</td>
<td>Allopathic &amp; Osteopathic Physicians: Psychiatry &amp; Neurology, Addiction Medicine</td>
</tr>
<tr>
<td>2084P0802X</td>
<td>Allopathic &amp; Osteopathic Physicians: Psychiatry &amp; 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>
<tr>
<td>3245S0500X</td>
<td>Residential Treatment Facilities: Substance Abuse Rehabilitation Facility, Substance Abuse Treatment, Children</td>
</tr>
</tbody>
</table>
For Substance Use Disorder Taxonomy Codes, please visit http://www.wpc-edi.com/reference/
**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

**VALUES:**


Null/missing = source value is missing or unknown

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

Values and websites referenced may change over time.
**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:** [http://www.x12.org/codes/health-care-claim-status-codes/](http://www.x12.org/codes/health-care-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:** —
**LINE_MDCD_ALOWD_AMT**

**LABEL:** Line Medicaid Allowed Amount

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

**SHORT NAME:** LINE_MDCD_ALOWD_AMT

**LONG NAME:** LINE_MDCD_ALOWD_AMT

**TYPE:** NUM

**LENGTH:** 8

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

**FILE(S):** All Line Files

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

Null/missing = source value is missing or unknown

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

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**LINE_OTHR_INSRNC_PD_AMT**

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

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

**SHORT NAME:** LINE_OTHR_INSRNC_PD_AMT

**LONG NAME:** LINE_OTHR_INSRNC_PD_AMT

**TYPE:** NUM

**LENGTH:** 8

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

**FILE(S):** All Line Files

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

**COMMENT:** —
**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](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.
<table>
<thead>
<tr>
<th>LABEL:</th>
<th>Date Line Procedure Performed</th>
</tr>
</thead>
<tbody>
<tr>
<td>DESCRIPTION:</td>
<td>The date upon which the procedure was performed.</td>
</tr>
<tr>
<td>SHORT NAME:</td>
<td>LINE_PRCDR_CD_DT</td>
</tr>
<tr>
<td>LONG NAME:</td>
<td>LINE_PRCDR_CD_DT</td>
</tr>
<tr>
<td>TYPE:</td>
<td>DATE</td>
</tr>
<tr>
<td>LENGTH:</td>
<td>8</td>
</tr>
<tr>
<td>SOURCE:</td>
<td>T-MSIS Analytic File (TAF) Claims</td>
</tr>
<tr>
<td>FILE(S):</td>
<td>OT Line</td>
</tr>
<tr>
<td>VALUES:</td>
<td>Date (numeric, system dependent)</td>
</tr>
<tr>
<td></td>
<td>Null/missing = source value is missing or unknown</td>
</tr>
<tr>
<td>COMMENT:</td>
<td>Date of the LINE_PRCDR_CD.</td>
</tr>
</tbody>
</table>
**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:** —
**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_2
- LINE_PRCDR_MDFR_CD_3
- LINE_PRCDR_MDFR_CD_4

**LONG NAME:**
- LINE_PRCDR_MDFR_CD_1
- LINE_PRCDR_MDFR_CD_2
- LINE_PRCDR_MDFR_CD_3
- LINE_PRCDR_MDFR_CD_4

**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.
| **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/icd10manual/version31-fullcode-cms/P0001.html
**MDCD_ACMDTN_PD_AMT**

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

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

**SHORT NAME:** MDCD_ACMDTN_PD_AMT

**LONG NAME:** MDCD_ACMDTN_PD_AMT

**TYPE:** NUM

**LENGTH:** 8

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

**FILE(S):** LT Header

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

Null/missing = source value is missing or unknown

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

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

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

**LABEL:** Medicaid Amount Paid Disproportionate Share Hospital (DSH)

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

**SHORT NAME:** MCD_DSH_PD_AMT

**LONG NAME:** MCD_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:** —
**MCDP_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:** MCDP_PD_AMT

**LONG NAME:** MCDP_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 ^
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.
**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_REIMBRSMT_TYPE_CD**

**LABEL:** Medicare Reimbursement Type Code  
**DESCRIPTION:** This code indicates the type of Medicare reimbursement.  
**SHORT NAME:** MDCR_REIMBRSMT_TYPE_CD  
**LONG NAME:** MDCR_REIMBRSMT_TYPE_CD  
**TYPE:** CHAR  
**LENGTH:** 2  
**SOURCE:** T-MSIS Analytic File (TAF) Claims  
**FILE(S):** IP Header  
LT Header  
OT Header  
**VALUES:**  
- **01 = IPPS** — Acute Inpatient Prospective Payment system (PPS)  
- **02 = LTCHPPS** — Long-term Care Hospital (LTCH) PPS  
- **03 = SNFPPS** — Skilled Nursing Facility (SNF) PPS  
- **04 = HHPPS** — Home Health (HH) PPS  
- **05 = IRFPPS** — Inpatient Rehabilitation Facility (IRF) PPS  
- **06 = IPFPPS** — Inpatient Psychiatric Facility (IPF) PPS  
- **07 = OPPS** — Outpatient PPS  
- **08 = Fee Schedules** (for physicians, DME, ambulance, and clinical lab)  
- **09 = Part C Hierarchical Condition Category Risk Assessment (CMS-HCC RA) Capitation Payment Model**  
  
**Null/missing = source value is missing or unknown**  
**COMMENT:** —
### 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:

Codes Classification and area of specialization
(a) Individual or Groups of Individuals
101Y00000X Behavioral Health & Social Service Providers: Counselor
101YM0800X Behavioral Health & Social Service Providers: Counselor, Mental Health
101YP1600X Behavioral Health & Social Service Providers: Counselor, Pastoral
101YP2500X Behavioral Health & Social Service Providers: Counselor, Professional
101YS0200X Behavioral Health & Social Service Providers: Counselor, School
102L00000X Behavioral Health & Social Service Providers: Psychoanalyst
102X00000X Behavioral Health & Social Service Providers: Poetry Therapist
103G00000X Behavioral Health & Social Service Providers: Clinical Neuropsychologist
103GC0700X Behavioral Health & Social Service Providers: Clinical Neuropsychologist, Clinical
103K00000X Behavioral Health & Social Service Providers: Behavior Analyst
103T00000X Behavioral Health & Social Service Providers: Psychologist
103TA0700X Behavioral Health & Social Service Providers: Psychologist, Adult Development & Aging
103TB0200X Behavioral Health & Social Service Providers: Psychologist, Cognitive & Behavioral
103TC0700X Behavioral Health & Social Service Providers: Psychologist, Clinical
103TC1900X Behavioral Health & Social Service Providers: Psychologist, Counseling
103TC2200X Behavioral Health & Social Service Providers: Psychologist, Clinical Child & Adolescent
103TE1000X Behavioral Health & Social Service Providers: Psychologist, Educational
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>103TE1100X</td>
<td>Behavioral Health &amp; Social Service Providers: Psychologist, Exercise &amp; Sports</td>
</tr>
<tr>
<td>103TF0000X</td>
<td>Behavioral Health &amp; Social Service Providers: Psychologist, Family</td>
</tr>
<tr>
<td>103TF0200X</td>
<td>Behavioral Health &amp; Social Service Providers: Psychologist, Forensic</td>
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<tr>
<td>103TH0004X</td>
<td>Behavioral Health &amp; Social Service Providers: Psychologist, Health</td>
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<td>103TH0100X</td>
<td>Behavioral Health &amp; Social Service Providers: Psychologist, Health Service</td>
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<td>103TM1700X</td>
<td>Behavioral Health &amp; Social Service Providers: Psychologist, Men &amp; Masculinity</td>
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<tr>
<td>103TM1800X</td>
<td>Behavioral Health &amp; Social Service Providers: Psychologist, Mental Retardation &amp; Developmental Disabilities</td>
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<tr>
<td>103TP0016X</td>
<td>Behavioral Health &amp; Social Service Providers: Psychologist, Prescribing (Medical)</td>
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<td>103TP0814X</td>
<td>Behavioral Health &amp; Social Service Providers: Psychologist, Psychoanalysis</td>
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<td>Behavioral Health &amp; Social Service Providers: Psychologist, Psychotherapy</td>
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<td>103TS0200X</td>
<td>Behavioral Health &amp; Social Service Providers: Psychologist, School</td>
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<td>103TW0100X</td>
<td>Behavioral Health &amp; Social Service Providers: Psychologist, Women</td>
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<td>104100000X</td>
<td>Behavioral Health &amp; Social Service Providers: Social Worker</td>
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<tr>
<td>1041C0700X</td>
<td>Behavioral Health &amp; Social Service Providers: Social Worker, Clinical</td>
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<tr>
<td>1041S0200X</td>
<td>Behavioral Health &amp; Social Service Providers: Social Worker, School</td>
</tr>
<tr>
<td>106E00000X</td>
<td>Behavioral Health &amp; Social Service Providers: Assistant Behavior Analyst</td>
</tr>
<tr>
<td>106H00000X</td>
<td>Behavioral Health &amp; Social Service Providers: Marriage &amp; Family Therapist</td>
</tr>
<tr>
<td>106S00000X</td>
<td>Behavioral Health &amp; Social Service Providers: Behavior Technician</td>
</tr>
<tr>
<td>163WP0807X</td>
<td>Nursing Service Providers: Registered Nurse, Psychiatric/Mental Health, Child &amp; Adolescent</td>
</tr>
<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>
</tr>
<tr>
<td>1835P1300X</td>
<td>Pharmacy Service Providers: Pharmacist, Psychiatric</td>
</tr>
<tr>
<td>2080P006X</td>
<td>Allopathic &amp; Osteopathic Physicians: Pediatrics, Developmental — Behavioral Pediatrics</td>
</tr>
<tr>
<td>2080P008X</td>
<td>Allopathic &amp; Osteopathic Physicians: Pediatrics, Neurodevelopmental Disabilities</td>
</tr>
<tr>
<td>2084B0040X</td>
<td>Allopathic &amp; Osteopathic Physicians: Psychiatry &amp; Neurology, Behavioral Neurology &amp; Neuropsychiatry</td>
</tr>
<tr>
<td>2084F0202X</td>
<td>Allopathic &amp; Osteopathic Physicians: Psychiatry &amp; Neurology, Forensic Psychiatry</td>
</tr>
<tr>
<td>2084P0005X</td>
<td>Allopathic &amp; Osteopathic Physicians: Psychiatry &amp; Neurology, Neurodevelopmental Disabilities</td>
</tr>
<tr>
<td>2084P0015X</td>
<td>Allopathic &amp; Osteopathic Physicians: Psychiatry &amp; Neurology, Psychosomatic Medicine</td>
</tr>
<tr>
<td>2084P0800X</td>
<td>Allopathic &amp; Osteopathic Physicians: Psychiatry &amp; Neurology, Psychiatry</td>
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<tr>
<td>2084P0804X</td>
<td>Allopathic &amp; Osteopathic Physicians: Psychiatry &amp; Neurology, Child &amp; Adolescent Psychiatry</td>
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<td>2084P0805X</td>
<td>Allopathic &amp; Osteopathic Physicians: Psychiatry &amp; 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 &amp; Advanced Practice Nursing Providers: Nurse Practitioner, Psychiatric/Mental Health</td>
</tr>
<tr>
<td>364SP0807X</td>
<td>Physician Assistants &amp; Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health, Child &amp; Adolescent</td>
</tr>
<tr>
<td>364SP0808X</td>
<td>Physician Assistants &amp; Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health</td>
</tr>
<tr>
<td>364SP0809X</td>
<td>Physician Assistants &amp; Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health, Adult</td>
</tr>
<tr>
<td>364SP0810X</td>
<td>Physician Assistants &amp; Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health, Child &amp; Family</td>
</tr>
<tr>
<td>364SP0811X</td>
<td>Physician Assistants &amp; Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health, Chronically Ill</td>
</tr>
<tr>
<td>364SP0812X</td>
<td>Physician Assistants &amp; Advanced Practice Nursing Providers: Clinical Nurse Specialist, Psychiatric/Mental Health, Community</td>
</tr>
</tbody>
</table>
Variable Details

364SP0813X  Physician Assistants & 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 & Custodial Care Facilities: Assisted Living Facility, Assisted Living, Mental Illness
3104A0630X  Nursing & Custodial Care Facilities: Assisted Living Facility, Assisted Living, Behavioral Disturbances
310500000X  Nursing & Custodial Care Facilities: Intermediate Care Facility, Mental Illness
311500000X  Nursing & Custodial Care Facilities: Alzheimer Center (Dementia Center)
315P00000X  Nursing & 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.
Variable Details

**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.

See 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
  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:** —
**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
**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
- 01–98 = 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:**

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 THRU 09 =</td>
<td>Accident</td>
</tr>
<tr>
<td>10 THRU 19 =</td>
<td>Medical condition</td>
</tr>
<tr>
<td>20 THRU 39 =</td>
<td>Insurance related</td>
</tr>
<tr>
<td>40 THRU 69 =</td>
<td>Service related</td>
</tr>
<tr>
<td>A1–G3 =</td>
<td>Miscellaneous</td>
</tr>
</tbody>
</table>

---

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
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>07</td>
<td>Reserved for national assignment.</td>
</tr>
<tr>
<td>08</td>
<td>Reserved for national assignment.</td>
</tr>
<tr>
<td>09</td>
<td>Start of Infertility Treatment Cycle — Code indicating the start of infertility treatment cycle</td>
</tr>
<tr>
<td>10</td>
<td>Last Menstrual Period — Code indicating the date of the last menstrual period. ONLY applies when patient is being treated for maternity related condition.</td>
</tr>
<tr>
<td>11</td>
<td>Onset of symptoms/illness — The date the patient first became aware of symptoms/illness.</td>
</tr>
<tr>
<td>12</td>
<td>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.</td>
</tr>
<tr>
<td>13</td>
<td>Reserved for national assignment.</td>
</tr>
<tr>
<td>14</td>
<td>Reserved for national assignment.</td>
</tr>
<tr>
<td>15</td>
<td>Reserved for national assignment.</td>
</tr>
<tr>
<td>16</td>
<td>Date of Last Therapy — Code indicates the last day of therapy services (e.g., physical, occupational or speech therapy).</td>
</tr>
<tr>
<td>17</td>
<td>Date outpatient occupational therapy plan established or last reviewed — Code indicating the date an occupational therapy plan was established or last reviewed.</td>
</tr>
<tr>
<td>18</td>
<td>Date of retirement (patient/bene) — Code indicates the date of retirement for the patient/bene.</td>
</tr>
<tr>
<td>19</td>
<td>Date of retirement spouse — Code indicates the date of retirement for the patient's spouse.</td>
</tr>
<tr>
<td>20</td>
<td>Guarantee of payment began — (Part A hospital claims only.) Date on which the hospital begins claiming payment under the guarantee of payment provision.</td>
</tr>
<tr>
<td>21</td>
<td>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.</td>
</tr>
<tr>
<td>22</td>
<td>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 &quot;21&quot; is used.</td>
</tr>
<tr>
<td>23</td>
<td>Cancellation of Hospice benefits — The date of cancellation of hospice election period. For FI Use Only. Providers Do Not Report.</td>
</tr>
<tr>
<td>24</td>
<td>Date insurance denied — The date of receipt of the insurer's denial of coverage (by a higher priority payer).</td>
</tr>
<tr>
<td>25</td>
<td>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.</td>
</tr>
</tbody>
</table>
26 = Date skilled nursing facility (SNF) bed available — The date on which a SNF bed became available to a hospital inpatient who required only SNF level of care.

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

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

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

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

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

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

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

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

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

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

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

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

39 = Date discharged on a continuous course of IV therapy — Date the patient was discharged from the hospital on a continuous course of IV therapy.
40 = Scheduled date of admission — The date on which a patient will be admitted as an inpatient to the hospital. (This code may only be used on an outpatient claim.)

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

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

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

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

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

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

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

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

50–69 = Reserved for state assignment

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

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

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

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

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

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

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

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

C2 = Effective date, Insured C policy — A code indicating the first date insurance is in force.
C3 = Benefits exhausted — Code indicating the last date for which benefits are available and after which no payment can be made to payer C.

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

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

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

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

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

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

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

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

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

Null/missing= source value is missing or unknown

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

**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).
**OCRNC_CD_SEQ**

**LABEL:** Occurrence Code Sequence

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

**SHORT NAME:** OCRNC_CD_SEQ

**LONG NAME:** OCRNC_CD_SEQ

**TYPE:** CHAR

**LENGTH:** 2

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

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

**VALUES:** 1–XX

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

^ Back to TOC ^
<table>
<thead>
<tr>
<th><strong>LABEL:</strong></th>
<th>Other Services Accommodation Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DESCRIPTION:</strong></td>
<td>For outpatient hospital facility claims, HCPCS/CPT is captured here.</td>
</tr>
<tr>
<td><strong>SHORT NAME:</strong></td>
<td>OT_ACCMDTN_HCPCS_RATE</td>
</tr>
<tr>
<td><strong>LONG NAME:</strong></td>
<td>OT_ACCMDTN_HCPCS_RATE</td>
</tr>
<tr>
<td><strong>TYPE:</strong></td>
<td>CHAR</td>
</tr>
<tr>
<td><strong>LENGTH:</strong></td>
<td>14</td>
</tr>
<tr>
<td><strong>SOURCE:</strong></td>
<td>T-MSIS Analytic File (TAF) Claims</td>
</tr>
<tr>
<td><strong>FILE(S):</strong></td>
<td>OT Line</td>
</tr>
<tr>
<td><strong>VALUES:</strong></td>
<td><a href="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</a></td>
</tr>
<tr>
<td>Null/missing = source value is missing or unknown</td>
<td></td>
</tr>
<tr>
<td><strong>COMMENT:</strong></td>
<td>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).</td>
</tr>
</tbody>
</table>
**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–XXXXXX; 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)

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, camp ground, 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, that 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, that 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.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>61</td>
<td>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.</td>
</tr>
<tr>
<td>62</td>
<td>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.</td>
</tr>
<tr>
<td>63</td>
<td>Unassigned. N/A</td>
</tr>
<tr>
<td>64</td>
<td>Unassigned. N/A</td>
</tr>
<tr>
<td>65</td>
<td>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.</td>
</tr>
<tr>
<td>66–70</td>
<td>Unassigned. N/A</td>
</tr>
<tr>
<td>71</td>
<td>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.</td>
</tr>
<tr>
<td>72</td>
<td>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.</td>
</tr>
<tr>
<td>73–80</td>
<td>Unassigned. N/A</td>
</tr>
<tr>
<td>81</td>
<td>Independent Laboratory. A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.</td>
</tr>
<tr>
<td>82–98</td>
<td>Unassigned. N/A</td>
</tr>
<tr>
<td>99</td>
<td>Other Place of Service. Other place of service not identified above.</td>
</tr>
</tbody>
</table>

**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:**

- PRCDR_CD_1
- PRCDR_CD_4
- PRCDR_CD_2
- PRCDR_CD_5
- PRCDR_CD_3
- PRCDR_CD_6

**LONG NAME:**

- PRCDR_CD_1
- PRCDR_CD_4
- PRCDR_CD_2
- PRCDR_CD_5
- PRCDR_CD_3
- PRCDR_CD_6

**TYPE:** CHAR

**LENGTH:** 8

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

**FILE(S):** IP Header

**VALUES:** —

**COMMENT:** The record layout allows for up to six procedure codes; PRCDR_CD_2 through PRCDR_CD_6 (and related data elements) record secondary, tertiary, etc. procedures.
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRCDR_CD_DT_1</td>
<td>Date Procedures Performed (1–6)</td>
</tr>
<tr>
<td>PRCDR_CD_DT_2</td>
<td>The date upon which the procedure was performed (refer to the PRCDR_CD_1–6 fields).</td>
</tr>
<tr>
<td>PRCDR_CD_DT_3</td>
<td></td>
</tr>
<tr>
<td>PRCDR_CD_DT_4</td>
<td></td>
</tr>
<tr>
<td>PRCDR_CD_DT_5</td>
<td></td>
</tr>
<tr>
<td>PRCDR_CD_DT_6</td>
<td></td>
</tr>
</tbody>
</table>

**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_2
- PRCDR_CD_SYS_3
- PRCDR_CD_SYS_4
- PRCDR_CD_SYS_5
- PRCDR_CD_SYS_6

**LONG NAME:**
- PRCDR_CD_SYS_1
- PRCDR_CD_SYS_2
- PRCDR_CD_SYS_3
- PRCDR_CD_SYS_4
- PRCDR_CD_SYS_5
- 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.
**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**
Variable Details

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:** —
### PRSCRBNG_PRVDR_ID

**LABEL:** Prescribing Provider Identification Number  

**DESCRIPTION:** A unique identification number assigned by the state to the provider who prescribed the drug, device, or supply. This must be the individual’s ID number, not a group identification number.  

**SHORT NAME:** PRSCRBNG_PRVDR_ID  

**LONG NAME:** PRSCRBNG_PRVDR_ID  

**TYPE:** CHAR  

**LENGTH:** 30  

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

**FILE(S):** RX Header  

**VALUES:** Valid values are supplied by the state  

Null/missing = source value is missing or unknown  

**COMMENT:** —
**PRSRBNG_PRVDR_NPI**

**LABEL:**  Prescribing Provider NPI

**DESCRIPTION:**  The National Provider ID (NPI) of the provider who prescribed a medication to a patient.

**SHORT NAME:**  PRSRBNG_PRVDR_NPI

**LONG NAME:**  PRSRBNG_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/
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 & 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 other short term general hospital for inpatient care.
03 = Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care — (For hospitals with an approved swing bed arrangement, use Code 61 — swing bed. For reporting discharges/transfers to a non-certified SNF, the hospital must use Code 04 — ICF.
04 = Discharged/transferred to intermediate care facility (ICF).
05 = Discharged/transferred to another type of institution for inpatient care (including distinct parts).
06 = Discharged/transferred to home care of organized home health service organization.
07 = Left against medical advice or discontinued care.
08 = Discharged/transferred to home under care of a home IV drug therapy provider.
09 = Admitted as an inpatient to this hospital. In situations where a patient is admitted before midnight of the third day following the day of an outpatient service, the outpatient services are considered inpatient.
20 = Expired (patient did not recover).
21 = Discharged/transferred to court/law enforcement.
30 = Still patient.
40 = Expired at home (hospice claims only).

41 = Expired in a medical facility such as hospital, SNF, ICF, or freestanding hospice. (Hospice claims only).

42 = Expired — place unknown (Hospice claims only).

43 = Discharged/transferred to a federal hospital.

50 = Discharged/transferred to a Hospice — home.

51 = Discharged/transferred to a Hospice — medical facility.

61 = Discharged/transferred within this institution to a hospital-based Medicare approved swing bed.

62 = Discharged/transferred to an inpatient rehabilitation facility including distinct parts units of a hospital.

63 = Discharged/transferred to a long term care hospital.

64 = Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare.

65 = Discharged/Transferred to a psychiatric hospital or psychiatric distinct unit of a hospital (these types of hospitals were pulled from patient/discharge status code '05' and given their own code).

66 = Discharged/transferred to a Critical Access Hospital (CAH)

69 = Discharged/transferred to a designated disaster alternative care site (starting 10/2013; applies only to particular MS-DRGs*).

70 = Discharged/transferred to another type of health care institution not defined elsewhere in code list.

71 = Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (eff. 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 (eff. 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
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 & Board ward (medical or general) — general classification
0151 = Room & Board ward (medical or general) — medical/surgical/GYN
0152 = Room & Board ward (medical or general) — OB
0153 = Room & Board ward (medical or general) — pediatric
0154 = Room & Board ward (medical or general) — psychiatric
0155 = Room & Board ward (medical or general) — hospice
0156 = Room & Board ward (medical or general) — detoxification
0157 = Room & Board ward (medical or general) — oncology
0158 = Room & Board ward (medical or general) — rehabilitation
0159 = Room & Board ward (medical or general) — other
0160 = Other Room & Board — general classification
0164 = Other Room & Board — sterile environment
0167 = Other Room & Board — self care
0169 = Other Room & 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 infarction
0212 = Coronary care — pulmonary care
0213 = Coronary care — heart transplant
0214 = Coronary care — post CCU; redefined as intermediate CCU
0219 = Coronary care — other coronary care
0220 = Special charges — general classification
0221 = Special charges — admission charge
0222 = Special charges — technical support charge
0223 = Special charges — UR service charge
0224 = Special charges — late discharge, medically necessary
0229 = Special charges — other special charges
0230 = Incremental nursing charge rate — general classification
0231 = Incremental nursing charge rate — nursery
0232 = Incremental nursing charge rate — OB
0233 = Incremental nursing charge rate — ICU (include transitional care)
0234 = Incremental nursing charge rate — CCU (include transitional care)
0235 = Incremental nursing charge rate — hospice
0239 = Incremental nursing charge rate — other
0240 = All-inclusive ancillary — general classification
0241 = All-inclusive ancillary — basic
0242 = All-inclusive ancillary — comprehensive
0243 = All-inclusive ancillary — specialty
0249 = All-inclusive ancillary — other inclusive ancillary
0250 = Pharmacy — general classification
0251 = Pharmacy — generic drugs
0252 = Pharmacy — nongeneric drugs
0253 = Pharmacy — take home drugs
0254 = Pharmacy — drugs incident to other diagnostic service-subject to payment limit
0255 = Pharmacy — drugs incident to radiology-subject to payment limit
0256 = Pharmacy — experimental drugs
0257 = Pharmacy — non-prescription
0258 = Pharmacy — IV solutions
0259 = Pharmacy — other pharmacy
0260 = IV therapy — general classification
0261 = IV therapy — infusion pump
0262 = IV therapy — pharmacy services
0263 = IV therapy — drug supply/delivery
0264 = IV therapy — supplies
0269 = IV therapy — other IV therapy
0270 = Medical/surgical supplies — general classification (also see 062X)
0271 = Medical/surgical supplies — nonsterile supply
0272 = Medical/surgical supplies — sterile supply
0273 = Medical/surgical supplies — take home supplies
0274 = Medical/surgical supplies — prosthetic/orthotic devices
0275 = Medical/surgical supplies — pace maker
0276 = Medical/surgical supplies — intraocular lens
0277 = Medical/surgical supplies — oxygen-take home
0278 = Medical/surgical supplies — other implants
0279 = Medical/surgical supplies — other devices
0280 = Oncology — general classification
0289 = Oncology — other oncology
0290 = DME (other than renal) — general classification
0291 = DME (other than renal) — rental
0292 = DME (other than renal) — purchase of new DME
0293 = DME (other than renal) — purchase of used DME
0294 = DME (other than renal) — related to and listed as DME
0299 = DME (other than renal) — other
0300 = Laboratory — general classification
0301 = Laboratory — chemistry
0302 = Laboratory — immunology
0303 = Laboratory — renal patient (home)
0304 = Laboratory — non-routine dialysis
0305 = Laboratory — hematology
0306 = Laboratory — bacteriology & microbiology
0307 = Laboratory — urology
0309 = Laboratory — other laboratory
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>0310</td>
<td>Laboratory pathological — general classification</td>
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<tr>
<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>0314</td>
<td>Laboratory pathological — biopsy</td>
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<td>0319</td>
<td>Laboratory pathological — other</td>
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<tr>
<td>0320</td>
<td>Radiology diagnostic — general classification</td>
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<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>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>
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<td>0332</td>
<td>Radiology therapeutic — chemotherapy oral</td>
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<td>Radiology therapeutic — radiation therapy</td>
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<td>Radiology therapeutic — chemotherapy IV</td>
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<td>Radiology therapeutic — other</td>
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<td>Nuclear medicine — general classification</td>
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<td>Nuclear medicine — diagnostic</td>
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<td>0342</td>
<td>Nuclear medicine — therapeutic</td>
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<td>0349</td>
<td>Nuclear medicine — other</td>
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<tr>
<td>0350</td>
<td>Computed tomographic (CT) scan-general classification</td>
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<td>0351</td>
<td>CT scan-head scan</td>
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<tr>
<td>0352</td>
<td>CT scan-body scan</td>
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<tr>
<td>0359</td>
<td>CT scan-other CT scans</td>
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<td>0360</td>
<td>Operating room services — general classification</td>
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<tr>
<td>0361</td>
<td>Operating room services — minor surgery</td>
</tr>
<tr>
<td>0362</td>
<td>Operating room services — organ transplant, other than kidney</td>
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</tbody>
</table>
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 (eff. 7/1/06). Prior to 7/1/06 — Rural Health-Clinic
0522 = Free-standing clinic — Home visit by RHC/FQHC practitioner (eff. 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. (eff. 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. (eff. 7/1/06)

0526 = Free-standing clinic — urgent care (eff 10/96)

0527 = Free-standing clinic — RHC/FQHC visiting nurse service(s) to a member's home when in a home health shortage area. (eff. 7/1/06)

0528 = Free-standing clinic — visit by RHC/FQHC practitioner to other non-RHC/FQHC site (e.g. scene of accident). (eff. 7/1/06)

0529 = Free-standing clinic — other

0530 = Osteopathic services — general classification

0531 = Osteopathic services — osteopathic therapy

0539 = Osteopathic services — other

0540 = Ambulance — general classification

0541 = Ambulance — supplies

0542 = Ambulance — medical transport

0543 = Ambulance — heart mobile

0544 = Ambulance — oxygen

0545 = Ambulance — air ambulance

0546 = Ambulance — neo-natal ambulance

0547 = Ambulance — pharmacy

0548 = Ambulance — telephone transmission EKG

0549 = Ambulance — other

0550 = Skilled nursing — general classification

0551 = Skilled nursing — visit charge

0552 = Skilled nursing — hourly charge

0559 = Skilled nursing — other

0560 = Medical social services — general classification

0561 = Medical social services — visit charge

0562 = Medical social services — hourly charges

0569 = Medical social services — other
0570 = Home health aid (home health) — general classification
0571 = Home health aid (home health) — visit charge
0572 = Home health aid (home health) — hourly charge
0579 = Home health aid (home health) — other
0580 = Other visits (home health) — general classification (under HHPPS, not allowed as covered charges)
0581 = Other visits (home health) — visit charge (under HHPPS, not allowed as covered charges)
0582 = Other visits (home health) — hourly charge (under HHPPS, not allowed as covered charges)
0589 = Other visits (home health) — other (under HHPPS, not allowed as covered charges)
0590 = Units of service (home health) — general classification (under HHPPS, not allowed as covered charges)
0599 = Units of service (home health) — other (under HHPPS, not allowed as covered charges)
0600 = Oxygen/Home Health — general classification
0601 = Oxygen/Home Health — stat or port equip/supply or count
0602 = Oxygen/Home Health — stat/equip/under 1 LPM
0603 = Oxygen/Home Health — stat/equip/over 4 LPM
0604 = Oxygen/Home Health — stat/equip/portable add-on
0610 = Magnetic resonance technology (MRT) — general classification
0611 = MRT/MRI — brain (including brainstem)
0612 = MRT/MRI — spinal cord (including spine)
0614 = MRT/MRI — other
0615 = MRT/MRA — Head and Neck
0616 = MRT/MRA — Lower Extremities
0618 = MRT/MRA — other
0619 = MRT/Other MRI
0621 = Medical/surgical supplies-incident to radiology-subject to the payment limit — extension of 027X
0622 = Medical/surgical supplies-incident to other diagnostic service-subject to the payment limit — extension of 027X
0623 = Medical/surgical supplies-surgical dressings — extension of 027X
0624 = Medical/surgical supplies-medical investigational devices and procedures with FDA approved IDE’s — extension of 027X
0630 = Reserved
0631 = Drugs requiring specific identification — single drug source
0632 = Drugs requiring specific identification — multiple drug source
0633 = Drugs requiring specific identification — restrictive prescription
0634 = Drugs requiring specific identification — EPO under 10,000 units
0635 = Drugs requiring specific identification — EPO 10,000 units or more
0636 = Drugs requiring specific identification — detailed coding
0637 = Self-administered drugs administered in an emergency situation — not requiring detailed coding
0640 = Home IV therapy — general classification
0641 = Home IV therapy — nonroutine nursing
0642 = Home IV therapy — IV site care, central line
0643 = Home IV therapy — IV start/change peripheral line
0644 = Home IV therapy — nonroutine nursing, peripheral line
0645 = Home IV therapy — train patient/caregiver, central line
0646 = Home IV therapy — train disabled patient, central line
0647 = Home IV therapy — train patient/caregiver, peripheral line
0648 = Home IV therapy — train disabled patient, peripheral line
0649 = Home IV therapy — other IV therapy services
0650 = Hospice services — general classification
0651 = Hospice services — routine home care
0652 = Hospice services — continuous home care-1/2
0655 = Hospice services — inpatient care
0656 = Hospice services — general inpatient care (non-respite)
0657 = Hospice services — physician services
0659 = Hospice services — other
0660 = Respite care (HHA) — general classification
0661 = Respite care (HHA) — hourly charge/skilled nursing
0662 = Respite care (HHA) — hourly charge/home health aide/homemaker
0670 = OP special residence charges — general classification
0671 = OP special residence charges — hospital based
0672 = OP special residence charges — contracted
0679 = OP special residence charges — other special residence charges
0700 = Cast room — general classification
0709 = Cast room — other
0710 = Recovery room — general classification
0719 = Recovery room — other
0720 = Labor room/delivery — general classification
0721 = Labor room/delivery — labor
0722 = Labor room/delivery — delivery
0723 = Labor room/delivery — circumcision
0724 = Labor room/delivery — birthing center
0729 = Labor room/delivery — other
0730 = EKG/ECG — general classification
0731 = EKG/ECG — Holter monitor
0732 = EKG/ECG — telemetry
0739 = EKG/ECG — other
0740 = EEG — general classification
0749 = EEG (electroencephalogram) — other
0750 = Gastro-intestinal services — general classification
0759 = Gastro-intestinal services — other
0760 = Treatment or observation room — general classification
0761 = Treatment or observation room — treatment room
0762 = Treatment or observation room — observation room
0769 = Treatment or observation room — other
0770 = Preventative care services — general classification
0771 = Preventative care services — vaccine administration
0779 = Preventative care services — other
0780 = Telemedicine — general classification
0789 = Telemedicine — telemedicine
0790 = Lithotripsy — general classification
0799 = Lithotripsy — other
0800 = Inpatient renal dialysis — general classification
0801 = Inpatient renal dialysis — inpatient hemodialysis
0802 = Inpatient renal dialysis — inpatient peritoneal (non-CAPD)
0803 = Inpatient renal dialysis — inpatient CAPD
0804 = Inpatient renal dialysis — inpatient CCPD
0809 = Inpatient renal dialysis — other inpatient dialysis
0810 = Organ acquisition — general classification
0811 = Organ acquisition — living donor
0812 = Organ acquisition — cadaver donor
0813 = Organ acquisition — unknown donor
0814 = Organ acquisition — unsuccessful organ search-donor bank charges
0815 = Allogeneic Stem Cell Acquisition/Donor Services
0819 = Organ acquisition — other donor
0820 = Hemodialysis OP or home dialysis — general classification
0821 = Hemodialysis OP or home dialysis — hemodialysis-composite or other rate
0822 = Hemodialysis OP or home dialysis — home supplies
0823 = Hemodialysis OP or home dialysis — home equipment
0824 = Hemodialysis OP or home dialysis — maintenance/100%
0825 = Hemodialysis OP or home dialysis — support services
0829 = Hemodialysis OP or home dialysis — other
0830 = Peritoneal dialysis OP or home — general classification
0831 = Peritoneal dialysis OP or home-peritoneal — composite or other rate
0832 = Peritoneal dialysis OP or home — home supplies
0833 = Peritoneal dialysis OP or home — home equipment
0834 = Peritoneal dialysis OP or home — maintenance/100%
0835 = Peritoneal dialysis OP or home — support services
0839 = Peritoneal dialysis OP or home — other
0840 = CAPD outpatient — general classification
0841 = CAPD outpatient — CAPD/composite or other rate
0842 = CAPD outpatient — home supplies
0843 = CAPD outpatient — home equipment
0844 = CAPD outpatient — maintenance/100%
0845 = CAPD outpatient — support services
0849 = CAPD outpatient — other
0850 = CCPD outpatient — general classification
0851 = CCPD outpatient — CCPD/composite or other rate
0852 = CCPD outpatient — home supplies
0853 = CCPD outpatient — home equipment
0854 = CCPD outpatient — maintenance/100%
0855 = CCPD outpatient — support services
0859 = CCPD outpatient — other
0880 = Miscellaneous dialysis — general classification
0881 = Miscellaneous dialysis — ultrafiltration
0882 = Miscellaneous dialysis — home dialysis aide visit
0889 = Miscellaneous dialysis — other
0890 = Other donor bank-general classification; changed to reserved for national assignment
0891 = Other donor bank — bone; changed to reserved for national assignment
0892 = Other donor bank — organ (other than kidney); changed to reserved for national assignment
0893 = Other donor bank — skin; changed to reserved for national assignment
0899 = Other donor bank — other; changed to reserved for national assignment
0900 = Behavior Health Treatment/Services — general classification (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments-general classification
0901 = Behavior Health Treatment/Services — electroshock treatment (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments-electroshock treatment
0902 = Behavior Health Treatment/Services — milieu therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments-milieu therapy
0903 = Behavior Health Treatment/Services — play therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments-play therapy
0904 = Behavior Health Treatment/Services — activity therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments-activity therapy
0905 = Behavior Health Treatment/Services — intensive outpatient services- psychiatric (eff. 10/2004)
0906 = Behavior Health Treatment/Services — intensive outpatient services-chemical dependency (eff. 10/2004)
0907 = Behavior Health Treatment/Services — community behavioral health program-day treatment (eff. 10/2004)
0909 = Reserved for National Use (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments-other
0910 = Behavioral Health Treatment/Services — Reserved for National Assignment (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-general classification
0911 = Behavioral Health Treatment/Services — rehabilitation (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-rehabilitation
0912 = Behavioral Health Treatment/Services — partial hospitalization-less intensive (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-less intensive
0913 = Behavioral Health Treatment/Services — partial hospitalization-intensive (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-intensive
0914 = Behavioral Health Treatment/Services — individual therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-individual therapy
0915 = Behavioral Health Treatment/Services — group therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-group therapy
0916 = Behavioral Health Treatment/Services — family therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-family therapy
0917 = Behavioral Health Treatment/Services — biofeedback (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-biofeedback

0918 = Behavioral Health Treatment/Services — testing (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-testing

0919 = Behavioral Health Treatment/Services — other (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-other

0920 = Other diagnostic services — general classification

0921 = Other diagnostic services — peripheral vascular lab

0922 = Other diagnostic services — electromyelogram

0923 = Other diagnostic services — pap smear

0924 = Other diagnostic services — allergy test

0925 = Other diagnostic services — pregnancy test

0929 = Other diagnostic services — other

0931 = Medical Rehabilitation Day Program — Half Day

0932 = Medical Rehabilitation Day Program — Full Day

0940 = Other therapeutic services — general classification

0941 = Other therapeutic services — recreational therapy

0942 = Other therapeutic services — education/training (include diabetes diet training)

0943 = Other therapeutic services — cardiac rehabilitation

0944 = Other therapeutic services — drug rehabilitation

0945 = Other therapeutic services — alcohol rehabilitation

0946 = Other therapeutic services — routine complex medical equipment

0947 = Other therapeutic services — ancillary complex medical equipment

0949 = Other therapeutic services — other

0951 = Professional Fees — athletic training (extension of 094X)

0952 = Professional Fees — kinesiotherapy (extension of 094X)

0960 = Professional fees — general classification

0961 = Professional fees — psychiatric

0962 = Professional fees — ophthalmology
0963 = Professional fees — anesthesiologist (MD)
0964 = Professional fees — anesthetist (CRNA)
0969 = Professional fees — other (NOTE: 097X is an extension of 096X)
0971 = Professional fees — laboratory
0972 = Professional fees — radiology diagnostic
0973 = Professional fees — radiology therapeutic
0974 = Professional fees — nuclear medicine
0975 = Professional fees — operating room
0976 = Professional fees — respiratory therapy
0977 = Professional fees — physical therapy
0978 = Professional fees — occupational therapy
0979 = Professional fees — speech pathology (NOTE: 098X is an extension of 096X & 097X)
0981 = Professional fees — emergency room
0982 = Professional fees — outpatient services
0983 = Professional fees — clinic
0984 = Professional fees — medical social services
0985 = Professional fees — EKG
0986 = Professional fees — EEG
0987 = Professional fees — hospital visit
0988 = Professional fees — consultation
0989 = Professional fees — private duty nurse
0990 = Patient convenience items — general classification
0991 = Patient convenience items — cafeteria/guest tray
0992 = Patient convenience items — private linen service
0993 = Patient convenience items — telephone/telegraph
0994 = Patient convenience items — tv/radio
0995 = Patient convenience items — nonpatient room rentals
0996 = Patient convenience items — late discharge charge
0997 = Patient convenience items — admission kits
0998 = Patient convenience items — beauty shop/barber
0999 = Patient convenience items — other
1000 = Behavioral health Accommodations — general
1001 = Behavioral health Accommodations — residential treatment psychiatric
1002 = Behavioral health Accommodations — residential treatment chemical dependency
2101 = Alternative Therapy Services — Acupuncture
2103 = Alternative Therapy Services — Massage
3101 = Adult Day Care — Medical and Social (hourly)
3103 = Adult Day Care — Medical and Social (daily)
3104 = Adult Day Care — Social (daily)
3109 = Adult Day Care — other

Null/missing = source value is missing or unknown

**COMMENT:** Revenue code is a data set that health care providers or insurers usually pay for to use. These values may change annually but are typically very stable.

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/.

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<table>
<thead>
<tr>
<th><strong>RFRG_PRVDR_SPCLTY_CD</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LABEL:</strong></td>
<td>Referring Provider Specialty Code</td>
</tr>
<tr>
<td><strong>DESCRIPTION:</strong></td>
<td>This code indicates the area of specialty of the referring provider.</td>
</tr>
<tr>
<td><strong>SHORT NAME:</strong></td>
<td>RFRG_PRVDR_SPCLTY_CD</td>
</tr>
<tr>
<td><strong>LONG NAME:</strong></td>
<td>RFRG_PRVDR_SPCLTY_CD</td>
</tr>
<tr>
<td><strong>TYPE:</strong></td>
<td>CHAR</td>
</tr>
<tr>
<td><strong>LENGTH:</strong></td>
<td>2</td>
</tr>
<tr>
<td><strong>SOURCE:</strong></td>
<td>T-MSIS Analytic File (TAF) Claims</td>
</tr>
</tbody>
</table>
| **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 & 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
Variable Details

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
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
Variable Details

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:**

<table>
<thead>
<tr>
<th>Value</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No</td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**COMMENT:** —
**SPRVSNG_PRVDR_NPI**

**LABEL:** Supervising Provider NPI  

**DESCRIPTION:** The National Provider ID (NPI) of the provider who supervised another provider.  

**SHORT NAME:** SPRVSNG_PRVDR_NPI  

**LONG NAME:** SPRVSNG_PRVDR_NPI  

**TYPE:** CHAR  

**LENGTH:** 10  

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

**FILE(S):** OT Header  


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://npireregistry.cms.hhs.gov/](https://npireregistry.cms.hhs.gov/)
**SPRVSNG_PRVDR_TXNMY_CD**

**LABEL:** Supervising Provider Taxonomy Code

**DESCRIPTION:** The Provider Taxonomy of the provider who supervised another provider.

**SHORT NAME:** SPRVSNG_PRVDR_TXNMY_CD

**LONG NAME:** SPRVSNG_PRVDR_TXNMY_CD

**TYPE:** CHAR

**LENGTH:** 12

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

**FILE(S):** OT Header


Null/missing = source value is missing or unknown

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

LABEL: Servicing Provider Specialty Code

DESCRIPTION: This code indicates the area of specialty for the servicing provider.

SHORT NAME: SRVC_PRVDR_SPCLTY_CD

LONG NAME: SRVC_PRVDR_SPCLTY_CD

TYPE: CHAR

LENGTH: 2

SOURCE: T-MSIS Analytic File (TAF) Claims

FILE(S): IP Line
         LT Line
         OT Line

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


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  

03 = Oral Surgery (Dentist only)  

04 = Cardiac Rehabilitation and Intensive Cardiac Rehabilitation  

05 = Anesthesiology Assistant  

06 = Chiropractic  

07 = Optometry  

08 = Certified Nurse Midwife  

09 = Certified Registered Nurse Anesthetist (CRNA)  

10 = Mammography Center  

11 = Independent Diagnostic Testing Facility (IDTF)  

12 = Podiatry  

13 = Ambulatory Surgical Center  

14 = Nurse Practitioner  

15 = Medical Supply Company with Orthotist  

16 = Medical Supply Company with Prosthetist  

17 = Medical Supply Company with Orthotist-Prosthetist
18 = Other Medical Supply Company
19 = Individual Certified Orthotist
20 = Individual Certified Prosthetist
21 = Individual Certified Prosthetist-Orthotist
22 = Medical Supply Company with Pharmacist
23 = Ambulance Service Provider
24 = Public Health or Welfare Agency
25 = Voluntary Health or Charitable Agency
26 = Psychologist, Clinical
27 = Portable X-Ray Supplier
28 = Audiologist
29 = Physical Therapist in Private Practice
30 = Occupational Therapist in Private Practice
31 = Clinical Laboratory
32 = Clinic or Group Practice
33 = Registered Dietitian or Nutrition Professional
34 = Mass Immunizer Roster Biller
35 = Radiation Therapy Center
36 = Slide Preparation Facility
37 = Licensed Clinical Social Worker
38 = Certified Clinical Nurse Specialist
39 = Advance Diagnostic Imaging
40 = Optician
41 = Physician Assistant
42 = Hospital-General
43 = Skilled Nursing Facility
44 = Intermediate Care Nursing Facility
45 = Other Nursing Facility
46 = Home Health Agency
47 = Pharmacy
48 = Medical Supply Company with Respiratory Therapist
49 = Department Store
50 = Grocery Store
51 = Indian Health Service Facility
52 = Oxygen supplier
53 = Pedorthic personnel
54 = Medical supply company with pedorthic personnel
55 = Rehabilitation Agency
56 = Ocularist
57 = All Other

Null/missing = source value is missing or unknown

**COMMENT:** If the state uses state-specific codes, they should map their internal codes to the CMS standard list provided.
**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

AK = Alaska
AL = Alabama
AR = Arkansas
AZ = Arizona
CA = California
CO = Colorado
CT = Connecticut
DC = District of Columbia
DE = Delaware
FL = Florida
GA = Georgia
HI = Hawaii
IA = Iowa
ID = Idaho
IL = Illinois
IN = Indiana
KS = Kansas
KY = Kentucky
LA = Louisiana
MA = Massachusetts
MD = Maryland
ME = Maine
MI = Michigan
MN = Minnesota
MO = Missouri
MS = Mississippi
MT = Montana
NC = North Carolina
ND = North Dakota
NE = Nebraska
NH = New Hampshire
NJ = New Jersey
NM = New Mexico
NV = Nevada
NY = New York
<table>
<thead>
<tr>
<th>State Abbreviation</th>
<th>State Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>OH</td>
<td>Ohio</td>
</tr>
<tr>
<td>OK</td>
<td>Oklahoma</td>
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<tr>
<td>OR</td>
<td>Oregon</td>
</tr>
<tr>
<td>PA</td>
<td>Pennsylvania</td>
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<tr>
<td>PR</td>
<td>Puerto Rico</td>
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<tr>
<td>RI</td>
<td>Rhode Island</td>
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<td>South Carolina</td>
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<td>Virgin Islands</td>
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<td>VT</td>
<td>Vermont</td>
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<td>WA</td>
<td>Washington</td>
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<td>WI</td>
<td>Wisconsin</td>
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<td>WV</td>
<td>West Virginia</td>
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<tr>
<td>WY</td>
<td>Wyoming</td>
</tr>
<tr>
<td>Null</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

**COMMENT:** This variable is the two-letter postal abbreviation for the state that submitted the TAF.
### SUBMTG_STATE_CD

**LABEL:** Submitting State FIPS Code  
**DESCRIPTION:** The ANSI 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:**

<table>
<thead>
<tr>
<th>Code</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Alabama</td>
</tr>
<tr>
<td>02</td>
<td>Alaska</td>
</tr>
<tr>
<td>04</td>
<td>Arizona</td>
</tr>
<tr>
<td>05</td>
<td>Arkansas</td>
</tr>
<tr>
<td>06</td>
<td>California</td>
</tr>
<tr>
<td>08</td>
<td>Colorado</td>
</tr>
<tr>
<td>09</td>
<td>Connecticut</td>
</tr>
<tr>
<td>10</td>
<td>Delaware</td>
</tr>
<tr>
<td>11</td>
<td>District of Columbia</td>
</tr>
<tr>
<td>12</td>
<td>Florida</td>
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<td>Georgia</td>
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<td>Hawaii</td>
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<tr>
<td>16</td>
<td>Idaho</td>
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<td>17</td>
<td>Illinois</td>
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<tr>
<td>18</td>
<td>Indiana</td>
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<td>34</td>
<td>New Jersey</td>
</tr>
<tr>
<td>35</td>
<td>New Mexico</td>
</tr>
<tr>
<td>36</td>
<td>New York</td>
</tr>
<tr>
<td>37</td>
<td>North Carolina</td>
</tr>
</tbody>
</table>
38 = North Dakota
39 = Ohio
40 = Oklahoma
41 = Oregon
42 = Pennsylvania
44 = Rhode Island
45 = South Carolina
46 = South Dakota
47 = Tennessee
48 = Texas
49 = Utah
50 = Vermont
51 = Virginia
53 = Washington
54 = West Virginia
55 = Wisconsin
56 = Wyoming
60 = American Samoa
66 = Guam
69 = Commonwealth of the Northern Marianas Islands
72 = Puerto Rico
78 = U.S. Virgin Islands

COMMENT: Values obtained from https://www.census.gov/library/reference/code-lists/ansi/ansi-codes-for-states.html
**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

 **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 & Social Service Providers: Counselor, Addiction (Substance Use Disorder)
- 103TA0400X Behavioral Health & Social Service Providers: Psychologist, Addiction (Substance Use Disorder)
- 163WA0400X Nursing Service Providers: Registered Nurse, Addiction (Substance Use Disorder)
- 207LA0401X Allopathic & Osteopathic Physicians: Anesthesiology, Addiction Medicine
- 207QA0401X Allopathic & Osteopathic Physicians: Family Medicine, Addiction Medicine
- 207RA0401X Allopathic & Osteopathic Physicians: Internal Medicine, Addiction Medicine
- 2084A0401X Allopathic & Osteopathic Physicians: Psychiatry & Neurology, Addiction Psychiatry
- 2084P0802X Allopathic & Osteopathic Physicians: Psychiatry & Neurology, Addiction Psychiatry
- 2083A0300X Preventive Medicine - Addiction Medicine

(b) Non-Individual

- 261QM2800X Ambulatory Health Care Facilities: Clinic/Center, Methadone
- 261QR0405X Ambulatory Health Care Facilities: Clinic/Center, Rehabilitation, Substance Use Disorder
- 276400000X Hospital Units: Rehabilitation, Substance Use Disorder Unit
- 324500000X Residential Treatment Facilities: Substance Abuse Rehabilitation Facility
3245S0500X Residential Treatment Facilities: Substance Abuse Rehabilitation Facility, Substance Abuse Treatment, Children

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

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

**COMMENT:** —
**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 = Occlusa – 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:** —
**TOS_CD**

**LABEL:** Type of Service Code

**DESCRIPTION:** A code to categorize the services provided to a Medicaid or CHIP enrollee.

**SHORT NAME:** TOS_CD

**LONG NAME:** TOS_CD

**TYPE:** CHAR

**LENGTH:** 3

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

**FILE(S):** All Line Files

**VALUES:** 3-digit value; may have leading zeros

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>001</td>
<td>Inpatient hospital services, other than services in an institution for mental diseases</td>
</tr>
<tr>
<td>002</td>
<td>Outpatient hospital services</td>
</tr>
<tr>
<td>003</td>
<td>Rural health clinic services</td>
</tr>
<tr>
<td>004</td>
<td>Other ambulatory services furnished by a rural health clinic</td>
</tr>
<tr>
<td>005</td>
<td>Professional laboratory services, Technical laboratory services</td>
</tr>
<tr>
<td>006</td>
<td>Technical laboratory services</td>
</tr>
<tr>
<td>007</td>
<td>Professional radiological services</td>
</tr>
<tr>
<td>008</td>
<td>Technical radiological services</td>
</tr>
<tr>
<td>009</td>
<td>Nursing facility services for individuals age 21 or older (other than services in an institution for mental disease)</td>
</tr>
<tr>
<td>010</td>
<td>Early and periodic screening and diagnosis and treatment (EPSDT) services</td>
</tr>
<tr>
<td>011</td>
<td>Family planning services and supplies for individuals of child-bearing age</td>
</tr>
<tr>
<td>012</td>
<td>Physicians' services</td>
</tr>
<tr>
<td>013</td>
<td>Medical and surgical services of a dentist</td>
</tr>
<tr>
<td>014</td>
<td>Outpatient substance abuse treatment services.</td>
</tr>
<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>
</tr>
<tr>
<td>016</td>
<td>Home health services — Nursing services</td>
</tr>
<tr>
<td>017</td>
<td>Home health services — Home health aide services</td>
</tr>
<tr>
<td>018</td>
<td>Home health services — Medical supplies, equipment, and appliances suitable for use in the home</td>
</tr>
<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>
</tr>
<tr>
<td>021</td>
<td>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</td>
</tr>
<tr>
<td>022</td>
<td>Private duty nursing services</td>
</tr>
<tr>
<td>023</td>
<td>Advanced practice nurse services</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>024</td>
<td>Pediatric nurse</td>
</tr>
<tr>
<td>025</td>
<td>Nurse-midwife service</td>
</tr>
<tr>
<td>026</td>
<td>Nurse practitioner services</td>
</tr>
<tr>
<td>027</td>
<td>Respiratory care for ventilator — dependent individuals</td>
</tr>
<tr>
<td>028</td>
<td>Clinic services</td>
</tr>
<tr>
<td>029</td>
<td>Dental services</td>
</tr>
<tr>
<td>030</td>
<td>Physical therapy services (when not provided under home health services)</td>
</tr>
<tr>
<td>031</td>
<td>Occupational therapy services (when not provided under home health services)</td>
</tr>
<tr>
<td>032</td>
<td>Speech, hearing, and language disorders services (when not provided under home health services)</td>
</tr>
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<td>Prescribed drugs</td>
</tr>
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<td>034</td>
<td>Over-the-counter medications</td>
</tr>
<tr>
<td>035</td>
<td>Dentures</td>
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<td>Medical equipment/prosthetic devices</td>
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<tr>
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<td>038</td>
<td>Hearing Aids</td>
</tr>
<tr>
<td>039</td>
<td>Diagnostic services</td>
</tr>
<tr>
<td>040</td>
<td>Screening services</td>
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<tr>
<td>041</td>
<td>Preventive services</td>
</tr>
<tr>
<td>042</td>
<td>Well-baby and well-child care services as defined by the State</td>
</tr>
<tr>
<td>043</td>
<td>Rehabilitative services</td>
</tr>
<tr>
<td>044</td>
<td>Inpatient hospital services for individuals age 65 or older in institutions for mental diseases</td>
</tr>
<tr>
<td>045</td>
<td>Nursing facility services for individuals age 65 or older in institutions for mental diseases</td>
</tr>
<tr>
<td>046</td>
<td>Intermediate care facility (ICF)/ Intermediate Care Facilities for individuals with Intellectual Disabilities (IIDCF)/ Individuals with Intellectual Disabilities (IID) services</td>
</tr>
<tr>
<td>047</td>
<td>Nursing facility services, other than in institutions for mental diseases</td>
</tr>
<tr>
<td>048</td>
<td>Inpatient psychiatric services for individuals under age 21</td>
</tr>
<tr>
<td>049</td>
<td>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.</td>
</tr>
<tr>
<td>050</td>
<td>Inpatient substance abuse treatment services and residential substance abuse treatment services.</td>
</tr>
<tr>
<td>051</td>
<td>Personal care services</td>
</tr>
<tr>
<td>052</td>
<td>Primary care case management services (PCCM)</td>
</tr>
<tr>
<td>053</td>
<td>Targeted case management services</td>
</tr>
<tr>
<td>054</td>
<td>Case Management services other than those that meet the definition of primary care case management services or targeted case management services</td>
</tr>
<tr>
<td>055</td>
<td>Care coordination services</td>
</tr>
<tr>
<td>056</td>
<td>Transportation services</td>
</tr>
<tr>
<td>057</td>
<td>Enabling services</td>
</tr>
<tr>
<td>058</td>
<td>Services furnished in a religious nonmedical health care institution</td>
</tr>
<tr>
<td>059</td>
<td>Skilled nursing facility services for individuals under age 21</td>
</tr>
<tr>
<td>060</td>
<td>Emergency hospital services</td>
</tr>
<tr>
<td>061</td>
<td>Critical access hospital services – OT</td>
</tr>
<tr>
<td>062</td>
<td>HCBS — Case management services</td>
</tr>
<tr>
<td>063</td>
<td>HCBS — Homemaker services</td>
</tr>
</tbody>
</table>
064 = HCBS — Home health aide services
065 = HCBS — Personal care services
066 = HCBS — Adult day health services
067 = HCBS — Habilitation services
068 = HCBS — Respite care services
069 = HCBS — Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness
070 = HCBS — Day Care
071 = HCBS — Training for family members
072 = HCBS — Minor modification to the home
073 = HCBS — Other services requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization
074 = HCBS — Expanded habilitation services — Prevocational services
075 = HCBS — Expanded habilitation services — Educational services
076 = HCBS — Expanded habilitation services — Supported employment services, which facilitate paid employment
077 = HCBS-65-plus — Case management services
078 = HCBS-65-plus — Homemaker services
079 = HCBS-65-plus — Home health aide services
080 = HCBS-65-plus — Personal care services
081 = HCBS-65-plus — Adult day health services
082 = HCBS-65-plus — Respite care services
083 = HCBS-65-plus — Other medical and social services
084 = Sterilizations
085 = Prenatal care and pre-pregnancy family planning services and supplies.
086 = Other Pregnancy-related Procedures
087 = Hospice services
088 = Any other health care services or items specified by the Secretary and not excluded under regulations.
089 = Disposable medical supplies.
090 = Critical access hospital services — IP
091 = Skilled care — hospital residing
092 = Exceptional care — hospital residing
093 = Non-acute care — hospital residing
115 = Residential care
119 = Capitated payments to HMOs, HIOs, or PACE plans
120 = Capitated payments for primary care case management (PCCM)
121 = Premium payments for private health insurance
122 = Capitated payments to prepaid health plans (PHPs)
123 = Disproportionate share hospital (DSH) payments
127 = Indian Health Service (IHS) - Family Plan
131 = Drug Rebates
132 = Supplemental payment — inpatient
133 = Supplemental payment — nursing
134 = Supplemental payment — outpatient
135 = EHR payments to provider
138 = Per member per month (PMPM) payments for health home services
139 = Per member per month (PMPM) payments for Medicare Part A premiums
140 = Per member per month (PMPM) payments for Medicare Part B premiums
141 = Per member per month (PMPM) payments for Medicare Advantage Dual Special Needs Plans (D-SNP) – Medicare Part C
142 = Per member per month (PMPM) payments for Medicare Part D premiums
143 = Per member per month (PMPM) payments for other payments
144 = Payments to individuals for personal assistance services under 1915(j)

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.
**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
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>1915(c) – Autism/Autism Spectrum Disorder</td>
</tr>
<tr>
<td>17</td>
<td>1915(c) – Developmental Disabilities</td>
</tr>
<tr>
<td>18</td>
<td>1915(c) – Mental Illness – Age 18 or Older</td>
</tr>
<tr>
<td>19</td>
<td>1915(c) – Mental Illness – Under Age 18</td>
</tr>
<tr>
<td>20</td>
<td>1915(c) waiver concurrent with an 1115 or 1915(b) managed care authority</td>
</tr>
<tr>
<td>21</td>
<td>1115 Health Insurance Flexibility and Accountability (HIFA) demonstration</td>
</tr>
<tr>
<td>22</td>
<td>1115 Pharmacy demonstration</td>
</tr>
<tr>
<td>23</td>
<td>1115 Disaster-related demonstration</td>
</tr>
<tr>
<td>24</td>
<td>1115 Family planning demonstration.</td>
</tr>
<tr>
<td>25</td>
<td>1115 Substance use demonstration</td>
</tr>
<tr>
<td>26</td>
<td>1115 Premium Assistance demonstration</td>
</tr>
<tr>
<td>27</td>
<td>1115 Beneficiary engagement demonstration</td>
</tr>
<tr>
<td>28</td>
<td>1115 Former foster care youth from another state</td>
</tr>
<tr>
<td>29</td>
<td>1115 Managed long term services and support</td>
</tr>
<tr>
<td>30</td>
<td>1115 Delivery system reform</td>
</tr>
<tr>
<td>31</td>
<td>1332 Demonstration</td>
</tr>
<tr>
<td>32</td>
<td>1915(b) waiver</td>
</tr>
<tr>
<td>33</td>
<td>1915(c) waiver</td>
</tr>
</tbody>
</table>

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
- 001D = Inpatient Hospital — GME Payments
- 002A = Mental Health Facility Services — Reg. Payments
- 003A = Nursing Facility Services — Reg. Payments
- 003B = Nursing Facility Services — Sup. Payments
- 004A = Intermediate Care Facility Services — Individuals with Intellectual Disabilities: Public Providers
- 004B = Intermediate Care Facility Services — Individuals with Intellectual Disabilities: Private Providers
- 005A = Physician & Surgical Services — Reg. Payments
- 006A = Outpatient Hospital Services — Reg. Payments
- 006B = Outpatient Hospital Services — Sup. Payments
- 0007 = Prescribed Drugs
- 0008 = Dental Services
- 009A = Other Practitioners Services — Reg. 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
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 & Community-Based Services — Reg. Pay. (Waiv)
019B = Home & Community-Based Services — St. Plan 1915(j) Only Pay
019C = Home & Community-Based Services — St. Plan 1915(j) Only Pay
019D = Home & 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 — State Wide
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 & Language
0033 = Prosthetic Devices, Dentures, Eyeglasses
0034 = Diagnostic Screening & Preventive Services
34A = 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
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
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
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>017</td>
<td>Other Pregnancy-related Procedures</td>
</tr>
<tr>
<td>018</td>
<td>Screening Services</td>
</tr>
<tr>
<td>019</td>
<td>Home Health</td>
</tr>
<tr>
<td>020</td>
<td>Health Services Initiatives</td>
</tr>
<tr>
<td>021</td>
<td>Home and Community</td>
</tr>
<tr>
<td>022</td>
<td>Hospice</td>
</tr>
<tr>
<td>023</td>
<td>Medical Transportation</td>
</tr>
<tr>
<td>024</td>
<td>Case Management</td>
</tr>
<tr>
<td>025</td>
<td>Translation and Interpretation</td>
</tr>
<tr>
<td>031</td>
<td>Other Services</td>
</tr>
<tr>
<td>032</td>
<td>Outreach</td>
</tr>
<tr>
<td>034</td>
<td>PERM Administration</td>
</tr>
<tr>
<td>035</td>
<td>Citizenship Verification Technology CHIPRA</td>
</tr>
<tr>
<td>049</td>
<td>Less: Collections; total computable amount of refunds or collections attributable to the CHIP program</td>
</tr>
</tbody>
</table>

Null/missing = source value is missing or unknown