

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
**** MEDICAID ANALYTIC EXTRACT INPATIENT RECORD	REC	753	1	753	<p>THE MEDICAID ANALYTIC EXTRACT (MAX) INPATIENT RECORD PROVIDES INFORMATION ON INPATIENT HOSPITAL STAYS FOR EACH RECIPIENT. INTERIM CLAIM RECORDS ARE COMBINED INTO A HOSPITAL STAY RECORD IF THEY HAVE THE SAME MSIS ELIGIBLE IDENTIFICATION NUMBER (DATA ELEMENT #1), THE SAME PROVIDER IDENTIFICATION NUMBER (DATA ELEMENT #19) AND ARE FOR CONTIGUOUS OR OVERLAPPING PERIODS OF TIME. CLAIMS ARE DEFINED TO BE CONTIGUOUS IF THE ENDING DATE OF SERVICE ON A PREVIOUS CLAIM IS THE SAME DAY OR THE DAY BEFORE THE BEGINNING DATE OF SERVICE FOR THE NEXT CLAIM. CONTIGUOUS CLAIMS ARE COMBINED IF THE "PATIENT STATUS CODE" (DATA ELEMENT #42) = 30 (STILL A PATIENT) OR = 99 (UNKNOWN). HOWEVER, CONTIGUOUS CLAIMS ARE NOT COMBINED INTO THE SAME STAY IF THE "PATIENT STATUS CODE" INDICATES THAT THE PATIENT WAS DISCHARGED AND WAS ADMITTED AGAIN ON THE SAME DAY (OR THE NEXT DAY).</p> <p>THE FILE FOR A GIVEN YEAR CONTAINS STAY RECORDS WHERE THE LAST DATE OF SERVICE IS IN THAT YEAR, EVEN IF THE STAY BEGAN IN A PREVIOUS YEAR. FOR ALL CLAIMS IN A COMBINED SET: (1) MEDICAID PAYMENTS AND COVERED DAYS ARE SUMMED, (2) ALL DIAGNOSIS AND PROCEDURE CODES ARE PICKED UP FROM THE INTERIM CLAIMS, AND (3) DEMOGRAPHIC INFORMATION AND THE DATE OF PAYMENT ARE TAKEN FROM THE LAST CLAIM IN THE SET. MSIS RECORDS WITH TYPE OF CLAIM = 4 AND/OR THOSE WITH THE FIRST CHARACTER OF THE ELIGIBLE IDENTIFICATION NUMBER HAVING VALUE "&" - AMPERSAND (SERVICE TRACKING CLAIMS) ARE EXCLUDED FROM ALL MAX FILES. IN ADDITION, MSIS RECORDS WITH TYPE OF CLAIM = 5 (SUPPLEMENTAL PAYMENT) ARE EXCLUDED FROM MAX IP AND LT FILES.</p> <p>IT IS POSSIBLE THAT SOME PATIENTS ARE ACTUALLY DISCHARGED (AND SOMETIMES READMITTED) BUT THEIR RECORDS DO NOT INDICATE A STATUS OF DISCHARGED, IN ERROR. IN THESE INSTANCES, SEPARATE CONTIGUOUS STAYS MAY BE COMBINED INCORRECTLY.</p> <p>SEPARATE HOSPITAL STAY RECORDS ARE CREATED FOR SETS OF INTERIM CLAIMS FOR MOTHERS AND INFANTS WHO USE THE SAME MSIS ELIGIBLE IDENTIFICATION NUMBER, BUT HAVE SEPARATE CLAIMS. IN CONTRAST, SOME STAYS FOR THE MOTHER'S DELIVERY AND INFANT'S NEWBORN WILL BE COMBINED. THIS IS BECAUSE THE PROVIDER HAS SUBMITTED CLAIMS WHICH INCLUDE SERVICES FOR THE MOTHER AND INFANT SO THAT IT IS NOT POSSIBLE TO GENERATE SEPARATE STAY RECORDS.</p> <p>THERE ARE CIRCUMSTANCES WHERE SEPARATE STAY RECORDS MAY BE CREATED FOR THE SAME HOSPITAL STAY:</p> <p>(1) IF THERE ARE MULTIPLE INTERIM CLAIMS WITH THE SAME ADMISSION DATE, BUT ONE OF THE INTERIM CLAIMS DURING THE SAY IS MISSING, SEPARATE STAY RECORDS WILL BE CREATED. THIS IS BECAUSE THERE IS A GAP OF</p>

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				ONE OR MORE DAYS BETWEEN THE ENDING DATE OF SERVICE ON ONE RECORD AND THE BEGINNING DATE OF SERVICE ON ANOTHER.
				(2) SOMETIMES, A HOSPITAL WILL SUBMIT A BILL FOR THE "CROSSOVER" PORTION OF A STAY USING THEIR MEDICARE PROVIDER IDENTIFIER AND WILL SUBMIT A SECOND BILL FOR THE "NON-CROSSOVER" PORTION OF THE SAME STAY USING THEIR MEDICAID PROVIDER IDENTIFIER. IN THIS SITUATION, SEPARATE STAY RECORDS ARE CREATED, BECAUSE THE RECORDS HAVE DIFFERENT PROVIDER IDENTIFIERS.
				(3) IF A HOSPITAL SUBMITS SEPARATE BILLS FROM DIFFERENT COST CENTERS IN THE HOSPITAL (E.G. ANCILLARY VERSUS ACCOMMODATION SERVICES), USING DIFFERENT PROVIDER IDENTIFIERS FOR THE COST CENTERS, SEPARATE STAY RECORDS ARE CREATED.
				THERE ARE INSTANCES WHERE THERE MAY BE MULTIPLE RECORDS FOR THE SAME MSIS ELIGIBLE IDENTIFICATION NUMBER AND THE SAME ADMISSION (OR SAME BEGINNING) DATE OF SERVICE. EXAMPLES INCLUDE THE FOLLOWING:
				(1) AN ADMISSION TO ONE FACILITY AND A SUBSEQUENT TRANSFER TO A DIFFERENT FACILITY ON THE SAME DAY.
				(2) AS NOTED ABOVE, A DELIVERY ADMISSION FOR THE MOTHER AND BIRTH OF A BABY WHERE MOTHER AND BABY SHARE THE SAME MEDICAID IDENTIFICATION NUMBER BUT HAVE SEPARATE RECORDS.
				(3) AS NOTED ABOVE, STAYS FOR DUAL ELIGIBLES WHERE DIFFERENT PROVIDER IDENTIFIERS ARE USED FOR CROSSOVER VERSUS NON-CROSSOVER SERVICES.
				(4) AS NOTED ABOVE, STAYS WHERE DIFFERENT COST CENTERS OF A HOSPITAL USE DIFFERENT PROVIDER IDENTIFIERS.
				THESE RECORDS REPRESENT ALL MEDICAID-COVERED SERVICES FOR THE ELIGIBLE. HOWEVER, THEY MAY NOT INCLUDE ALL INPATIENT HOSPITAL CARE OR COMPLETE INFORMATION ON MEDICAID COVERED SERVICES HOSPITAL CARE WHEN THE ELIGIBLE HAS OTHER HEALTH INSURANCE COVERAGE (E.G. MEDICARE AND/OR PRIVATE COVERAGE).
				FOR A COMPLETE LIST OF TYPES OF SERVICE THAT ARE CONTAINED IN THIS FILE, SEE "MAX TYPE OF SERVICE" (DATA ELEMENT #16). USERS SHOULD REFER TO THE "MSIS TECHNICAL SPECIFICATIONS AND DATA DICTIONARY" FOR A COMPLETE LIST OF MSIS DATA EDIT SPECIFICATIONS.

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NAME	TYPE	POSITIONS			CONTENTS
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*** ELIGIBILITY GROUP	GROUP	73	1	73	ELIGIBILITY INFORMATION ADDED TO EACH SERVICE RECORD, FROM MSIS ELIGIBILITY FILES (USING ELIGIBLE IDENTIFICATION NUMBER).
1. MSIS IDENTIFICATION NUMBER	CHAR	20	1	20	UNIQUE IDENTIFICATION NUMBER USED TO IDENTIFY A MEDICAID ELIGIBLE IN THE MEDICAID STATISTICAL INFORMATION SYSTEM (MSIS). SOURCE: MSIS ELIGIBILITY FILES: "MSIS-IDENTIFICATION-NUMBER"
2. STATE ABBREVIATION CODE	CHAR	2	21	22	U. S. POSTAL SERVICE 2-CHARACTER ABBREVIATION FOR THE STATE MEDICAID AGENCY SUBMITTING THE DATA. CODES: AL = ALABAMA AK = ALASKA AZ = ARIZONA AR = ARKANSAS AS = AMERICAN SAMOA CA = CALIFORNIA CO = COLORADO CT = CONNECTICUT DE = DELAWARE DC = DISTRICT OF COLUMBIA FL = FLORIDA GA = GEORGIA GU = GUAM HI = HAWAII ID = IDAHO IL = ILLINOIS IN = INDIANA IA = IOWA KS = KANSAS KY = KENTUCKY LA = LOUISIANA ME = MAINE MD = MARYLAND MA = MASSACHUSETTS MI = MICHIGAN MN = MINNESOTA MS = MISSISSIPPI MO = MISSOURI MT = MONTANA

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NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
				NE = NEBRASKA
				NV = NEVADA
				NH = NEW HAMPSHIRE
				NJ = NEW JERSEY
				NM = NEW MEXICO
				NY = NEW YORK
				NC = NORTH CAROLINA
				ND = NORTH DAKOTA
				OH = OHIO
				OK = OKLAHOMA
				OR = OREGON
				PA = PENNSYLVANIA
				PR = PUERTO RICO
				RI = RHODE ISLAND
				SC = SOUTH CAROLINA
				SD = SOUTH DAKOTA
				TN = TENNESSEE
				TX = TEXAS
				UT = UTAH
				VT = VERMONT
				VI = VIRGIN ISLANDS
				VA = VIRGINIA
				WA = WASHINGTON
				WV = WEST VIRGINIA
				WI = WISCONSIN
				WY = WYOMING

SOURCE: MSIS ELIGIBILITY FILES

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NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
3. ELIGIBLE SOCIAL SECURITY NUMBER	CHAR	9	23	31	<p>SOCIAL SECURITY NUMBER OF THE MEDICAID ELIGIBLE.</p> <p><i>USER NOTE: NOT AVAILABLE FOR SOME NEW YORK ELIGIBLES IN 1999.</i></p> <p>SOURCE: MSIS ELIGIBILITY FILES: "SOCIAL-SECURITY-NUMBER".</p>
4. MEDICARE HEALTH INSURANCE CLAIM (HIC) NUMBER	CHAR	12	32	43	<p>THE ELIGIBLE'S HEALTH INSURANCE CLAIM (HIC) NUMBER. THIS NUMBER IS APPLICABLE ONLY TO MEDICAID ELIGIBLES WHO ARE ALSO ELIGIBLE FOR MEDICARE AND IS ASSIGNED TO AN ELIGIBLE BY THE MEDICARE PROGRAM.</p> <p><i>USER NOTE: AN ELIGIBLE'S HIC NUMBER MAY CHANGE AS HIS/HER ENROLLMENT MEDICARE ELIGIBILITY STATUS CHANGES. THE ACCURACY OF REPORTING OF HIC NUMBERS IN MEDICAID ELIGIBILITY DATA IS UNKNOWN. THIS MSIS DATA ELEMENT IS AVAILABLE BEGINNING IN 10/98.</i></p> <p>SOURCE: MSIS ELIGIBILITY FILES: "HIC-NUMBER"</p>
5. ELIGIBLE BIRTH DATE	NUM	8	44	51	<p>BIRTH DATE OF THE MEDICAID ELIGIBLE.</p> <p>8 DIGITS EDIT-RULES: YYYYMMDD</p> <p>SOURCE: MSIS ELIGIBILITY FILES: "DATE-OF-BIRTH". MSIS DATES WITH 8- OR 9-FILL VALUES ARE CHANGED TO 0-FILL (ZERO-FILL).</p>
6. ELIGIBLE SEX CODE	CHAR	1	52	52	<p>GENDER OF THE MEDICAID ELIGIBLE.</p> <p>1 CHARACTER CODES: M = FEMALE F = MALE U = UNKNOWN/ERROR</p> <p><i>USER NOTE: THESE CODES CHANGE TO F, M AND U IN THE 1999 MSIS DATA.</i></p> <p>SOURCE: MSIS ELIGIBILITY FILES: "SEX-CODE"</p>

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NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
7. ELIGIBLE RACE/ETHNICITY CODE	CHAR	1	53	53	RACE/ETHNICITY OF THE MEDICAID ELIGIBLE. 1 DIGIT CODES: 1 = WHITE, NOT OF HISPANIC ORIGIN (CHANGED TO "WHITE" BEGINNING 10/98) 2 = BLACK, NOT OF HISPANIC ORIGIN (CHANGED TO "BLACK OR AFRICAN AMERICAN" BEGINNING 10/98) 3 = AMERICAN INDIAN OR ALASKAN NATIVE 4 = ASIAN OR PACIFIC ISLANDER (CHANGED TO "ASIAN" BEGINNING 10/98) 5 = HISPANIC (CHANGED TO "HISPANIC OR LATINO - NO RACE INFORMATION AVAILABLE" BEGINNING 10/98) 6 = NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER (NEW CODE BEGINNING 10/98) 7 = HISPANIC OR LATINO <u>AND</u> ONE OR MORE RACES (NEW CODE BEGINNING 10/98) 8 = MORE THAN ONE RACE (NEW CODE BEGINNING 10/98) 9 = UNKNOWN <i>USER NOTE: SINCE SPECIFICATIONS FOR CODE VALUES = 7 AND 8 WERE NOT ISSUED UNTIL MAY 2000, THESE CODE VALUES MAY NOT APPEAR. THE METHODS OF COLLECTING INFORMATION ON RACE AND ETHNICITY DIFFER SUBSTANTIALLY ACROSS STATES AND TIME PERIODS.</i> SOURCE: MSIS ELIGIBILITY FILES: "RACE-ETHNICITY-CODE"

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NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
8. STATE SPECIFIC ELIGIBILITY CODE - MOST RECENT	CHAR	6	54	59	STATE SPECIFIC ELIGIBILITY CODE CLASSIFICATION UNDER WHICH THE MEDICAID ELIGIBLE IS COVERED - MOST RECENT OBSERVATION.
<p>USER NOTES: THESE SOURCE CODES ARE GENERALLY NOT APPLICABLE FOR MOST RESEARCH ACTIVITIES. THE DATA ELEMENT CHANGES OVER TIME, VARIES ACROSS STATES IN TERMS OF THE LEVEL AND TYPE OF ELIGIBILITY DESCRIBED, REQUIRE A DETAILED KNOWLEDGE OF MEDICAID ELIGIBILITY AND REQUIRE AN UNDERSTANDING OF THE IDIOSYNCRACIES OF INDIVIDUAL STATE ELIGIBILITY SYSTEMS. THESE CODES HAVE BEEN MAPPED INTO MAX UNIFORM ELIGIBILITY CODES. THEREFORE, MOST USERS WILL WANT TO USE MAX UNIFORM ELIGIBILITY CODES. THROUGH 9/98 THIS DATA ELEMENT WAS 4 CHARACTERS IN LENGTH AND IS LEFT-JUSTIFIED AND BLANK FILLED (TWO RIGHT POSITIONS). BEGINNING IN 10/98, IT IS 6 CHARACTERS IN LENGTH. THIS CODE VALUE IS APPENDED TO EACH RECORD FOR THE ELIGIBLE PERSON, FROM THE MAX PERSON SUMMARY FILE. THEREFORE, THIS CODE MAY NOT MATCH THE ELIGIBILITY GROUP IN WHICH THE PERSON WAS ENROLLED IN THE MONTH THE SERVICE WAS DELIVERED. FOR THIS REASON, SOME USERS MAY WANT TO USE THE STATE SPECIFIC ELIGIBILITY CODE FROM THE MAX PERSON SUMMARY FILE.</p> <p>SOURCE: THIS CODE WAS DERIVED BY USING MONTHLY OBSERVATIONS OF THE MSIS STATE SPECIFIC "ELIGIBILITY GROUP" FROM THE MAX PERSON SUMMARY FILE AND SELECTING THE FIRST MEANINGFUL CODE (NOT 0- OR 9-FILLED) BEGINNING WITH DECEMBER AND MOVING BACKWARDS IN TIME MONTH BY MONTH. IT HAS NOT BEEN RECODED FROM THE MAX PERSON SUMMARY FILE.</p>					

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NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
9. STATE SPECIFIC ELIGIBILITY CODE - FOR MONTH OF SERVICE	CHAR	6	60	65	STATE SPECIFIC ELIGIBILITY CODE CLASSIFICATION UNDER WHICH THE MEDICAID ELIGIBLE IS COVERED - FOR THE MONTH OF SERVICE. <p>USER NOTES: THESE SOURCE CODES ARE GENERALLY NOT APPLICABLE FOR MOST RESEARCH ACTIVITIES. THE DATA ELEMENT CHANGES OVER TIME, VARIES ACROSS STATES IN TERMS OF THE LEVEL AND TYPE OF ELIGIBILITY DESCRIBED, REQUIRE A DETAILED KNOWLEDGE OF MEDICAID ELIGIBILITY AND REQUIRE AN UNDERSTANDING OF THE IDIOSYNCRACIES OF INDIVIDUAL STATE ELIGIBILITY SYSTEMS. THESE CODES HAVE BEEN MAPPED INTO MAX UNIFORM ELIGIBILITY CODES. THEREFORE, MOST USERS WILL WANT TO USE MAX UNIFORM ELIGIBILITY CODES. THROUGH 9/98, THIS DATA ELEMENT WAS 4 CHARACTERS IN LENGTH AND IS LEFT-JUSTIFIED AND BLANK FILLED (TWO RIGHT POSITIONS). BEGINNING IN 10/98, IT IS 6 CHARACTERS IN LENGTH. THIS CODE VALUE (FOR ENDING MONTH OF SERVICE) IS APPENDED TO EACH RECORD FOR THE ELIGIBLE PERSON, FROM THE MAX PERSON SUMMARY FILE.</p> <p>SOURCE: THIS CODE WAS DERIVED BY USING MONTHLY OBSERVATIONS OF THE STATE SPECIFIC "ELIGIBILITY GROUP" FROM THE MAX PERSON SUMMARY FILE AND SELECTING THE MONTHLY VALUE WHICH CORRESPONDS TO THE ENDING MONTH FOR THIS SERVICE. IT IS BLANK FILLED IF NO ELIGIBILITY IS RECORDED FOR THAT MONTH.</p>
10. MAX UNIFORM ELIGIBILITY CODE - MOST RECENT	CHAR	2	66	67	MEDICAID ANALYTIC EXTRACTS (MAX) UNIFORM ELIGIBILITY CODE FOR THE MEDICAID ELIGIBLE - MOST RECENT OBSERVATION <p>CODES: 00 = NOT ELIGIBLE 11 = AGED, CASH 12 = BLIND/DISABLED, CASH 14 = CHILD (NOT CHILD OF UNEmployed ADULT, NOT FOSTER CARE CHILD), ELIGIBLE UNDER SECTION 1931 OF THE ACT 16 = CHILD OF UNEmployed ADULT, ELIGIBLE UNDER SECTION 1931 OF THE ACT 15 = ADULT (NOT BASED ON UNEmployment STATUS), ELIGIBLE UNDER SECTION 1931 OF THE ACT 17 = UNEmployed ADULT, ELIGIBLE UNDER SECTION 1931 OF THE ACT 21 = AGED, MN 22 = BLIND/DISABLED, MN 24 = CHILD, MN (FORMERLY AFDC CHILD, MN) 25 = ADULT, MN (FORMERLY AFDC ADULT, MN) 31 = AGED, POVERTY 32 = BLIND/DISABLED, POVERTY 34 = CHILD, POVERTY (INCLUDES MEDICAID EXPANSION SCHIP CHILDREN) 35 = ADULT, POVERTY</p>

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NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
				3A = INDIVIDUAL COVERED UNDER THE BREAST AND CERVICAL CANCER PREVENTION ACT OF 2000, POVERTY 41 = OTHER AGED 42 = OTHER BLIND/DISABLED 48 = FOSTER CARE CHILD 44 = OTHER CHILD 45 = OTHER ADULT 51 = AGED, SECTION 1115 DEMONSTRATION EXPANSION 52 = DISABLED, SECTION 1115 DEMONSTRATION EXPANSION 54 = CHILD, SECTION 1115 DEMONSTRATION EXPANSION 55 = ADULT, SECTION 1115 DEMONSTRATION EXPANSION 99 = UNKNOWN ELIGIBILITY USER NOTE: MSIS "MAINTENANCE ASSISTANCE STATUS" (MAS) IS IN POSITION #1 AND "BASIS OF ELIGIBILITY" (BOE) IS IN POSITION #2. CODING IS THE SAME AS IN 1996-98 MAX FILES, EXCEPT THAT VALUES 51-55 ARE ADDED FOR 1999 AND VALUE 3A IS ADDED FOR 2000. THERE MAY BE SMALL NUMBERS OF RECORDS WITH INCONSISTENT VALUES BECAUSE MSIS HAS NO MAS/BOE CONSISTENCY CHECKS. PRIOR TO THE END OF THE AFDC PROGRAM, GROUPS 14-17 WERE AFDC CASH RECIPIENTS. SOURCE: THIS CODE IS EXTRACTED FROM "MAX UNIFORM ELIGIBILITY CODE - MOST RECENT" IN THE MAX PERSON SUMMARY FILE.
11.MAX UNIFORM ELIGIBILITY CODE - FOR MONTH OF SERVICE	CHAR	2	68 69	MEDICAID ANALYTIC EXTRACT (MAX) UNIFORM ELIGIBILITY CODE FOR THE MEDICAID ELIGIBLE - FOR THE MONTH OF SERVICE. CODES: 00 = NOT ELIGIBLE 11 = AGED, CASH 12 = BLIND/DISABLED, CASH 14 = CHILD (NOT CHILD OF UNEmployed ADULT, NOT FOSTER CARE CHILD), ELIGIBLE UNDER SECTION 1931 OF THE ACT 16 = CHILD OF UNEmployed ADULT, ELIGIBLE UNDER SECTION 1931 OF THE ACT 15 = ADULT (NOT BASED ON UNEMPLOYMENT STATUS), ELIGIBLE UNDER SECTION 1931 OF THE ACT 17 = UNEmployed ADULT, ELIGIBLE UNDER SECTION 1931 OF THE ACT 21 = AGED, MN 22 = BLIND/DISABLED, MN 24 = CHILD, MN (FORMERLY AFDC CHILD, MN) 25 = ADULT, MN (FORMERLY AFDC ADULT, MN) 31 = AGED, POVERTY

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NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
				32 = BLIND/DISABLED, POVERTY
				34 = CHILD, POVERTY (INCLUDES MEDICAID EXPANSION SCHIP CHILDREN)
				35 = ADULT, POVERTY
				3A = INDIVIDUAL COVERED UNDER THE BREAST AND CERVICAL CANCER PREVENTION ACT OF 2000, POVERTY
				41 = OTHER AGED
				42 = OTHER BLIND/DISABLED
				48 = FOSTER CARE CHILD
				44 = OTHER CHILD
				45 = OTHER ADULT
				51 = AGED, SECTION 1115 DEMONSTRATION EXPANSION
				52 = DISABLED, SECTION 1115 DEMONSTRATION EXPANSION
				54 = CHILD, SECTION 1115 DEMONSTRATION EXPANSION
				55 = ADULT, SECTION 1115 DEMONSTRATION EXPANSION
				99 = UNKNOWN ELIGIBILITY
				<i>USER NOTE: MSIS "MAINTENANCE ASSISTANCE STATUS" (MAS) IS POSITION #1 AND "BASIS OF ELIGIBILITY" (BOE) IS IN POSITION #2. CODING IS THE SAME AS IN 1996-98 SMRF FILES, EXCEPT THAT VALUES 51-55 ARE ADDED FOR 1999 AND VALUE 3A IS ADDED FOR 2000. THERE MAY BE SMALL NUMBERS OF RECORDS WITH INCONSISTENT VALUES BECAUSE MSIS HAS NO MAS/BOE CONSISTENCY CHECKS. PRIOR TO THE END OF THE AFDC PROGRAM, GROUPS 14-17 WERE AFDC CASH RECIPIENTS.</i>
				<i>SOURCE: THIS CODE WAS DERIVED BY USING MONTHLY OBSERVATIONS OF "MONTHLY MAX UNIFORM ELIGIBILITY GROUP" IN THE MAX PERSON SUMMARY FILE AND SELECTING THE MONTHLY VALUE WHICH CORRESPONDS TO THE ENDING MONTH FOR THIS SERVICE. IT IS BLANK FILLED IF NO ELIGIBILITY IS RECORDED FOR THAT MONTH.</i>

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NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
*** CROSSOVER GROUP	GROUP	4	70	73	INFORMATION FROM MSIS ELIGIBILITY AND CLAIMS FILES ON CROSSOVER STATUS (DUAL ELIGIBILITY FOR MEDICAID AND MEDICARE).
12. ELIGIBLE MEDICARE CROSSOVER CODE - ANNUAL OLD VALUES	NUM	1	70	70	INDICATES THAT THE ELIGIBLE IS OR HAS BEEN COVERED BY MEDICARE (KNOWN AS CROSSOVER, DUAL ELIGIBILITY OR MEDICARE CODE) 1 DIGIT CODES: 0 = NO CROSSOVER 1 = IN MSIS, THE DUAL ELIGIBILITY FLAG HAS A VALUE OF 1 (MEANING THAT THE PERSON IS COVERED BY MEDICARE) 2 = IN MSIS, MEDICARE DEDUCTIBLE OR COINSURANCE WAS PAID BY MEDICAID ON AT LEAST ONE (INPATIENT HOSPITAL) CLAIM DURING THE YEAR. 3 = IN MSIS, BOTH 1 AND 2 APPLY 4 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE, AND NEITHER 1 NOR 2 APPLY. 5 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE, AND 1 APPLIES. 6 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE, AND 2 APPLIES. 7 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE, AND BOTH 1 AND 2 APPLY. 9 = ELIGIBLE'S MEDICARE STATUS IS UNKNOWN <i>USER NOTE: BEGINNING IN 10/98, MSIS CAPTURES GREATER DETAIL ON DUAL ELIGIBILITY. GIVEN THE IMPORTANCE OF CROSSOVER STATUS FOR SOME DATA USERS, THE EXPANDED DETAIL APPEARS AS DATA ELEMENT #14 IN THIS FILE. USERS SHOULD NOTE THAT THIS IS AN ANNUAL OBSERVATION OF MEDICARE CROSSOVER STATUS WHICH MAY OR MAY NOT CORRESPOND TO ACTUAL CROSSOVER STATUS FOR THE DATE(S) OF SERVICE IN THIS RECORD.</i> SOURCE: THIS DATA ELEMENT IS TAKEN FROM THE MAX PERSON SUMMARY FILE.

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		LENGTH	BEG	END	
13. ELIGIBLE MEDICARE CROSSOVER CODE - CLAIM-BASED	NUM	1	71	71	INDICATES THAT THE ELIGIBLE WAS COVERED BY MEDICARE WHEN THIS SERVICE WAS RENDERED. 1 DIGIT CODES: 0 = NO MEDICARE DEDUCTIBLE OR COINSURANCE PAID BY MEDICAID ON THIS SERVICE 1 = MEDICARE DEDUCTIBLE OR COINSURANCE PAID BY MEDICAID ON THIS SERVICE SOURCE: MSIS DATA ELEMENTS: "MEDICARE-DEDUCTIBLE-PAYMENT" AND "MEDICARE-COINSURANCE-PAYMENT". IF EITHER THE MEDICARE DEDUCTIBLE OR THE MEDICARE COINSURANCE AMOUNT IS > \$0, THE CODE =1, OTHERWISE THE CODE = 0.
14. ELIGIBLE MEDICARE CROSSOVER CODE - ANNUAL NEW VALUES	NUM	2	72	73	INDICATES THAT THE ELIGIBLE WAS COVERED BY MEDICARE (KNOWN AS CROSSOVER, DUAL OR MEDICARE ELIGIBILITY, ACCORDING TO MEDICAID (MSIS), MEDICARE (EDB) OR BOTH. 2 CHARACTERS CODES: 00 = IN MSIS, ELIGIBLE IS NOT A MEDICARE BENEFICIARY 01 = IN MSIS, ELIGIBLE IS ENTITLED TO MEDICARE-QMB ONLY 02 = IN MSIS, ELIGIBLE IS ENTITLED TO MEDICARE-QMB AND FULL MEDICAID COVERAGE 03 = IN MSIS, ELIGIBLE IS ENTITLED TO MEDICARE-SLMB ONLY 04 = IN MSIS, ELIGIBLE IS ENTITLED TO MEDICARE-SLMB AND FULL MEDICAID COVERAGE 05 = IN MSIS, ELIGIBLE IS ENTITLED TO MEDICARE-QDWI 06 = IN MSIS, ELIGIBLE IS ENTITLED TO MEDICARE-QUALIFYING INDIVIDUALS (1) 07 = IN MSIS, ELIGIBLE IS ENTITLED TO MEDICARE-QUALIFYING INDIVIDUALS (2) 08 = IN MSIS, ELIGIBLE IS ENTITLED TO MEDICARE-OTHER DUAL ELIGIBLES 09 = IN MSIS, ELIGIBLE IS ENTITLED TO MEDICARE-DUAL ELIGIBILITY CATEGORY UNKNOWN 50 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE AND CODES 01-09 DO NOT APPLY 51 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE AND CODE 01 APPLIES 52 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE AND CODE 02 APPLIES 53 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE AND CODE 03 APPLIES

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NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
				54 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE AND CODE 04 APPLIES
				55 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE AND CODE 05 APPLIES
				56 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE AND CODE 06 APPLIES
				57 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE AND CODE 07 APPLIES
				58 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE AND CODE 08 APPLIES
				59 = A RECORD WAS FOUND IN THE MEDICARE ENROLLMENT DATA BASE (EDB) FOR THE ELIGIBLE AND CODE 09 APPLIES
				99 = ELIGIBLE'S MEDICARE STATUS IS UNKNOWN

USER NOTE: USERS SHOULD NOTE THAT THIS IS AN ANNUAL OBSERVATION OF MEDICARE CROSSOVER STATUS WHICH MAY OR MAY NOT CORRESPOND TO ACTUAL CROSSOVER STATUS FOR THE DATE(S) OF SERVICE IN THIS RECORD. PRIOR TO IN 10/98, MSIS DID NOT CAPTURE AS MUCH DETAIL ON DUAL ELIGIBILITY. GIVEN THE IMPORTANCE OF CROSSOVER STATUS FOR SOME DATA USERS AND THE NEED FOR SOME USERS TO HAVE CONTINUITY WITH PAST DEFINITIONS, THE ODL VALUES APPEAR AS DATA ELEMENT #12 IN THIS FILE.

SOURCE: THIS DATA ELEMENT IS TAKEN FROM THE MAX PERSON SUMMARY FILE.

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NAME	TYPE	LENGTH	POSITIONS		CONTENTS
			BEG	END	
*** UTILIZATION SUMMARY REGION	REGION	680	74	753	DETAILED INFORMATION FROM MSIS CLAIMS ON THE SERVICE PROVIDED.
** SERVICE GROUP	GROUP	17	74	90	DETAILED INFORMATION ON THE TYPE OF SERVICE, PLACE OF SERVICE AND PROVIDER IDENTIFICATION.
15. MSIS TYPE OF SERVICE CODE	NUM	2	74	75	CODE INDICATING THE MEDICAID STATISTICAL INFORMATION SYSTEM (MSIS) TYPE OF SERVICE.

2 DIGITS

CODES (TYPES OF SERVICE THAT APPLY TO THIS FILE TYPE ARE IN BOLD):

01 INPATIENT HOSPITAL
 02 MENTAL HOSPITAL SERVICES FOR THE AGED
 04 INPATIENT PSYCHIATRIC FACILITY FOR INDIVIDUALS UNDER THE AGE OF 21
 05 INTERMEDIATE CARE FACILITY (ICF) FOR THE MENTALLY RETARDED
 07 NURSING FACILITY SERVICES (NFS) - ALL OTHER
 08 PHYSICIANS
 09 DENTAL
 10 OTHER PRACTITIONERS
 11 OUTPATIENT HOSPITAL
 12 CLINIC
 13 HOME HEALTH
 15 LAB AND X-RAY
 16 PRESCRIBED DRUGS
 19 OTHER SERVICES
 20 CAPITATED PAYMENTS TO HMO OR HIO PLAN
 21 CAPITATED PAYMENTS TO PREPAID HEALTH PLANS - PHPs
 22 CAPITATED PAYMENTS FOR PRIMARY CARE CASE MANAGEMENT - PCCM
24 STERILIZATIONS
25 ABORTIONS
 26 TRANSPORTATION SERVICES
 30 PERSONAL CARE SERVICES
 31 TARGETED CASE MANAGEMENT
 33 REHABILITATION SERVICES
 34 PT, OT, SPEECH, HEARING SERVICES
 35 HOSPICE BENEFITS
 36 NURSE MIDWIFE SERVICES
 37 NURSE PRACTITIONER SERVICES
 38 PRIVATE DUTY NURSING
39 RELIGIOUS NON-MEDICAL HEALTH CARE INSTITUTIONS
 99 UNKNOWN

MEDICAID ANALYTIC EXTRACT INPATIENT RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
<p>USER NOTE: THE ONLY MSIS TYPES OF SERVICE THAT APPEAR IN THIS FILE ARE:</p> <p>TOS = 01 INPATIENT HOSPITAL</p> <p>24 STERILIZATIONS</p> <p>25 ABORTIONS</p> <p>39 RELIGIOUS NON-MEDICAL HEALTH CARE INSTITUTION3</p> <p>USER NOTE: THE FOLLOWING CODES ARE INVALID: 03, 06, 14, 17, 18, 23, 27, 28, 29, 32 AND 40. BEGINNING IN 10/98, MSIS IDENTIFIED EPSDT; FAMILY PLANNING; RURAL HEALTH CLINIC; FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs); INDIAN HEALTH; HOME AND COMMUNITY BASED CARE FOR DISABLED, ELDERLY AND INDIVIDUALS AGE 65 AND OLDER; AND HOME AND COMMUNITY BASED CARE WAIVER SERVICES USING A NEW DATA ELEMENT, "PROGRAM TYPE". A SUBSTANTIAL NUMBER OF NEW MSIS TYPE OF SERVICE CODES WERE ADDED IN FISCAL YEAR 1998.</p> <p>SOURCE: MSIS CLAIMS FILE: "TYPE-OF-SERVICE"</p>				

MEDICAID ANALYTIC EXTRACT INPATIENT RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
16. MSIS TYPE OF PROGRAM CODE	NUM	1	76	76	CODE INDICATING THE SPECIAL MEDICAID PROGRAM UNDER WHICH THE SERVICE WAS PROVIDED. 1 DIGIT CODES: 0 = NO SPECIAL PROGRAM 1 = EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT) 2 = FAMILY PLANNING 3 = RURAL HEALTH CLINIC 4 = FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs) 5 = INDIAN HEALTH SERVICES 6 = HOME AND COMMUNITY BASED CARE FOR DISABLED ELDERLY AND INDIVIDUALS AGE 65 AND OLDER 7 = HOME AND COMMUNITY BASED CARE WAIVER SERVICES 9 = UNKNOWN

USER NOTE: UNDER EPSDT REQUIREMENTS, STATES MUST PROVIDE HEALTH SCREENING, VISION, HEARING AND DENTAL SERVICES TO CHILDREN UNDER THE AGE OF 21. THESE SERVICES MUST BE PROVIDED AT INTERVALS TO MEET RECOGNIZED STANDARDS OF MEDICAL AND DENTAL PRACTICE AND OTHER INTERVALS TO DETERMINE IF PHYSICAL OR MENTAL ILLNESSES OR CONDITIONS EXIST. STATES MUST ALSO PROVIDE ANY SERVICE NEEDED TO TREAT AN ILLNESS OR CONDITION IDENTIFIED BY A SCREEN (TO THE EXTENT THAT IS A SERVICE THAT IS PERMITTED UNDER MEDICAID LAW), REGARDLESS OF WHETHER THE SERVICE IS OTHERWISE INCLUDED UNDER THE STATE MEDICAID PLAN. ALTHOUGH EPSDT MAY BE VIEWED AS A PROGRAM BY SOME, IT CAN BE MORE ACCURATELY DESCRIBED AS A GROUP OF SERVICES, WITH A STRONG EMPHASIS ON PREVENTIVE CARE. HOWEVER, THERE IS NO STANDARD DEFINITION OF EPSDT SERVICES AND THERE ARE NO STANDARD REPORTING REQUIREMENTS FOR EPSDT SERVICES IN MEDICAID DATA SYSTEMS. THEREFORE, THERE IS SUBSTANTIAL VARIATION IN REPORTING FOR EPSDT ACROSS STATES. FOR THESE REASONS, USE OF TYPE OF PROGRAM = 1 (EPSDT) IS UNRELIABLE FOR CROSS-STATE COMPARISONS OR DEVELOPMENT OF NATIONAL STATISTICS. EXTREME CAUTION SHOULD BE EXERCISED IN ATTRIBUTING MEANING TO THIS CODE VALUE.

SOURCE: MSIS CLAIMS FILE: "PROGRAM-TYPE"

MEDICAID ANALYTIC EXTRACT INPATIENT RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
17. MAX TYPE OF SERVICE CODE	NUM	2	77	78	CODE INDICATING THE MEDICAID ANALYTIC EXTRACTS (MAX) TYPE OF SERVICE FOR THIS RECORD. 2 DIGITS CODES (TYPES OF SERVICE THAT APPLY TO THIS FILE TYPE ARE IN BOLD): 01 INPATIENT HOSPITAL 02 MENTAL HOSPITAL SERVICES FOR THE AGED 04 INPATIENT PSYCHIATRIC FACILITY FOR INDIVIDUALS UNDER THE AGE OF 21 05 INTERMEDIATE CARE FACILITY (ICF) FOR THE MENTALLY RETARDED 07 NURSING FACILITY SERVICES (NFS) - ALL OTHER 08 PHYSICIANS 09 DENTAL 10 OTHER PRACTITIONERS 11 OUTPATIENT HOSPITAL 12 CLINIC 13 HOME HEALTH 15 LAB AND X-RAY 16 PRESCRIBED DRUGS 19 OTHER SERVICES 20 CAPITATED PAYMENTS TO HMO OR HIO PLAN 21 CAPITATED PAYMENTS TO PREPAID HEALTH PLANS - PHPs 22 CAPITATED PAYMENTS FOR PRIMARY CARE CASE MANAGEMENT - PCCM 24 STERILIZATIONS 25 ABORTIONS 26 TRANSPORTATION SERVICES 30 PERSONAL CARE SERVICES 31 TARGETED CASE MANAGEMENT 33 REHABILITATION SERVICES 34 PT, OT, SPEECH, HEARING SERVICES 35 HOSPICE BENEFITS 36 NURSE MIDWIFE SERVICES 37 NURSE PRACTITIONER SERVICES 38 PRIVATE DUTY NURSING 39 RELIGIOUS NON-MEDICAL HEALTH CARE INSTITUTIONS 51 DURABLE MEDICAL EQUIPMENT AND SUPPLIES (INCLUDING EMERGENCY RESPONSE SYSTEMS AND HOME MODIFICATIONS) 52 RESIDENTIAL CARE (DEFINITION CHANGED FOR 2003 AND LATER YEARS - ADDITIONAL INFORMATION IS AVAILABLE ON REQUEST) 53 PSYCHIATRIC SERVICES (EXCLUDING ADULT DAY CARE) 54 ADULT DAY CARE 99 UNKNOWN

MEDICAID ANALYTIC EXTRACT INPATIENT RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
<p>USER NOTE: THE FOLLOWING CODES ARE INVALID: 03, 06, 14, 17, 18, 23, 27, 28, 29, 32 AND 40. BEGINNING IN 10/98, MSIS IDENTIFIED EPSDT; FAMILY PLANNING; RURAL HEALTH CLINIC; FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs); INDIAN HEALTH; HOME AND COMMUNITY BASED CARE FOR DISABLED, ELDERLY AND INDIVIDUALS AGE 65 AND OLDER; AND HOME AND COMMUNITY BASED CARE WAIVER SERVICES USING A NEW DATA ELEMENT, "PROGRAM TYPE". A SUBSTANTIAL NUMBER OF NEW MSIS TYPE OF SERVICE CODES WERE ADDED IN FISCAL YEAR 1998. THE FOLLOWING TYPES OF SERVICE ARE DEFINED IN THE MAX PROCESS USING STATE PROCEDURE (SERVICE) CODES:</p> <p>51 DURABLE MEDICAL EQUIPMENT AND SUPPLIES (INCLUDING EMERGENCY RESPONSE SYSTEMS AND HOME MODIFICATIONS)</p> <p>52 RESIDENTIAL CARE (DEFINITION CHANGED FOR 2003 AND LATER YEARS - ADDITIONAL INFORMATION IS AVAILABLE ON REQUEST)</p> <p>53 PSYCHIATRIC SERVICES (EXCLUDING ADULT DAY CARE)</p> <p>54 ADULT DAY CARE</p> <p>SOURCE: MSIS CLAIMS FILE: "TYPE-OF-SERVICE" EXCEPT FOR CODE VALUES 51-54 AS NOTED ABOVE.</p>				

MEDICAID ANALYTIC EXTRACT INPATIENT RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
18. BILLING PROVIDER IDENTIFICATION NUMBER	CHAR	12	79	90	STATE ASSIGNED UNIQUE IDENTIFICATION NUMBER FOR THE BILLING PROVIDER. 12 CHARACTERS SOURCE: MSIS CLAIMS FILE: "PROVIDER-ID-NUMBER-BILLING"
** CLAIMS AND PAYMENT GROUP	GROUP	72	91	162	DETAILED DATA FROM MSIS CLAIMS ON TYPE OF CLAIM, TYPE OF COVERAGE, PAYMENTS AND CHARGES FROM MSIS CLAIMS.
19. TYPE OF CLAIM CODE	NUM	1	91	91	CODE INDICATING THE TYPE OF CLAIM. 1 DIGIT CODES: 1 = A CURRENT FEE-FOR-SERVICE CLAIM FOR MEDICAL SERVICES. 2 = CAPITATED PAYMENT. 3 = ENCOUNTER (A.K.A. "DUMMY") RECORD THAT SIMULATES A BILL FOR A SERVICE RENDERED TO A PATIENT COVERED UNDER SOME FORM OF CAPITATION PLAN. 4 = A 'SERVICE TRACKING CLAIM' THAT DOCUMENTS SERVICES RECEIVED BY AN INDIVIDUAL PATIENT, WHEN THE STATE ACCEPTS A LUMP SUM BILL FROM A PROVIDER THAT COVERED SIMILAR SERVICES DELIVERED TO MORE THAN ONE PATIENT, SUCH AS GROUP SCREENING FOR EPSDT. 5 = SUPPLEMENTAL PAYMENT (ABOVE CAPITATION FEE OR ABOVE NEGOTIATED RATE) (E.G. FQHC ADDITIONAL REIMBURSEMENT). 9 = UNKNOWN USER NOTE: VOIDED CLAIMS ARE NOT RETAINED IN MAX AS \$0 PAID CLAIMS. SOURCE: MSIS CLAIMS FILE: "TYPE-OF-CLAIM"

MEDICAID ANALYTIC EXTRACT INPATIENT RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
20. ADJUSTMENT CODE	NUM	1	92	92	<p>CODE INDICATING IF THE CLAIMS FOR THIS SERVICE WERE ONLY ORIGINAL SUBMISSIONS, INCLUDED ADJUSTMENTS OF ANY TYPE OR IF ONE OR MORE ORIGINAL SUBMISSIONS WAS MISSING.</p> <p>1 DIGIT</p> <p>CODES:</p> <p>0 = NO ADJUSTMENT OF CLAIMS WAS REQUIRED, SINCE ALL CLAIMS FOR THIS RECORD WERE ORIGINAL CLAIMS (ALL CLAIMS FOR THIS RECORD HAD VALUE = 0 IN THE MSIS DATA ELEMENT "ADJUSTMENT INDICATOR"). IN THIS CASE, ORIGINAL CLAIMS WERE COMBINED FOR THIS RECORD.</p> <p>1 = THIS RECORD REPRESENTS A CLAIMS SET WHERE IT WAS POSSIBLE TO CORRECTLY COMPLETE THE ADJUSTMENT PROCESS, BY COMBINING ORIGINAL AND ADJUSTMENT CLAIMS FOR THIS RECORD. THIS MEANS THAT THERE WAS AT LEAST ONE ORIGINAL CLAIM AND AT LEAST ONE ADJUSTMENT CLAIM IN THE SET OF CLAIMS FOR THIS RECORD (AT LEAST ONE CLAIM FOR THIS RECORD HAD VALUE = 0 IN THE MSIS DATA ELEMENT "ADJUSTMENT INDICATOR" AND AT LEAST ONE CLAIM FOR THIS RECORD HAD A VALUE OTHER THAN 0 IN THE MSIS DATA ELEMENT "ADJUSTMENT INDICATOR").</p> <p>2 = THIS RECORD REPRESENTS A CLAIMS SET WHERE IT WAS NOT POSSIBLE TO CORRECTLY COMPLETE THE ADJUSTMENT PROCESS (NONE OF THE CLAIMS FOR THIS RECORD HAD A VALUE = 0 IN THE MSIS DATA ELEMENT "ADJUSTMENT INDICATOR").</p> <p>SOURCE: RECODED USING THE MSIS CLAIMS FILES DATA ELEMENT: "ADJUSTMENT-INDICATOR".</p>

MEDICAID ANALYTIC EXTRACT INPATIENT RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
21. MANAGED CARE TYPE OF PLAN CODE	NUM	2	93	94	<p>CODE INDICATING THE TYPE OF MANAGED CARE PLAN, IF ANY, UNDER WHICH THE NON-FEE-FOR-SERVICE ENCOUNTER WAS PROVIDED.</p> <p>1 DIGIT CODES:</p> <p>00 = INDIVIDUAL WAS NOT ELIGIBLE FOR MEDICAID THIS MONTH. 01 = ELIGIBLE IS ENROLLED IN A MEDICAL OR COMPREHENSIVE MANAGED CARE PLAN THIS MONTH (E.G. HMO). 02 = ELIGIBLE IS ENROLLED IN A DENTAL MANAGED CARE PLAN THIS MONTH. 03 = ELIGIBLE IS ENROLLED IN A BEHAVIORAL MANAGED CARE PLAN THIS MONTH. 04 = ELIGIBLE IS ENROLLED IN A PRENATAL/DELIVERY MANAGED CARE PLAN THIS MONTH. 05 = ELIGIBLE IS ENROLLED IN A LONG-TERM CARE MANAGED CARE PLAN THIS MONTH. 06 = ELIGIBLE IS ENROLLED IN A PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) THIS MONTH. 07 = ELIGIBLE IS ENROLLED IN A PRIMARY CARE CASE MANAGEMENT MANAGED CARE PLAN THIS MONTH. 08 = ELIGIBLE IS ENROLLED IN AN OTHER MANAGED CARE PLAN THIS MONTH. 66 = THIS RECORD IS AN ENCOUNTER RECORD, BUT THERE IS NO REPORT OF MANAGED CARE ENROLLMENT IN THE ELIGIBILITY RECORD FOR THIS PERSON IN THIS MONTH. 77 = THIS RECORD IS AN ENCOUNTER RECORD, BUT THERE WAS NO MATCH BETWEEN THE PLAN IDENTIFICATION NUMBER (DATA ELEMENT #22) AND THE PLAN IDENTIFIERS IN THE ELIGIBILITY RECORD FOR THIS PERSON IN THIS MONTH. 88 = NOT APPLICABLE, THIS RECORD IS NOT AN ENCOUNTER RECORD. 99 = ELIGIBLE'S MANAGED CARE PLAN STATUS IS UNKNOWN.</p> <p><i>USER NOTE: THIS DATA ELEMENT IS 8-FILLED FOR NON-ENCOUNTER RECORDS.</i></p> <p>SOURCE: MSIS ELIGIBILITY FILE, BY MATCHING THE ELIGIBLE'S MSIS "PLAN-ID-NUMBER" FROM THE CLAIM(S) TO THE ELIGIBLE'S ELIGIBILITY RECORD FOR THE MONTH OF THE ENCOUNTER RECORD. SEE DATA ELEMENT #22.</p>
22. MANAGED CARE PLAN IDENTIFICATION NUMBER	CHAR	12	95	106	<p>A UNIQUE IDENTIFIER WHICH REPRESENTS THE HEALTH PLAN UNDER WHICH THE NON-FEE-FOR-SERVICE ENCOUNTER WAS PROVIDED.</p> <p>12 CHARACTERS</p> <p><i>USER NOTE: THIS DATA ELEMENT IS 8-FILLED FOR NON-ENCOUNTER RECORDS.</i></p> <p>SOURCE: MSIS CLAIMS FILE: "PLAN-ID-NUMBER"</p>

MEDICAID ANALYTIC EXTRACT INPATIENT RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
23. MEDICAID PAYMENT AMOUNT	NUM	8	107	114	TOTAL AMOUNT OF MONEY PAID BY MEDICAID FOR THIS SERVICE. 8 DIGITS (DISPLAY SIGNED NUMERIC) (SAS USERS: ZONED DECIMAL - ZD8) USER NOTES: THIS PAYMENT AMOUNT IS = \$0 FOR ENCOUNTER RECORDS. IN MSIS, STATES ARE INSTRUCTED TO SET MEDICAID PAYMENT AMOUNT = \$0 FOR RECORDS WITH TYPE OF CLAIM = 3 (ENCOUNTERS). IN MAX, WE AGAIN SET MEDICAID PAYMENT AMOUNT = \$0 FOR ENCOUNTERS, TO ELIMINATE THE POSSIBILITY OF AMOUNTS > \$0 APPEARING, IN ERROR. MEDICAID AMOUNT PAID IS SET VALUE = \$0 BECAUSE MEDICAID PAYMENT FOR THESE ENCOUNTER RECORDS IS ALREADY CAPTURED IN PREMIUM PAYMENT RECORDS (WITH AMOUNTS > \$0). THE PREMIUM PAYMENT RECORDS CONTAIN EITHER MSIS TYPE OF SERVICE = 20 (CAPITATED PAYMENTS TO HMO OR HIO PLAN), TOS=21 (CAPITATED PAYMENTS TO PREPAID HEALTH PLANS - PHPs) OR TOS=22 (CAPITATED PAYMENT FOR PRIMARY CARE CASE MANAGEMENT - PCCMs). THERE ARE INSTANCES WHERE THIS PAYMENT AMOUNT MAY BE SET VALUE < \$0 FOR FEE-FOR-SERVICE RECORDS. THIS SHOULD OCCUR ONLY ON CLINIC, PHYSICIAN OR OUTPATIENT DEPARTMENT BILLS FOR SELECTED STATES. THIS SITUATION HAS OCCURRED IN SEVERAL STATES, BUT HAS NOT BEEN A SIGNIFICANT ISSUE EXCEPT IN MONTANA WHERE OVER 8 PERCENT OF MSIS ORIGINAL OTHER SERVICES CLAIMS HAD A MEDICAID PAYMENT AMOUNT < \$0. WHERE THE MEDICAID PAYMENT AMOUNT IS SET < \$0 IN A MAX RECORD, THE PROVIDER BILLS USUALLY CONSIST OF A SUMMARY AND ONE OR MORE LINE ITEMS. THE SUMMARY CONTAINS INFORMATION ABOUT MEDICAID PAYMENT AMOUNT AND OTHER PAYMENTS, E.G. PAYMENTS BY OTHER INSURERS, KNOWN AS THIRD PARTY LIABILITY (TPL). THE SUMMARY DOES NOT INCLUDE DETAIL ON THE ACTUAL SERVICES PROVIDED. THAT DETAIL IS FOUND IN THE LINE ITEMS, BUT THE LINE ITEMS DO NOT INCLUDE THE ACTUAL MEDICAID PAYMENT AMOUNT. FOR THESE REASONS, STATES ARE INSTRUCTED TO SUBMIT BOTH THE SUMMARY AND THE LINE ITEMS IN MSIS SO THAT WE WILL HAVE THE MOST COMPLETE RECORD POSSIBLE OF SERVICES AND PAYMENTS. FOR THE SAME REASON, BOTH TYPES OF RECORDS ARE ALSO CAPTURED IN MAX.

MEDICAID ANALYTIC EXTRACT INPATIENT RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
				<p>THE INDIVIDUAL LINE ITEMS CONTAIN AN "ALLOWED PAYMENT AMOUNT", AN AMOUNT THAT HAS NOT BEEN REDUCED BY PAYMENTS FROM OTHER INSURERS (TPL) OR OUT-OF-POCKET PAYMENTS BY THE ELIGIBLE (PATIENT SHARE AMOUNTS). IF BOTH ALLOWED AND ACTUAL PAYMENTS ARE RETAINED, SUMS OF PAYMENT AMOUNTS ACROSS THE SUMMARY AND LINE ITEMS WILL OVERSTATE ACTUAL MEDICAID PAYMENTS. FURTHERMORE, THERE IS NO WAY TO APPORTION OR DISTRIBUTE THE ACTUAL MEDICAID PAYMENT AMOUNT FROM THE SUMMARY TO THE INDIVIDUAL LINE ITEMS. SO, THE DECISION WAS MADE TO RETAIN THE ALLOWED PAYMENT AMOUNTS IN THE LINE ITEMS, RETAIN THE TPL AMOUNT IN THE SUMMARY AND ADJUST MEDICAID PAYMENT (IN THE SUMMARY) SO THAT THE SUM ACROSS ALL RECORDS (SUMMARY AND LINE ITEMS) IS EQUAL TO THE ACTUAL MEDICAID PAYMENT AMOUNT. BECAUSE OF THIS, MEDICAID PAYMENT AMOUNT MAY BE ADJUSTED TO AN AMOUNT < \$0 SO THAT THE SUM OF ALL PAYMENT AMOUNTS LESS TPL IS EQUAL TO THE ACTUAL MEDICAID PAYMENT AMOUNT.</p> <p>SOURCE: RECODED AS NOTED ABOVE USING MSIS CLAIMS FILE: "MEDICAID-AMOUNT-PAID".</p>
24. THIRD PARTY PAYMENT AMOUNT	NUM	8	115 122	<p>TOTAL AMOUNT OF MONEY PAID BY A THIRD PARTY (I.E. ALL SOURCES OTHER THAN MEDICAID, MEDICARE AND THE ELIGIBLE'S PERSONAL FUNDS) FOR THIS SERVICE.</p> <p>8 DIGITS (DISPLAY SIGNED NUMERIC) (SAS USERS: ZONED DECIMAL - ZD8)</p> <p>USER NOTE: THERE MAY BE SUBSTANTIAL VARIATION IN THE REPORTING OF THIRD PARTY LIABILITY (TPL) AMOUNTS ACROSS STATES. THIS IS BECAUSE STATES USE DIFFERENT METHODS OF COLLECTING TPL PAYMENTS. SOME STATES MAY REQUIRE PROVIDERS TO THOROUGHLY PURSUE COLLECTION OF TPL PAYMENTS BEFORE CLAIMS ARE ADJUDICATED FOR MEDICAID PAYMENT. OTHER STATES MAY DESIRE TO PAY PROVIDERS PROMPTLY AND THEN RECOVER TPL PAYMENTS FROM OTHER PAYERS. FOR THESE REASONS, THE EXTENT TO WHICH TPL COLLECTIONS ARE ACCURATELY REPORTED IN MSIS IS UNKNOWN.</p> <p>SOURCE: MSIS CLAIMS FILE: "OTHER-THIRD-PARTY-PAYMENT"</p>

MEDICAID ANALYTIC EXTRACT INPATIENT RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
25. PAYMENT DATE	NUM	8	123	130	<p>DATE ON WHICH THE CLAIM OR ENCOUNTER RECORD WAS ADJUDICATED BY THE STATE.</p> <p>8 DIGITS</p> <p>EDIT-RULES: YYYYMMDD</p> <p>USER NOTE: FOR FEE-FOR-SERVICE CLAIMS THIS IS THE DATE THE CLAIM WAS ADJUDICATED FOR PAYMENT.</p> <p>SOURCE: MSIS CLAIMS FILE: "DATE-OF-PAYMENT-ADJUDICATION". MSIS DATES WITH 8- OR 9-FILL VALUES ARE CHANGED TO 0-FILL (ZERO-FILL).</p>
26. CHARGE AMOUNT	NUM	8	131	138	<p>TOTAL AMOUNT OF CHARGES SUBMITTED BY THE PROVIDER FOR THIS SERVICE.</p> <p>8 DIGITS (DISPLAY SIGNED NUMERIC) (SAS USERS: ZONED DECIMAL - ZD8)</p> <p>USER NOTE: THIS PAYMENT AMOUNT IS = \$0 FOR ENCOUNTER RECORDS. IN MSIS, FOR TYPE OF CLAIM = 3 (ENCOUNTERS), STATES ARE INSTRUCTED TO REPORT PAYMENT AMOUNTS BY A PLAN TO A PROVIDER IN THE "AMOUNT CHARGED" DATA ELEMENT. HOWEVER, SUCH PAYMENTS ARE NOT ACTUAL PROVIDER CHARGES. THEREFORE, IN MAX FOR TYPE OF CLAIM = 3 (ENCOUNTERS), THE MSIS VALUE OF "AMOUNT CHARGED" HAS BEEN MOVED TO DATA ELEMENT #27 (PREPAID PLAN SERVICE VALUE) AND MAX CHARGE AMOUNT HAS BEEN RESET TO VALUE = \$0. AS A RESULT, MAX CHARGE AMOUNT WILL HAVE VALUE = \$0 FOR ALL RECORDS WITH TYPE OF CLAIM = 3 (ENCOUNTER) AND VALUE >= \$0 FOR OTHER TYPE OF CLAIM VALUES, INCLUDING VALUE = 1 (FEE-FOR-SERVICE).</p> <p>SOURCE: RECODED AS NOTED ABOVE USING THE MSIS CLAIMS FILE: "AMOUNT-CHARGED".</p>

MEDICAID ANALYTIC EXTRACT INPATIENT RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
27. PREPAID PLAN SERVICE VALUE	NUM	8	139	146	<p>DOLLAR VALUE PLACED ON THE SERVICE BY THE PROVIDER.</p> <p>8 DIGITS (DISPLAY SIGNED NUMERIC) (SAS USERS: ZONED DECIMAL - ZD8)</p> <p>USER NOTES: THIS PAYMENT AMOUNT IS > \$0 ONLY FOR ENCOUNTER RECORDS. WHILE THIS PAYMENT AMOUNT COULD HAVE VALUE = \$0 FOR SOME ENCOUNTER RECORDS, IT WILL ALWAYS HAVE VALUE = \$0 FOR OTHER TYPES OF RECORDS. FOR RECORDS IN WHICH TYPE OF CLAIM = 3 (ENCOUNTER), THE MSIS VALUE OF "AMOUNT CHARGED" HAS BEEN MOVED TO DATA ELEMENT #27 (PREPAID PLAN SERVICE VALUE) AND MAX CHARGE AMOUNT HAS BEEN RESET TO VALUE = \$0. SEE DATA ELEMENT #24 (MEDICAID PAYMENT AMOUNT) AND DATA ELEMENT #26 CHARGE AMOUNT FOR ADDITIONAL INFORMATION. AS A RESULT, MAX PREPAID PLAN SERVICE VALUE WILL HAVE VALUE >= \$0 FOR ALL RECORDS WITH TYPE OF CLAIM = 3 (ENCOUNTER) AND VALUE = \$0 FOR OTHER TYPE OF CLAIM VALUES, INCLUDING VALUE = 1 (FEE-FOR-SERVICE). DEPENDING ON THE PROVIDER AND TYPE OF PREPAID PLAN, THE DOLLAR AMOUNTS IN THIS DATA ELEMENT MAY HAVE DIFFERENT MEANINGS. FOR EXAMPLE, IN AN INDEPENDENT PRACTICE PLAN THE AMOUNT MAY BE A PROVIDER'S CHARGE TO THE PLAN. IN A STAFF MODEL PLAN, THE AMOUNT MAY BE A MEASURE OF RESOURCES USED. FOR THIS REASON, EXTREME CAUTION SHOULD BE EXERCISED WHEN USING THIS DATA ELEMENT.</p> <p>SOURCE: RECODED AS NOTED ABOVE USING MSIS CLAIMS FILE</p>
28. MEDICARE COINSURANCE PAYMENT AMOUNT	NUM	8	147	154	<p>THE AMOUNT PAID BY MEDICAID, FOR THIS SERVICE, TOWARD THE RECIPIENT'S MEDICARE COINSURANCE LIABILITY.</p> <p>8 DIGITS (DISPLAY SIGNED NUMERIC) (SAS USERS: ZONED DECIMAL - ZD8)</p> <p>SOURCE: MSIS CLAIMS FILE: "MEDICARE-COINSURANCE-PAYMENT".</p>
29. MEDICARE DEDUCTIBLE PAYMENT AMOUNT	NUM	8	155	162	<p>THE AMOUNT PAID BY MEDICAID, FOR THIS SERVICE, TOWARD THE RECIPIENT'S MEDICARE DEDUCTIBLE LIABILITY.</p> <p>8 DIGITS (DISPLAY SIGNED NUMERIC) (SAS USERS: ZONED DECIMAL - ZD8)</p> <p>USER NOTE: THIS DATA ELEMENT IS NOT APPLICABLE FOR THE FOLLOWING MAX TYPES OF SERVICE: TOS = 5 (INTERMEDIATE CARE FACILITY - ICF - FOR THE MENTALLY RETARDED) OR TOS = 7 (NURSING FACILITY SERVICES - NFS - ALL OTHER). THEREFORE, THIS DATA ELEMENT WILL BE 0-FILLED FOR THESE TYPES OF SERVICE.</p> <p>SOURCE: MSIS CLAIMS FILE: "MEDICARE-DEDUCTIBLE-PAYMENT".</p>

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MEDICAID ANALYTIC EXTRACT INPATIENT RECORD (1999 AND LATER YEARS)

NAME	TYPE	LENGTH	POSITIONS		CONTENTS
-----	-----	-----	BEG	END	-----
** INPATIENT GROUP	GROUP	591	163	753	
30. ADMISSION DATE	NUM	8	163	170	DATE WHICH THE RECIPIENT WAS ADMITTED FOR THIS INPATIENT STAY. 8 DIGITS EDIT-RULES: YYYYMMDD SOURCE: MSIS CLAIMS FILE: "ADMISSION-DATE". MSIS DATES WITH 8- OR 9-FILL VALUES ARE CHANGED TO 0-FILL (ZERO-FILL).
31. SERVICE BEGINNING DATE	NUM	8	171	178	BEGINNING DATE OF SERVICE FOR THIS CLAIM. 8 DIGITS EDIT-RULES: YYYYMMDD USER NOTE: THIS DATE MAY OR MAY NOT BE THE ADMISSION DATE. SOURCE: MSIS CLAIMS FILE: "BEGINNING-DATE-OF-SERVICE". MSIS DATES WITH 8- OR 9-FILL VALUES ARE CHANGED TO 0-FILL (ZERO-FILL).
32. ENDING DATE OF SERVICE	NUM	8	179	186	THE DATE RECORDED HERE IS THE LATEST DATE OF SERVICE FOR ANY CLAIM RELATED TO THIS HOSPITAL STAY. THIS DATE MAY OR MAY NOT BE THE DISCHARGE DATE. 8 DIGITS EDIT-RULES: YYYYMMDD USER NOTES: THIS DATA ELEMENT IS BEST USED TOGETHER WITH DATA ELEMENT #37, DISCHARGE STATUS CODE. SOURCE: MSIS CLAIMS FILE: "ENDING-DATE-OF-SERVICE". MSIS DATES WITH 8- OR 9-FILL VALUES ARE CHANGED TO 0-FILL (ZERO-FILL).

MEDICAID ANALYTIC EXTRACT INPATIENT RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
33. PRINCIPAL DIAGNOSIS CODE	CHAR	6	187 192	<p>PRINCIPAL ICD-9-CM DIAGNOSIS FOR THIS RECORD.</p> <p>EDIT-RULES: LEFT JUSTIFIED, NO DECIMAL POINT</p> <p>USER NOTE: USERS SHOULD EXERCISE CAUTION SINCE THIS DATA ELEMENT IS AS IT WAS REPORTED BY EACH STATE. IT MAY CONTAIN EITHER BLANK-PADDING OR ZERO-PADDING TO THE RIGHT FOR 3- OR 4-CHARACTER ICD-9-CM CODES.</p> <p>SOURCE: MSIS CLAIMS FILE: "DIAGNOSIS-CODE-1 (PRINCIPAL)"</p>
* DIAGNOSIS CODE GROUP	GROUP	48	193 240	<p>ICD-9-CM DIAGNOSES FOR THIS RECORD. THERE A EIGHT OCCURENCES, ONE EACH FOR DIAGNOSIS 2 TO 9. THE EXAMPLE (DATA ELEMENT #34) IS FOR DIAGNOSIS CODE-2.</p> <p>DIAGNOSIS CODE-2 (POSITIONS 193 TO 198) DIAGNOSIS CODE-3 (POSITIONS 199 TO 204) DIAGNOSIS CODE-4 (POSITIONS 205 TO 210) DIAGNOSIS CODE-5 (POSITIONS 211 TO 216) DIAGNOSIS CODE-6 (POSITIONS 217 TO 222) DIAGNOSIS CODE-7 (POSITIONS 223 TO 228) DIAGNOSIS CODE-8 (POSITIONS 229 TO 234) DIAGNOSIS CODE-9 (POSITIONS 235 TO 240)</p>
34. DIAGNOSIS CODE-2	CHAR	6	193 198	<p>SECOND ICD-9-CM DIAGNOSIS CODE FOR THIS RECORD.</p> <p>EDIT-RULES: LEFT JUSTIFIED, NO DECIMAL POINT.</p> <p>USER NOTE: USERS SHOULD EXERCISE CAUTION SINCE THIS DATA ELEMENT IS AS IT WAS REPORTED BY EACH STATE. IT MAY CONTAIN EITHER BLANK-PADDING OR ZERO-PADDING TO THE RIGHT FOR 3- OR 4-CHARACTER ICD-9-CM CODES.</p> <p>SOURCE: MSIS CLAIMS FILE: "DIAGNOSIS-CODE-2".</p>
35. PRINCIPAL PROCEDURE DATE	NUM	8	241 248	<p>DATE ON WHICH THE PRINCIPAL PROCEDURE, IF ANY, WAS PERFORMED.</p> <p>8 DIGITS</p> <p>EDIT-RULES: YYYYMMDD</p> <p>SOURCE: MSIS CLAIMS FILE: "PROC-DATE-PRINCIPAL". MSIS DATES WITH 8- OR 9-FILL VALUES ARE CHANGED TO 0-FILL (ZERO-FILL).</p>

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MEDICAID ANALYTIC EXTRACT INPATIENT RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
36. PROCEDURE CODING SYSTEM CODE - PRINCIPAL	CHAR	2	249 250	CODE SPECIFYING THE PROCEDURE CODING SYSTEM USED FOR THE PRINCIPAL PROCEDURE. 2 DIGITS CODES: 01 = CPT-4 (HCPCS LEVEL 1) 02 = ICD-9-CM 06 = HCPCS (HCPCS LEVELS 2 AND 3) 07 = ICD-10 (FUTURE USE) 10-87 = OTHER SYSTEMS 88 = NOT APPLICABLE 99 = UNKNOWN <i>USER NOTES: THIS DATA ELEMENT SHOULD BE USED WITH DATA ELEMENT #37. USERS SHOULD MAKE SURE THE CODE VALUE IN THIS DATA ELEMENT ACCURATELY REFLECTS THE CODING SCHEME IN USE. THE FOLLOWING CODE VALUES ARE OBSOLETE: 03 = CRVS 74, 04 = CRVS 69, AND 05 = CRVS 64.</i> SOURCE: MSIS CLAIMS FILE: "PROC-CODE-FLAG-PRINCIPAL"
37. PRINCIPAL PROCEDURE CODE	CHAR	7	251 257	PRINCIPAL PROCEDURE PERFORMED FOR DEFINITIVE TREATMENT (RATHER THAN DIAGNOSTIC OR EXPLORATORY PURPOSES). IT IS RELATED TO EITHER THE DIAGNOSIS OR TO COMPLICATIONS. SEE DATA ELEMENT #36 PROCEDURE CODING SYSTEM CODE. SOURCE: MSIS CLAIMS FILE: "PROC-CODE-PRINCIPAL"

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MEDICAID ANALYTIC EXTRACT INPATIENT RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
** PROCEDURE CODE GROUP - ADDITIONAL PROCEDURES	GROUP	45	258	302	INDICATES WHICH, IF ANY, ADDITIONAL PROCEDURES WERE PERFORMED. THERE ARE FIVE OCCURRENCES FOR DATA ELEMENTS #38 AND #39 FOR THE SECOND TO SIXTH PROCEDURES. THE EXAMPLES BELOW ARE THE SECOND PROCEDURE. SECOND PROCEDURE (POSITIONS 258 TO 266) PROCEDURE CODING SYSTEM CODE (POSITIONS 258 TO 259) PROCEDURE CODE (POSITIONS 260 TO 266) THIRD PROCEDURE (POSITIONS 267 TO 275) PROCEDURE CODING SYSTEM CODE (POSITIONS 267 TO 268) PROCEDURE CODE (POSITIONS 269 TO 275) FOURTH PROCEDURE (POSITIONS 276 TO 284) PROCEDURE CODING SYSTEM CODE (POSITIONS 276 TO 277) PROCEDURE CODE (POSITIONS 278 TO 284) FIFTH PROCEDURE (POSITIONS 285 TO 293) PROCEDURE CODING SYSTEM CODE (POSITIONS 285 TO 286) PROCEDURE CODE (POSITIONS 287 TO 293) SIXTH PROCEDURE (POSITIONS 294 TO 302) PROCEDURE CODING SYSTEM CODE (POSITIONS 294 TO 295) PROCEDURE CODE (POSITIONS 296 TO 302)
38. PROCEDURE CODING SYSTEM CODE - ADDITIONAL PROCEDURE	CHAR	2	258	259	CODE SPECIFYING THE PROCEDURE CODING SYSTEM USED FOR THE PROCEDURE. 2 DIGITS CODES: 01 = CPT-4 (HCPCS LEVEL 1) 02 = ICD-9-CM 06 = HCPCS (HCPCS LEVELS 2 AND 3) 07 = ICD-10 (FUTURE USE) 10-87 = OTHER SYSTEMS 88 = NOT APPLICABLE 99 = UNKNOWN <i>USER NOTES: THIS DATA ELEMENT SHOULD BE USED WITH DATA ELEMENT #39. USERS SHOULD MAKE SURE THE CODE VALUE IN THIS DATA ELEMENT ACCURATELY REFLECTS THE CODING SCHEME IN USE. THE FOLLOWING CODE VALUES ARE OBSOLETE:</i> 03 = CRVS 74, 04 = CRVS 69, AND 05 = CRVS 64. SOURCE: MSIS CLAIMS FILE: "PROC-CODE-FLAG-2".

MEDICAID ANALYTIC EXTRACT INPATIENT RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
39. PROCEDURE CODE - ADDITIONAL PROCEDURE	CHAR	7	260 266	<p>PROCEDURE PERFORMED FOR DEFINITIVE TREATMENT (RATHER THAN DIAGNOSTIC OR EXPLORATORY PURPOSES). IT IS RELATED TO EITHER THE DIAGNOSIS OR TO COMPLICATIONS. SEE DATA ELEMENT #38 PROCEDURE CODING SYSTEM CODE.</p> <p>USER NOTE: MSIS DOES NOT OBTAIN PROCEDURE DATES FOR ADDITIONAL PROCEDURES</p> <p>SOURCE: MSIS CLAIMS FILE: "PROC-CODE-2".</p>
40. RECIPIENT DELIVERY CODE	NUM	1	303 303	<p>CODE INDICATING WHETHER THIS IS A DELIVERY STAY.</p> <p>1 DIGIT</p> <p>CODES:</p> <p>0 = NOT A DELIVERY STAY 1 = MATERNAL DELIVERY STAY 2 = NEWBORN DELIVERY STAY</p> <p>USER NOTE: CODE VALUE = 1 IS ASSIGNED IF ANY OF THE CLAIMS FOR THIS STAY HAVE A MATERNAL DELIVERY CODE. CODE VALUE = 2 IS ASSIGNED FOR SEPARATE NEWBORN DELIVERY CLAIMS THAT ARE KNOWN TO CONTAIN THE MOTHER'S MEDICAID IDENTIFIER. IF THERE ARE CLAIMS IDENTIFIED AS MATERNAL DELIVERIES AND NEWBORN DELIVERIES IN THE SAME CLAIMS "SET", TWO SEPARATE ADJUSTED STAY RECORDS ARE CREATED - ONE FOR THE MOTHER AND ONE FOR THE NEWBORN. THE DATE OF BIRTH ON THE NEWBORN DELIVERY CLAIM MUST BE WITHIN THE YEAR OF THE FILE. IF THERE ARE ONLY RECORDS FOR A NEWBORN DELIVERY, THE ADJUSTED STAY RECORD IS REPORTED AS VALUE = 0 (NOT A DELIVERY STAY).</p> <p>USERS ARE WARNED THAT COUNTING THE NUMBER OF DELIVERY STAYS MAY RESULT IN AN OVERCOUNT OF THE ACTUAL NUMBER OF DELIVERIES. THIS IS BECAUSE THERE MAY BE MORE THAN ONE STAY RECORD FOR THE SAME MATERNAL DELIVERY (E.G. STAYS FOR FALSE LABOR AND/OR STAYS FOR DELIVERY-RELATED COMPLICATIONS). THIS CAN OCCUR WHEN MATERNAL STAYS THAT DO NOT RESULT IN A DELIVERY ARE CODED INCORRECTLY. SIMILARLY, COUNTS OF NEWBORN DELIVERY STAYS MAY UNDERCOUNT ACTUAL DELIVERIES (OR CHILDREN BORN UNDER MEDICAID) SINCE CODING OF NEWBORN DELIVERIES MAY BE REPORTED FOR PROCESSING PURPOSES ONLY.</p> <p>FINALLY, THE METHOD OF CODING THIS DATA ELEMENT IS BASED ON THE PREDOMINANT METHOD OF REPORTING DELIVERIES IN EACH STATE. THEREFORE, CODING MAY BE INCORRECT FOR CLAIMS THAT HAVE BEEN SUBMITTED ACCORDING TO OTHER REPORTING METHODS.</p> <p>SOURCE: RECODED FROM MSIS CLAIMS RECORDS.</p>

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MEDICAID ANALYTIC EXTRACT INPATIENT RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
41. MEDICAID COVERED INPATIENT DAYS	NUM	3	304	306	NUMBER OF INPATIENT DAYS COVERED BY MEDICAID ON THIS INPATIENT STAY, INCLUDING NEWBORN DAYS. 3 DIGITS (DISPLAY SIGNED NUMERIC) (SAS USERS: ZONED DECIMAL - ZD3) <i>USER NOTE: FOR STATES THAT REIMBURSE HOSPITALS USING DIAGNOSIS RELATED GROUPS (DRGs) OR SELECTIVE CONTRACTING, USERS SHOULD DISREGARD THE VALUES IN THIS DATA ELEMENT. IN THESE CASES, MEDICAID COVERED INPATIENT DAYS ARE ACTUALLY THE LENGTH OF STAY = THE NUMBER OF DAYS FROM ADMISSION TO DISCHARGE (+1 IF THE PERSON WAS ADMITTED AND DISCHARGED ON THE SAME DAY).</i> SOURCE: MSIS CLAIMS FILE: "MEDICAID-COVERED-INPATIENT-DAYS".

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MEDICAID ANALYTIC EXTRACT INPATIENT RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
42. PATIENT STATUS CODE	NUM	2	307 308	CODE INDICATING THE RECIPIENT'S DISCHARGE STATUS. 1 DIGIT CODES: 01 = DISCHARGED TO HOME OR SELF CARE (ROUTINE DISCHARGE) 02 = DISCHARGED/TRANSFERRED TO ANOTHER SHORT-TERM HOSPITAL 03 = DISCHARGED/TRANSFERRED TO A NURSING FACILITY 04 = DISCHARGED/TRANSFERRED TO AN INTERMEDIATE CARE FACILITY 05 = DISCHARGED/TRANSFERRED TO ANOTHER TYPE INSTITUTION (INCLUDING DISTINCT PARTS) OR REFERRED FOR OUTPATIENT SERVICES TO ANOTHER INSTITUTION 06 = DISCHARGED/TRANSFERRED TO HOME UNDER CARE OF ORGANIZED HOME HEALTH SERVICE ORGANIZATION 07 = LEFT AGAINST MEDICAL ADVICE OR DISCONTINUED CARE 08 = DISCHARGED/TRANSFERRED TO HOME UNDER CARE OF A HOME IV DRUG THERAPY PROVIDER 09 = ADMITTED AS AN INPATIENT TO THIS HOSPITAL 20 = EXPIRED (OR DID NOT RECOVER - CHRISTIAN SCIENCE) PATIENT 30 = STILL A PATIENT 40 = EXPIRED AT HOME (HOSPICE CLAIMS ONLY) 41 = EXPIRED IN A MEDICAL FACILITY SUCH AS A HOSPITAL, NF OR FREE- STANDING HOSPICE (HOSPICE CLAIMS ONLY) 42 = EXPIRED - PLACE UNKNOWN (HOSPICE CLAIMS ONLY) 50 = HOSPICE - HOME 51 = HOSPICE - MEDICAL FACILITY 99 = UNKNOWN

USER NOTE: THE DATA ELEMENT WAS PREVIOUSLY KNOWN AS DISCHARGE STATUS.

SOURCE: MSIS CLAIMS FILE: "PATIENT-STATUS".

MEDICAID ANALYTIC EXTRACT INPATIENT RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
43. DIAGNOSIS RELATED GROUP INDICATOR	CHAR	4	309 312	<p>IDENTIFIES THE GROUPING ALGORITHM USED TO ASSIGN DIAGNOSIS RELATED GROUP (DRG) VALUES</p> <p>CODES: 8888 = NO DRG SYSTEM WAS USED 9999 = UNKNOWN</p> <p>OTHERWISE, THE FOLLWING CODES ARE USED: POSITIONS 300 AND 301: PP = WHERE "PP" IS US POSTAL CODE FOR THE STATE, IF THE DRG VALUES ARE FROM A SYSTEM DEVELOPED BY THE STATE. HG = IF THE DRG VALUES ARE FROM THE CMS SYSTEM. XX = IF THE DRG VALUES ARE FROM ANOTHER SYSTEM.</p> <p>POSITIONS 302 AND 303: NN = WHERE "NN" IS A NUMBER THAT REPRESENTS THE DRG VERSION THAT WAS USED (VALUE 01-98). 99 = VERSION IS UNKNOWN.</p> <p>USER NOTE: FOR EXAMPLE "HG15" WOULD REPRESENT THE DRG GROUPER, VERSION 15.</p> <p>SOURCE: MSIS CLAIMS FILE: "DIAGNOSIS-RELATED-GROUP-INDICATOR".</p>
44. DIAGNOSIS RELATED GROUP	NUM	4	313 316	<p>DIAGNOSIS RELATED GROUP (DRG) CODE FOR THIS INPATIENT RECORD.</p> <p>USER NOTE: IF DRGs ARE NOT USED, THIS DATA ELEMENT IS 8-FILLED. IF DRGs ARE USED BUT THE DRG VALUE IS UNKNOWN, THIS DATA ELEMENT IS 9-FILLED.</p> <p>SOURCE: MSIS CLAIMS FILE: "DIAGNOSIS-RELATED-GROUP (DRG)".</p>

MEDICAID ANALYTIC EXTRACT INPATIENT RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS			CONTENTS
		LENGTH	BEG	END	
** UB-92 REVENUE CODE GROUP	GROUP	437	317	753	<p>LISTS UB-92 REVENUE CODES WITH ASSOCIATED CHARGES AND UNITS. THERE ARE 23 OCCURRENCES FOR DATA ELEMENTS #45-#47 FOR UB-92 REVENUE CODES #1-323. THE EXAMPLE BELOW IS FOR THE FIRST REVENUE CODE.</p> <p>UB-92 REVENUE CODE-1 DATA (POSITIONS 317 TO 335) UB-92 REVENUE CODE-1 (POSITIONS 317 TO 320) UB-92 REVENUE CODE-1 CHARGES (POSITIONS 321 TO 328) UB-92 REVENUE CODE-1 UNITS (POSITIONS 329 TO 335) UB-92 REVENUE CODE-2 DATA (POSITIONS 336 TO 354) UB-92 REVENUE CODE-2 (POSITIONS 336 TO 339) UB-92 REVENUE CODE-2 CHARGES (POSITIONS 340 TO 347) UB-92 REVENUE CODE-2 UNITS (POSITIONS 348 TO 354) UB-92 REVENUE CODE-3 DATA (POSITIONS 355 TO 373) UB-92 REVENUE CODE-3 (POSITIONS 355 TO 358) UB-92 REVENUE CODE-3 CHARGES (POSITIONS 359 TO 366) UB-92 REVENUE CODE-3 UNITS (POSITIONS 367 TO 373) UB-92 REVENUE CODE-4 DATA (POSITIONS 374 TO 392) UB-92 REVENUE CODE-4 (POSITIONS 374 TO 377) UB-92 REVENUE CODE-4 CHARGES (POSITIONS 378 TO 385) UB-92 REVENUE CODE-4 UNITS (POSITIONS 386 TO 392) UB-92 REVENUE CODE-5 DATA (POSITIONS 393 TO 411) UB-92 REVENUE CODE-5 (POSITIONS 393 TO 396) UB-92 REVENUE CODE-5 CHARGES (POSITIONS 397 TO 404) UB-92 REVENUE CODE-5 UNITS (POSITIONS 405 TO 411) UB-92 REVENUE CODE-6 DATA (POSITIONS 412 TO 430) UB-92 REVENUE CODE-6 (POSITIONS 412 TO 415) UB-92 REVENUE CODE-6 CHARGES (POSITIONS 416 TO 423) UB-92 REVENUE CODE-6 UNITS (POSITIONS 424 TO 430) UB-92 REVENUE CODE-7 DATA (POSITIONS 431 TO 449) UB-92 REVENUE CODE-7 (POSITIONS 431 TO 434) UB-92 REVENUE CODE-7 CHARGES (POSITIONS 435 TO 442) UB-92 REVENUE CODE-7 UNITS (POSITIONS 443 TO 449) UB-92 REVENUE CODE-8 DATA (POSITIONS 450 TO 468) UB-92 REVENUE CODE-8 (POSITIONS 450 TO 453) UB-92 REVENUE CODE-8 CHARGES (POSITIONS 454 TO 461) UB-92 REVENUE CODE-8 UNITS (POSITIONS 462 TO 468) UB-92 REVENUE CODE-9 DATA (POSITIONS 469 TO 487) UB-92 REVENUE CODE-9 (POSITIONS 469 TO 472) UB-92 REVENUE CODE-9 CHARGES (POSITIONS 473 TO 480) UB-92 REVENUE CODE-9 UNITS (POSITIONS 481 TO 487)</p>

MEDICAID ANALYTIC EXTRACT INPATIENT RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
				UB-92 REVENUE CODE-10 DATA (POSITIONS 488 TO 506)
				UB-92 REVENUE CODE-10 (POSITIONS 488 TO 491)
				UB-92 REVENUE CODE-10 CHARGES (POSITIONS 492 TO 499)
				UB-92 REVENUE CODE-10 UNITS (POSITIONS 500 TO 506)
				UB-92 REVENUE CODE-11 DATA (POSITIONS 507 TO 525)
				UB-92 REVENUE CODE-11 (POSITIONS 507 TO 510)
				UB-92 REVENUE CODE-11 CHARGES (POSITIONS 511 TO 518)
				UB-92 REVENUE CODE-11 UNITS (POSITIONS 519 TO 525)
				UB-92 REVENUE CODE-12 DATA (POSITIONS 526 TO 544)
				UB-92 REVENUE CODE-12 (POSITIONS 526 TO 529)
				UB-92 REVENUE CODE-12 CHARGES (POSITIONS 530 TO 537)
				UB-92 REVENUE CODE-12 UNITS (POSITIONS 538 TO 544)
				UB-92 REVENUE CODE-13 DATA (POSITIONS 545 TO 563)
				UB-92 REVENUE CODE-13 (POSITIONS 545 TO 548)
				UB-92 REVENUE CODE-13 CHARGES (POSITIONS 549 TO 556)
				UB-92 REVENUE CODE-13 UNITS (POSITIONS 557 TO 563)
				UB-92 REVENUE CODE-14 DATA (POSITIONS 564 TO 582)
				UB-92 REVENUE CODE-14 (POSITIONS 564 TO 567)
				UB-92 REVENUE CODE-14 CHARGES (POSITIONS 568 TO 575)
				UB-92 REVENUE CODE-14 UNITS (POSITIONS 576 TO 582)
				UB-92 REVENUE CODE-15 DATA (POSITIONS 583 TO 601)
				UB-92 REVENUE CODE-15 (POSITIONS 583 TO 586)
				UB-92 REVENUE CODE-15 CHARGES (POSITIONS 587 TO 594)
				UB-92 REVENUE CODE-15 UNITS (POSITIONS 595 TO 601)
				UB-92 REVENUE CODE-16 DATA (POSITIONS 602 TO 620)
				UB-92 REVENUE CODE-16 (POSITIONS 602 TO 605)
				UB-92 REVENUE CODE-16 CHARGES (POSITIONS 606 TO 613)
				UB-92 REVENUE CODE-16 UNITS (POSITIONS 614 TO 620)
				UB-92 REVENUE CODE-17 DATA (POSITIONS 621 TO 639)
				UB-92 REVENUE CODE-17 (POSITIONS 621 TO 624)
				UB-92 REVENUE CODE-17 CHARGES (POSITIONS 625 TO 632)
				UB-92 REVENUE CODE-17 UNITS (POSITIONS 633 TO 639)
				UB-92 REVENUE CODE-18 DATA (POSITIONS 640 TO 658)
				UB-92 REVENUE CODE-18 (POSITIONS 640 TO 643)
				UB-92 REVENUE CODE-18 CHARGES (POSITIONS 644 TO 651)
				UB-92 REVENUE CODE-18 UNITS (POSITIONS 652 TO 658)
				UB-92 REVENUE CODE-19 DATA (POSITIONS 659 TO 677)
				UB-92 REVENUE CODE-19 (POSITIONS 659 TO 662)
				UB-92 REVENUE CODE-19 CHARGES (POSITIONS 663 TO 670)
				UB-92 REVENUE CODE-19 UNITS (POSITIONS 671 TO 677)

MEDICAID ANALYTIC EXTRACT INPATIENT RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
				UB-92 REVENUE CODE-20 DATA (POSITIONS 678 TO 696) UB-92 REVENUE CODE-20 (POSITIONS 678 TO 681) UB-92 REVENUE CODE-20 CHARGES (POSITIONS 682 TO 689) UB-92 REVENUE CODE-20 UNITS (POSITIONS 690 TO 696) UB-92 REVENUE CODE-21 DATA (POSITIONS 697 TO 715) UB-92 REVENUE CODE-21 (POSITIONS 697 TO 700) UB-92 REVENUE CODE-21 CHARGES (POSITIONS 701 TO 708) UB-92 REVENUE CODE-21 UNITS (POSITIONS 709 TO 715) UB-92 REVENUE CODE-22 DATA (POSITIONS 716 TO 734) UB-92 REVENUE CODE-22 (POSITIONS 716 TO 719) UB-92 REVENUE CODE-22 CHARGES (POSITIONS 720 TO 727) UB-92 REVENUE CODE-22 UNITS (POSITIONS 728 TO 734) UB-92 REVENUE CODE-23 DATA (POSITIONS 735 TO 753) UB-92 REVENUE CODE-23 (POSITIONS 735 TO 738) UB-92 REVENUE CODE-23 CHARGES (POSITIONS 739 TO 746) UB-92 REVENUE CODE-23 UNITS (POSITIONS 747 TO 753)
45. UB-92 REVENUE CODE	NUM	4	317 320	A CODE WHICH IDENTIFIES A SPECIFIC ACCOMMODATION, ANCILLARY SERVICE OR BILLING CALCULATION (AS DEFINED BY THE UB-92 BILLING MANUAL, FORM LOCATOR 42). 4 DIGIT <i>USER NOTE: ONLY VALID CODES DEFINED BY THE NATIONAL UNIFORM BILLING COMMITTEE ARE USED. IF MORE THAN 23 CODES ARE CAPTURED IN THE STATE CLAIMS SYSTEM, ONLY THE FIRST 23 ARE REPORTED IN MSIS. WHEN THE STATE CAPTURES FEWER THAN 23 CODES, DATA ELEMENTS WHERE CODING IS NOT APPLICABLE ARE 8-FILLED. WHEN THE UB-92 REVENUE CODE IS UNKNOWN, THIS DATA ELEMENT IS 9-FILLED.</i> SOURCE: MSIS CLAIMS FILE: "UB-REV-CODE-1".

MEDICAID ANALYTIC EXTRACT INPATIENT RECORD (1999 AND LATER YEARS)

NAME	TYPE	POSITIONS		CONTENTS
		LENGTH	BEG END	
46. UB-92 REVENUE CODE CHARGE	NUM	8	321 328	<p>THE TOTAL CHARGE FOR THE RELATED UB-92 REVENUE CODE. TOTAL CHARGES INCLUDE BOTH COVERED AND NON-COVERED CHARGES (AS DEFINED BY THE UB-92 BILLING MANUAL, FORM LOCATOR 47).</p> <p>8 DIGITS SIGNED (SAS USERS: ZONED DECIMAL - ZD8)</p> <p><i>USER NOTE: IF MORE THAN 23 CODES ARE CAPTURED IN THE STATE CLAIMS SYSTEM, ONLY THE FIRST 23 ARE REPORTED IN MSIS. WHEN THE STATE CAPTURES FEWER THAN 23 CODES, DATA ELEMENTS WHERE CODING IS NOT APPLICABLE ARE 8-FILLED. IF THE CHARGE AMOUNT IS MISSING OR INVALID, THESE DATA ELEMENTS ARE ZERO -FILLED. THE SUM OF ALL 23 UB-92 REVENUE CODE CHARGES IS LESS THAN OR EQUAL TO CHARGE AMOUNT (DATA ELEMENT #27).</i></p> <p>SOURCE: MSIS CLAIMS FILE: "UB-REV-CHARGE-1".</p>
47. UB-92 REVENUE CODE UNITS	NUM	7	329 335	<p>UNITS ASSOCIATED WITH THE RELATED UB-92 REVENUE CODE. THIS DATA ELEMENT IS A QUANTITATIVE MEASURE OF SERVICES RENDERED FOR THE RELATED UB-92 REVENUE CODE. EXAMPLES INCLUDE ITEMS SUCH AS THE NUMBER OF ACCOMMODATION DAYS, MILES, PINTS OF BLOOD OR RENAL DIALYSIS TREATMENTS (AS DEFINED BY THE UB-92 BILLING MANUAL, FORM LOCATOR 46).</p> <p>7 DIGITS</p> <p><i>USER NOTE: IF MORE THAN 23 CODES ARE CAPTURED IN THE STATE CLAIMS SYSTEM, ONLY THE FIRST 23 ARE REPORTED IN MSIS. WHEN THE STATE CAPTURES FEWER THAN 23 CODES, DATA ELEMENTS WHERE CODING IS NOT APPLICABLE ARE 8-FILLED. IF THE UNITS ARE MISSING OR INVALID, THESE DATA ELEMENTS ARE ZERO-FILLED.</i></p> <p>SOURCE: MSIS CLAIMS FILE: "UB-REV-UNITS-1".</p>