# MEDS III Data Element Dictionary

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# MEDS III DATA ELEMENT DICTIONARY

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# I. Introduction

This ***MEDS III Data Element Dictionary*** contains descriptive information for the data elements that are required for submission by health care organizations as part of the redesigned Medicaid Encounter Data System (MEDS III). This document contains requirements by MEDS III Category of Service (COS), the transaction layout for data submission, descriptions of the individual data elements and an Appendices section.

An encounter is a professional face-to-face contact or transaction between an enrollee and a provider who delivers services. An encounter is comprised of the procedure(s) or service(s) rendered during the contact. An encounter should be operationalized in an information system as each unique occurrence of recipient and provider. Up to ten separate dates of service can be reported on one encounter line. All claim detail lines should be rolled up under the same encounter control number when possible. If a claim contains more than ten service lines, a second (continuation) encounter should be created with its own unique encounter control number to report the additional lines. Encounters for all incurred services in the plan's benefit package must be reported. Referrals to services outside of the benefit package, which are covered by another payer, should not be reported.

In general, the enrollee must be physically present for an encounter to be recorded. The exception to this criterion is laboratory services. Provider consultation with another provider about an enrollee in the absence of the enrollee or the act of referring the enrollee to another provider in the plan's network is not considered an encounter (the encounter resulting from the referral would be reported by that provider), nor is provider consultation with a third party for the purpose of developing and obtaining services for an enrollee.

There are four Encounter Types for which records are to be submitted:

- Institutional: Encounters extracted from electronic media 837I format or UB-92 paper claims (Encounter Type = “I”). Institutional encounters are reflective of both inpatient (COS 11) and non-inpatient services.
- Pharmacy: Encounters extracted from NCPDP format (Encounter Type = “D”).
- Dental: Encounters extracted from electronic media 837D format or ADA paper claims (Encounter Type = “T”).
- Professional: Encounters extracted from electronic media 837P format or CMS-1500 paper claims (Encounter Type = “P”).

Similar to the legacy MEDS system, each encounter will consist of a common segment and a detail segment (Institutional, Pharmacy, Dental or Professional).

All managed care plan types will report encounter data, however, not all segments will apply to every plan type. All services defined in a plan’s benefit package should be reported. Both paid and administratively denied services should be reported.

Each descriptive data element page in this data dictionary contains the following information:

MEDS III Transaction Segment**:** The MEDS III Transaction Segment that the data element applies to: Common Detail, Institutional, Pharmacy, Dental or Professional.

Data Element Name: The name of the MEDS III data element being described.

Submission Status: Whether the data element is optional, situational upon other information (e.g., other payer data) or required for reporting. If required for reporting, the MEDS Categories of Service (COS) that the data element applies to are listed.
Encounter Record Position(s): The positions on the transaction layout where the data should be reported.
Format - Length: The format (Character, Numeric, Date) and length of the data element.
Effective Date: This version of the data dictionary is dated 2/26/2015 forward.
Version Number - Date: This version of the data dictionary is Version 3.3 – February 2014.
MEDS III DE#/ DW#: eMedNY Data Element Number and Data Warehouse numbers (if applicable).
Definition: A description of the data element.
Mapping: The form based and electronic media mapping for the data element (if applicable).
Codes and Values: Valid codes and values for the data element.
Edit Applications: Edits applicable to the input record.

***Reporting***
Encounters submitted more than two years after the date of service will be rejected.

Encounter files must be submitted in accordance with the model contract and should include encounters incurred and processed by health organizations, as well as records that were previously submitted and rejected.

There are currently no size limits for production files. **However, test files are limited in size up to 1,000 encounters and (15) fifteen submissions per day based on user ID.**

***Connectivity Options***
Electronic submissions are available through eMedNY eXchange, file transfer protocol (FTP) or eMedNY FTS via SOAP.

**Information requests for MEDS III data submissions should be directed to CSC Provider Relations staff at: MEDSSupport@csc.com**

In order to utilize the MEDS III testing and production environments, a health plan must have established components of the following:

- An active New York State Medicaid Provider ID (MMIS ID);
- An active Provider Transmission Supplier Number (TSN); and
- An active eMedNY eXchange or FTP account.

**Connectivity Options**

| **Access Method** | |
|---|---|
| Internet batch file submission via eMedNY eXchange | Batch files may be conducted via https://emex.emedny.org/login.aspx?appName=emex. |
| Dial-up batch file submission using File Transfer Protocol (FTP) over Transmission Control Protocol/Internet Protocol (TCP/IP) | Dial-up batch submissions using FTP may be conducted by using 866-488-3006 and connecting to 172.27.16.79.<br><br>FTP connection should be established through MS-DOS for best results. Users will have to change the setting to 'binary' by using the 'bin' command. Follow the FTP instructions to ensure that the file is named properly. See MEVS Batch Authorization Manual |

| Access Method | |
|---|---|
| | http://www.emedny.org/ProviderManuals/index.html. |
| eMedNY File Transfer Service (FTS) using Service Oriented Architecture (SOA) with the Simple Object Access Protocol (SOAP) | Access to the eMedNY FTS via SOAP must be obtained through an enrollment process that results in the creation of an eMedNY SOAP Certificate and a SOAP Administrator.<br><br>Contact CSC Provider Relations Staff at: MEDSSupport@csc.com |

***Submission***

Plans are allowed to submit files on a daily basis. The list below indicates 2014-2015 extract dates of that month's data feed to NYSDOH. Anything accepted after the extract date will be included in the department's next month data feed. Test data are not included in the department's data feed. **Also, please remember to account for a minimum of a seven (7) day lag in processing.**

**2015 Data Extract Schedule:**

December 25, 2014
January 22, 2015
February 19, 2015
March 19, 2015
April 23, 2015
May 21, 2015
June 18, 2015
July 23, 2015
August 20, 2015
September 24, 2015
October 22, 2015
November 19, 2015
December 24, 2015

***Edits***

Data elements will be edited for missing or invalid data elements, duplicate encounters and valid enrollment in MMC. A Supplemental Manual of current encounter edit numbers, descriptions and severity is included as Appendix D. The following describes "Tier One Edits", or fatal edits which will stop a file from being processed.

**Tier One Edits**

| Tier One Error | Message Returned |
|---|---|
| Record is not 3000 bytes | 'Incomplete " ", Header Record' – will give the size and record that is not 3000 bytes |
| Required records missing (H1, D1, and a T1) | Required " " record missing' – will include the record type missing |
| Required records not in sequence (H1, D1, and a T1) | 'Record " " is of unknown type or invalid sequence' – will include the record type in error |
| Test/Prod indicator is incorrect – must be PROD | 'Specified mode " " does not match' 'Test/Prod Indicator' |

| Tier One Error | Message Returned |
|---|---|
| The carriage return (CR) is too short/long or misaligned | 'Misaligned ASCII " ", "CR" in record " " column " " '<br>'Unexpected ASCII " ", "CR" in record " " column " " ' |
| Newline/linefeed (NL) in record | 'Unexpected ASCII " ", "NL" in record " " column " " ' |
| Non-printable characters in file | 'Non-ASCII character' |
| End of file not in the correct place | 'Premature end-of-file' |
| No records are found | 'FILE CONTAINS NO CLAIM RECORDS' |
| H1 record is found when unexpected | 'UNEXPECTED H1 RECORD RECEIVED' 'AT RECORD #:' |
| H1 record is not found when expected (after user record) | 'EXPECTED H1 CONTROL RECORD NOT RECEIVED' 'AT RECORD #:' |
| D1 record is found, and it is expected, and the encounter type is other than I, D, T, or P | 'INVALID D1 RECORD RECEIVED' 'AT RECORD #:' |
| D1 record is found when unexpected | 'UNEXPECTED D1 RECORD RECEIVED' 'AT RECORD #:' |
| D1 record is not found when expected | 'EXPECTED D1 CONTROL RECORD NOT RECEIVED' 'AT RECORD #:' |
| T1 record is found when unexpected | 'UNEXPECTED T1 RECORD RECEIVED' 'AT RECORD #:' |
| Record is other than H1, D1, or T1 | 'RECEIVED RECORD NOT H1/D1/T1"AT RECORD #:' |
| Provider Check Digit | The Provider Identification is Invalid |
| Provider Zip Code | The Provider Service Location is Invalid/Non-Numeric |

***Response Reports***

Plans will receive a transmission file confirming the acceptance or rejection of each encounter file submitted. Files will stay within the plan's eMedNY Exchange mailbox for a period of twenty-eight (28) days. Responses returned via FTP will remain in the plan's FTP directory for twenty-eight (28) days or until downloaded. Plans will also receive a response file for all encounter files submitted during the processing cycle. When submitting to the Provider Test Environment (PTE) the processing cycle happens daily and the plan will receive a response file the following day after a test file is processed. When submitting to the Production System the processing cycle pulls encounter files in daily and processes them in a weekly cycle. Therefore, you will receive your response file 7 days after processing. The response file provides valuable feedback to the Plan on the quality of the encounter data submitted. The plan will receive information on whether the record was accepted or rejected as well as up to 24 edits.

**Response File Layout**

| Data Element | Width | Record Positions |
|---|---|---|
| Encounter Control Number | 11 | 1-11 |
| Claim Line Number | 04 | 12-15 |
| Edit Status Code | 01 | 16 |
| Claim Edit Code | 05 | 17-21 |
| COS Code | 04 | 22-25 |

| Data Element | Width | Record Positions |
|---|---|---|
| Transaction Control Number (TCN) | 16 | 26-41 |
| Plan ID | 08 | 42-49 |
| TSN | 03 | 50-52 |
| Filler | 28 | 53-80 |

***Encounter Control Number***
Encounter Control Number is a Managed Care Organization (MCO) assigned number used to uniquely identify an encounter transaction.

***Claim Line Number***
Claim Line Number specifies the line number of the service.
Line numbers 01 through 10 will be used to identify service line errors in the encounter record.
A value of 00 with an Edit Status Code of P will indicate the entire record has been accepted, with no edits.
A value of 00 and an Edit Status Code of 2 will indicate the entire record has been rejected. The error is identified through the Claim Edit Code.

***Edit Status Code***
Edit Status Code specifies the disposition of an edit that has been posted to a claim.
Valid codes and values include:

| Edit Status Code | Edit Severity |
|---|---|
| 2 | H=Hard Edit (Rejected) |
| 3 | S=Soft Edit (Accept) |
| P | Record passed through with no edits. |

***Claim Edit Code***
Claim Edit Code is a unique code attached to a claim as the result of logic applied during the claim adjudication cycle. The most current list of applicable edit codes, descriptions and severity status, by Encounter Type Indicator, Claim Type and Category of Service is listed as Appendix D, and is also available in the **MEDS III Supplemental Manual on Applicable Edits**.

***MEDS Category of Service Code***
MEDS Category of Service Code categorizes provider services for the processing and reporting.

| Code | Value |
|---|---|
| 01 | Physician Services |
| 03 | Podiatry |
| 04 | Psychology |
| 05 | Eye Care / Vision |
| 06 | Rehabilitation Therapy |
| 07 | Nursing |
| 11 | Inpatient |
| 12 | Institutional LTC |
| 13 | Dental |
| 14 | Pharmacy |
| 15 | Home Health Care/Non-Institutional Long Term Care |
| 16 | Laboratories |

| Code | Value |
|---|---|
| 19 | Transportation |
| 22 | DME and Hearing Aids |
| 28 | Intermediate Care Facilities |
| 41 | NPs/Midwives |
| 73 | Hospice |
| 75 | Clinical Social Worker |
| 85 | Freestanding Clinic |
| 87 | Hospital OP/ER Room |

***Transaction Control Number***

Transaction Control Number is a unique identifier assigned to each claim or encounter transaction received. This number is essential to adjust or void records.

***Reconciling the Response Report***

The plan should use the response report data elements to appropriately tag the encounter status for their internal data system, and resubmit rejected or edited records as appropriate.

Plans should use the [Encounter Control Number (ECN), Line Number, Edit Status Code, Claim Edit Number, Category of Service (COS), and Transaction Control Number (TCN)] to match the status of each line of your encounter.

Since the Response File will report errors on a service line level Plans should be aware of four general rules about feedback reports:

Rule # 1: If the encounter record passes through without any edits, one record line is reported with an edit status code of 'P' at line number '0000'. The Plan should store the associated TCN and the Accepted status in their data system. Any changes to these records should be handled as an adjustment.

Rule # 2: If the encounter record rejects at the header level (line number '0000' and Edit Status Code = '2') the entire encounter is rejected. Plans should correct all errors identified and resubmit the encounter as an original.

Rule # 3: If the encounter record includes both accepted and rejected service lines (line number(s) = '01' – '10' and Edit Status Codes of '2' and '3') the encounter record has been partially accepted. The Plan should store the associated TCN and the accepted and rejected status at each service line. All corrections to the encounter should be handled as an adjustment to the original encounter.

Rule # 4: For every adjusted encounter the Plan will receive two response lines back. The eMedNY claim system creates a 'void' line that removes the original encounter. It then creates a new replacement/adjustment line. The first TCN, which represents the 'void' line, will always end in '1'. Plans should disregard this TCN. The second TCN, which represents the 'replacement/adjustment' line, will always end in '2'. Plans should store this TCN with the new encounter record.

*Additional MEDS III Information and Reference Materials*

MEDS Home Page on the HCS:
For up to date information on MEDS III reporting requirements and associated activities, please visit the MEDS Home Page on the Health Commerce System (HCS) internet site at the following link: https://commerce.health.state.ny.us/hcsportal/appmanager/hcs/home.

CSC Contact Information:
Provider Services, Suite 270, 2nd Floor
MEDSSupport@csc.com
Fax: (518) 257-4637
www.csc.com

Visit the Help Desk at: http://www.emedny.org/HIPAA/index.html

MEDS-L Discussion Group:
To join the MEDS-L Listserv discussion group, please contact the MEDS Unit at omcmeds@health.ny.gov.

Please contact us at:

Provider Network - MEDS Compliance Unit
Bureau of Managed Care Fiscal Oversight
Division of Health Plan Contracting and Oversight
Office Health Insurance Programs
New York State Department of Health
Corning Tower, Room 2040
Empire State Plaza
Albany, New York 12237

Phone: (518) 474-5050
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Email: omcmeds@health.ny.gov

# II. ENCOUNTER TYPE ASSIGNMENT BY CATEGORY OF SERVICE

For MEDS III submissions, the Category of Service (COS) must be applicable to the encounter type being reported. The table below indicates submission standards for encounter types by MEDS COS. (The Encounter Type Indicator is reflective of the form or electronic media in which the encounter is being submitted to the health organization.)

| ***Category of Service*** | | ***Encounter Type*** | | ***Form Type/ EDI*** |
|---|---|---|---|---|
| **Code** | **Value** | **Code** | **Value** | |
| 01 | Physician Services | P | Professional | CMS-1500 / 837P |
| 03 | Podiatry | P | Professional | CMS-1500 / 837P |
| 04 | Psychology | P | Professional | CMS-1500 / 837P |
| 05 | Eye Care / Vision* | P | Professional | CMS-1500 / 837P |
| 06 | Rehabilitation Therapy | I | Institutional | UB-92 / 837I |
| 07 | Nursing | P | Professional | CMS-1500 / 837P |
| 11 | Inpatient | I | Institutional | UB-92 / 837I |
| 12 | Institutional LTC | I | Institutional | UB-92 / 837I |
| 13 | Dental | T | Dental | ADA / 837D |
| 14 | Pharmacy | D | Pharmacy/DME | NCPDP |
| 15 | Home Health Care/Non-Institutional Long Term Care | I | Institutional | UB-92 / 837I |
| 16 | Laboratories** | P | Professional | CMS-1500 / 837P |
| 19 | Transportation | P | Professional | CMS-1500 / 837P |
| 22 | DME and Hearing Aids | P | Professional | CMS-1500 / 837P |
| 28 | Intermediate Care Facilities | I | Institutional | UB-92 / 837I |
| 41 | NPs/Midwives | P | Professional | CMS-1500 / 837P |
| 73 | Hospice | I | Institutional | UB-92 / 837I |
| 75 | Clinical Social Worker | P | Professional | CMS-1500 / 837P |
| 85 | Freestanding Clinic | I | Institutional | UB-92 / 837I |
| 87 | Hospital OP/ER Room | I | Institutional | UB-92 / 837I |

* Eye glasses should be reported using a HCPCS code and COS 05 Eye Care/Vision.

**If laboratory data is submitted on a UB-92 form, these services should be reported under COS 85 (Freestanding Clinic) or COS 87 (Hospital Outpatient) with an Encounter Type Indicator of “I” and a provider specialty code of “599” All Laboratories.

# III. MEDS III DATA ELEMENT REPORTING

**Header Record Segment**

| Record Positions | Data Element - Header | Data Type | Field Length | Submission Status | Description |
|---|---|---|---|---|---|
| 1-2 | Record Type | Character | 2 | Required | H1=Header |
| 3-6 | Provider Transmission Supplier Number (TSN) | Character | 4 | Required | Provider Transmission Supplier Number (TSN) is a unique number assigned to the health organization submitting encounter records. The TSN should be left-justified and space-filled. |
| 7-12 | Input Serial Number | Character | 6 | Required | |
| 13-21 | TSN Certification | Character | 9 | Required | This field should contain the word “CERTIFIED”. |
| 22-26 | Vendor Software Number | Character | 5 | Optional | |
| 27-28 | Vendor Software Update Level | Character | 2 | Optional | |
| 29-32 | Test / Prod Indicator | Character | 4 | Required | This field must contain either the word “TEST” or “PROD”. |
| 33-40 | Plan Identification Number | Character | 8 | Required | The health organization’s MMIS ID number |
| 41-61 | Submitter Name | Character | 21 | Required | Submitter Name is the name of the health organization as used on official State records. |
| 62-79 | Submitter Address 1 | Character | 18 | Required | Submitter Address Line is the street address for the health organization submitting encounter data. |
| 80-97 | Submitter Address 2 | Character | 18 | Required | |
| 98-112 | Submitter Address City | Character | 15 | Required | Submitter Address City is the city in which the health organization does business or to which correspondence should be sent. |
| 113-114 | Submitter Address State | Character | 2 | Required | Submitter Address State/Province Code is the two character standard state postal code (i.e., NY) |
| 115-123 | Submitter Zip | Character | 9 | Required | This element specifies the health organizations geographic area denoted by the postal ZIP code. |
| 124-134 | Submitter Fax Number | Character | 11 | Required | Submitter Fax Number is the facsimile number for the health organization. |
| 135-145 | Submitter Phone Number | Character | 11 | Required | Phone Number is the telephone number of the health organization, including 1 and the area code and seven-digit number. |
| 146-148 | MEDS Version Number | Character | 3 | Required | Will contain “003” |
| 149-3000 | FILLER | Character | 2852 | Required | Space fill positions 149-3000. |

**Common Detail Segment**

| Record Positions | Data Element - Common Detail | Format | Field Length | Submission Status | Description |
|---|---|---|---|---|---|
| 1-2 | Record Type | Character | 2 | Required | D1=Detail |
| 3 | Encounter Type Indicator (ETI) | Character | 1 | Required | The code that indicates the type of encounter being reported: I=Institutional; D=Pharmacy; T=Dental; P=Professional. |
| 4-14 | Encounter Control Number (ECN) | Character | 11 | Required | Encounter Control Number is a health organization assigned number used to uniquely identify an encounter transaction. |
| 15-30 | Previous Transaction Control Number (TCN) | Character | 16 | Situational | Transaction Control Number (TCN) is a unique identifier assigned by CSC to each encounter transaction received. The TCN is used for internal control purposes and by plans to adjust or void records identified as failing soft edits. |
| 31 | Transaction Status Code | Character | 1 | Required | Transaction Status Code identifies a transaction as an original encounter or a voids or adjustment to a previously submitted encounter. |
| 32-39 | Client Identification Number | Character | 8 | Required | The CIN is assigned by the state to an enrollee upon determination that an individual is eligible for Medicaid services. |
| 40-64 | Beneficiary Identification Number | Character | 25 | Optional | Beneficiary Identification Number is an identifier given to an individual by the health organization for their internal purposes. |
| 65-67 | Provider Profession Code | Character | 3 | Required | Provider Profession Code specifies the profession of a Provider on the state license file. |
| 68-75 | Provider License Number | Character | 8 | Required | Provider License Number is an identifying number issued by the state licensing board, authorizing a provider to practice within that state under the specific license type applicable to the provider. |
| 76-85 | Provider Identification Number (NPI or MMIS ID) | Character | 10 | Required | National Provider Identification Number (NPI) is a unique number assigned to each provider. If the provider type in not recognized by NPI, you would report the unique MMIS Provider Id recognized in the Medicaid program. |
| 86-94 | Provider Service Location | ZIP+4 | 9 | Required | The Zip Code + 4 of the Service Location of the Provider on the encounter. |
| 95-96 | Category of Service (COS) Code | Character | 2 | Required | Category of Service is a two-digit code that classifies the services in the encounter. |
| 97-107 | Total Charged Amount | Numeric | 11 | Required | The total amount charged for each listed service. |

| Record Positions | Data Element - Common Detail | Format | Field Length | Submission Status | Description |
|---|---|---|---|---|---|
| 108-118 | Total Paid Amount | Numeric | 11 | Required | The total amount Medicaid paid for each listed service. |
| 119-129 | Medicare Total Paid Amount | Numeric | 11 | Required | The total amount Medicare paid for listed services that are received by dual eligible Medicaid/Medicare enrollees or beneficiaries. This is the Medicare Total Paid Amount on the Header Level. |
| 130-140 | Other Insurance Total Paid Amount | Numeric | 11 | Situational | Total amount paid by insurance other than Medicaid (if applicable). Medicare cost data should be reported the Medicare paid amount data fields. |
| 141-175 | Other Payer Name | Character | 35 | Situational | Other Payer Name identifies the secondary payer on the encounter (if applicable). |
| 176-177 | Other Insurance Type Code | Character | 2 | Situational | A code indicating insurance payers other than Medicaid (if applicable). |
| 178-188 | Medicare Total Deductible Paid | Numeric | 11 | Required | The amount the beneficiary is required to pay for health care or prescriptions before Medicare paid for the treatment. |
| 189-199 | Medicare Total Co-Insurance Paid | Numeric | 11 | Required | The amount the beneficiary is required to pay for healthcare services which is a set percentage of the covered costs after the deductible has been paid before Medicare paid for the treatment. |
| 200-210 | Medicare Total Copay Paid | Numeric | 11 | Required | The specified amount the beneficiary is required to pay out-of-pocket for healthcare services at the time the service is rendered before Medicare paid for the treatment. |
| 211-221 | Other Insurance Total Deductible Paid | Numeric | 11 | Required | The amount the beneficiary is required to pay for health care or prescriptions before the Other Payer paid for the treatment. |
| 222-232 | Other Insurance Total Co-Insurance Paid | Numeric | 11 | Required | The amount the beneficiary is required to pay for healthcare services which is a set percentage of the covered costs after the deductible has been paid before the Other Payer paid for the treatment. |
| 233-243 | Other Insurance Total Copay Paid | Numeric | 11 | Required | The specified amount the beneficiary is required to pay out-of-pocket for healthcare services at the time the service is rendered before the Other Payer paid for the treatment. |
| 244-257 | FILLER | Character | 14 | Required | Space-fill positions 244 to 257. |

| Record Positions | Data Element - Common Detail | Format | Field Length | Submission Status | Description |
|---|---|---|---|---|---|
| Individual Record Type Segments (i.e. Institutional, Pharmacy, Professional, Dental) fill positions 258-3000 | | | | | |

**Institutional Segment**

| Record Positions | Data Element - Institutional | Format | Field Length | Submission Status | Description |
|---|---|---|---|---|---|
| 258-260 | Provider Specialty Code | Character | 3 | Required: COS 06, 12, 15, 28, 73, 85, 87 | A code that identifies a provider's medical, dental, clinic or program type specialty. |
| 261 | Hospital Inpatient Claim/Encounter Indicator | Character | 1 | Required: COS 11 | Indicates whether the service provided was a capitated service within the health organization's contract ("E"); a within plan claim ("C") or an administratively denied service ("A"). |
| 262-265 | New York State Diagnosis Related Group Code | Character | 4 | Required: COS 11 | The NYS APR-DRG code assigned by the providing hospital to the inpatient stay for billing purposes. |
| 266-267 | Type of Bill Digits 1 & 2 Code | Character | 2 | Required: COS 06, 11, 12, 15, 28, 73, 85, 87 | The first two digits of a three-digit alphanumeric code. The first digit identifies the type of facility. The second classifies the type of care. |
| 268 | Type of Bill Digit 3 Code | Character | 1 | Required: COS 06, 11, 12, 15, 28, 73, 85, 87 | The third digit of a three digit alphanumeric code. The third digit indicates the sequence of the bill in the particular episode of care. It is referred to as the "frequency" code. |
| 269-276 | Statement Covers Period From | Date CCYYMMDD | 8 | Required: COS 06, 12, 15, 28, 73, 85, 87 | The begin date of the encounter period. |
| 277-284 | Statement Covers Period Thru | Date CCYYMMDD | 8 | Required: COS 06, 12, 15, 28, 73, 85, 87 | The end date of the encounter period. |
| 285 | Type of Admission | Character | 1 | Required: COS 11 | One-digit alphanumeric code indicating priority of the admission. |

| Record Positions | Data Element - Institutional | Format | Field Length | Submission Status | Description |
|---|---|---|---|---|---|
| 286 | Source of Admission | Character | 1 | Required: COS 11 | One digit alphanumeric code indicating the source of the admission or outpatient registration. |
| 287-288 | Patient Status or Disposition Code | Character | 2 | Required: COS 11, 12, 28, 73 | A two-digit, alphanumeric code indicating the patient's destination or status upon discharge. |
| 289-308 | Medical Record Number | Character | 20 | Required: | The number assigned to the patient's medical/health record by the provider. |
| 309-310<br>318-319 | Neonate Birth Weight Value Code [up to 2] | Character | 2 | Required: COS 11 | All newborn encounters will have a birth weight code of "54". |
| 311-317<br>320-326 | Neonate Birth Weight in Grams (Value Code Amount) [up to 2] | Numeric | 7 | Required: COS 11 | The birth weight of the neonate in grams. |
| 327-334<br>420-427<br>513-520<br>606-613<br>699-706<br>792-799<br>885-892<br>978-985<br>1071-1078<br>1164-1171 | Service Date [up to 10] | Date CCYYMMDD | 8 | Required: COS 06, 12, 15, 28, 73, 85, 87 | The associated Service Date for the reported CPT/HCPCS or Revenue code(s) describing non-inpatient procedure(s) performed. |
| 335-338<br>428-431<br>521-524<br>614-617<br>707-710<br>800-803<br>893-896<br>986-989<br>1079-1082<br>1172-1175 | Revenue Code [up to 10] | Character | 4 | Required: COS 06, 11, 12, 15, 28, 73, 85, 87 | The revenue code assigned for each cost center for which a separate charge is billed. |
| 339-343<br>432-436<br>525-529 | CPT/HCPCS Code [up to 10] | Character | 5 | Required COS 06, 11, 12, 15, 28, 73, 85, 87 | CPT/HCPCS code(s) describing non-inpatient procedure(s) performed. |

| Record Positions | Data Element - Institutional | Format | Field Length | Submission Status | Description |
|---|---|---|---|---|---|
| 618-622<br>711-715<br>804-808<br>897-901<br>990-994<br>1083-1087<br>1176-1180 | | | | | |
| 344-345<br>437-438<br>530-531<br>623-624<br>716-717<br>809-810<br>902-903<br>995-996<br>1088-1089<br>1181-1182 | Procedure Modifier Code 1 [up to 10] | Character | 2 | Required: COS 06, 12, 15, 28, 73, 85, 87 | Procedure Modifier Codes are used in conjunction with the CPT procedure code to uniquely describe the service(s) rendered by a provider during an encounter. Fields for reporting a single modifier on each of the up to ten procedures or services are available. |
| 346-347<br>439-440<br>532-533<br>625-626<br>718-719<br>811-812<br>904-905<br>997-998<br>1090-1091<br>1183-1184 | Procedure Modifier Code 2 [up to 10] | Character | 2 | Required: COS 06, 12, 15, 28, 73, 85, 87 | Procedure Modifier Codes are used in conjunction with the CPT procedure code to uniquely describe the service(s) rendered by a provider during an encounter. Fields for reporting a single modifier on each of the up to ten procedures or services are available. |
| 348-349<br>441-442<br>534-535<br>627-628<br>720-721<br>813-814<br>906-907<br>999-1000 | Procedure Modifier Code 3 [up to 10] | Character | 2 | Required: COS 06, 12, 15, 28, 73, 85, 87 | Procedure Modifier Codes are used in conjunction with the CPT procedure code to uniquely describe the service(s) rendered by a provider during an encounter. Fields for reporting a single modifier on each of the up to ten procedures or services are available. |

| Record Positions | Data Element - Institutional | Format | Field Length | Submission Status | Description |
|---|---|---|---|---|---|
| 1092-1093<br>1185-1186 | | | | | |
| 350-351<br>443-444<br>536-537<br>629-630<br>722-723<br>815-816<br>908-909<br>1001-1002<br>1094-1095<br>1187-1188 | Procedure Modifier Code 4 [up to 10] | Character | 2 | Required:<br>COS 06, 12, 15, 28, 73, 85, 87 | Procedure Modifier Codes are used in conjunction with the CPT procedure code to uniquely describe the service(s) rendered by a provider during an encounter. Fields for reporting a single modifier on each of the up to ten procedures or services are available. |
| 352-362<br>445-455<br>538-548<br>631-641<br>724-734<br>817-827<br>910-920<br>1003-1013<br>1096-1106<br>1189-1199 | Quantity or Units Submitted [up to 10] | Numeric | 11 | Required:<br>COS 06, 12, 15, 28, 73, 85, 87 | When revenue codes are assigned, this data element quantifies services by revenue category (e.g., number of days of a particular accommodation, pints of blood.) However, when CPT/HCPCS codes are assigned, units are equal to the number of times the procedure/service being reported was performed. |
| 363-373<br>456-466<br>549-559<br>642-652<br>735-745<br>828-838<br>921-931<br>1014-1024<br>1107-1117<br>1200-1210 | NDC (Formulary) Code [up to 10] | Character | 11 | Required:<br>COS 06, 12, 15, 28, 73, 85 | An 11-digit national drug identification number assigned by the Federal Drug Administration (or the HCPCS code) used to identify Durable Medical Equipment, Hearing Aids, OTC medications or other pharmacy products without an NDC code. |
| 374-385<br>467-478<br>560-571 | NDC (Formulary) Units [up to 10] | Numeric | 12 | Required:<br>COS 06, 12, 15, 28, 73, 85 | The dispensing quantity based upon the unit of measure as defined by the National Drug Code. |

| Record Positions | Data Element - Institutional | Format | Field Length | Submission Status | Description |
|---|---|---|---|---|---|
| 653-664<br>746-757<br>839-850<br>932-943<br>1025-1036<br>1118-1129<br>1211-1222 | | | | | |
| 386-396<br>479-489<br>572-582<br>665-675<br>758-768<br>851-861<br>944-954<br>1037-1047<br>1130-1140<br>1223-1233 | Charged Amount [up to 10] | Numeric | 11 | Required:<br>COS 06, 12, 15, 28, 73, 85, 87 | The amount charged for each listed service corresponding to the procedures defined in the CPT/HCPCS data element. |
| 397-407<br>490-500<br>583-593<br>676-686<br>769-779<br>862-872<br>955-965<br>1048-1058<br>1141-1151<br>1234-1244 | Medicare Paid Amount [up to 10] | Numeric | 11 | Required:<br>COS 06, 12, 15, 28, 73, 85, 87 | The amount Medicare paid for each listed service line that is received by dual eligible Medicaid/Medicare enrollees or beneficiaries. A service line is identified through either CPT/HCPCS procedure codes or revenue codes. This is the Medicare Paid Amount on the service line. |
| 408-418<br>501-511<br>594-604<br>687-697<br>780-790<br>873-883<br>966-976<br>1059-1069 | Paid Amount [up to 10] | Numeric | 11 | Required:<br>COS 06, 12, 15, 28, 73, 85, 87 | The amount Medicaid paid for each listed service corresponding to the procedures defined in the CPT/HCPCS data element. |

| Record Positions | Data Element - Institutional | Format | Field Length | Submission Status | Description |
|---|---|---|---|---|---|
| 1152-1162<br>1245-1255 | | | | | |
| 419<br>512<br>605<br>698<br>791<br>884<br>977<br>1070<br>1163<br>1256 | Non-Inpatient Claim/Encounter Indicator [up to 10] | Character | 1 | Required:<br>COS 06, 12, 15, 28, 73, 85, 87 | Indicates whether the service provided was a capitated service within the health organization's contract ("E"); a within plan claim ("C") or an administratively denied service ("A"). |
| 1257 | ICD Version Code | Character | 1 | Required:<br>COS 06, 11, 12, 15, 28, 73, 85, 87 | A one digit code to indicate whether the reported diagnosis is ICD-9 or ICD-10. |
| 1258-1264 | Principal/Primary Diagnosis Code | Character | 7 | Required:<br>COS 06, 11, 12, 15, 28, 73, 85, 87 | The ICD-9-CM or ICD-10 diagnosis code that indicates the primary condition for an inpatient stay. |
| 1265-1271<br>1272-1278<br>1279-1285<br>1286-1292<br>1293-1299<br>1300-1306<br>1307-1313<br>1314-1320 | Other Diagnosis Codes [up to 8] | Character | 7 | Required:<br>COS 06, 11, 12, 15, 28, 73, 85, 87 | Up to eight additional ICD-9-CM or ICD-10 diagnosis codes, indicating additional significant condition(s) during the encounter. |
| 1321-1327<br>1328-1334<br>1335-1341<br>1342-1348<br>1349-1355<br>1356-1362<br>1363-1369<br>1370-1376 | Other Diagnosis Codes [9 to 24] | Character | 7 | Required:<br>COS 06, 11, 12, 15, 28, 73, 85, 87 | Up to sixteen additional ICD-9-CM or ICD-10 diagnosis codes, indicating additional significant condition(s) during the encounter. |

| Record Positions | Data Element - Institutional | Format | Field Length | Submission Status | Description |
|---|---|---|---|---|---|
| 1377-1383<br>1384-1390<br>1391-1397<br>1398-1404<br>1405-1411<br>1412-1418<br>1419-1425<br>1426-1432 | | | | | |
| 1433-1439 | Admit Diagnosis | Character | 7 | Required: COS 11 | The diagnosis that describes the patient's condition upon admission to the hospital. |
| 1440-1446 | External Diagnosis Code (E Code) | Character | 7 | Required: COS 11 | The ICD-9-CM or ICD-10 code for the external cause of an injury, poisoning, or adverse effect. |
| 1447<br>1448<br>1449<br>1450<br>1451<br>1452<br>1453<br>1454<br>1455<br>1456<br>1457<br>1458<br>1459<br>1460<br>1461<br>1462<br>1463<br>1464<br>1465<br>1466<br>1467<br>1468<br>1469 | Present on Admission Code [up to 25] | Character | 1 | Required: COS 11 | Up to 25 instances of a one digit indicator for inpatient diagnoses that denotes whether or not each diagnosis was present at the time of admission. |

| Record Positions | Data Element - Institutional | Format | Field Length | Submission Status | Description |
|---|---|---|---|---|---|
| 1470<br>1471 | | | | | |
| 1472-1478 | Principal Procedure Code | Character | 7 | Required:<br>COS 11 | The ICD-9-CM or ICD-10 procedure code identifying the principal procedure performed during an inpatient stay. |
| 1487-1493<br>1502-1508<br>1517-1523<br>1532-1538<br>1547-1553 | Other Procedure Codes [up to 5] | Character | 7 | Required:<br>COS 11 | ICD-9-CM or ICD-10 Procedure Codes identifying the procedures performed during an inpatient stay |
| 1562-1568<br>1577-1583<br>1592-1598<br>1607-1613<br>1622-1628<br>1637-1643<br>1652-1658<br>1667-1673<br>1682-1688<br>1697-1703<br>1712-1718<br>1727-1733<br>1742-1748<br>1757-1763<br>1772-1778<br>1787-1793<br>1802-1808<br>1817-1823<br>1832-1838 | Other Procedure Codes [6 to 24] | Character | 7 | Required:<br>COS 11 | ICD-9-CM or ICD-10 Procedure Codes identifying the procedures performed during an inpatient stay |
| 1479-1486<br>1494-1501<br>1509-1516<br>1524-1531<br>1539-1546<br>1554-1561 | Procedure Date [1 to 25] | Date<br>CCYYMMDD | 8 | Required:<br>COS 11 | ICD-9-CM or ICD-10 Procedure Codes identifying the procedures performed during an inpatient stay. |

| Record Positions | Data Element - Institutional | Format | Field Length | Submission Status | Description |
|---|---|---|---|---|---|
| 1569-1576<br>1584-1591<br>1599-1606<br>1614-1621<br>1629-1636<br>1644-1651<br>1659-1666<br>1674-1681<br>1689-1696<br>1704-1711<br>1719-1726<br>1734-1741<br>1749-1756<br>1764-1771<br>1779-1786<br>1794-1801<br>1809-1816<br>1824-1831<br>1839-1846 | | | | | |
| 1847-1849 | Attending Provider Profession Code | Character | 3 | Required: COS 06, 11, 12, 15, 28, 73, 85, 87 | The profession code issued by the state of the attending provider for inpatient encounters and the servicing provider for non-Inpatient encounters. |
| 1850-1857 | Attending Provider License Number | Character | 8 | Required COS 06, 11, 12, 15, 28, 73, 85, 87 | The professional license number issued by the state of the attending provider for inpatient encounters and the servicing provider for non-Inpatient encounters. |
| 1858-1867 | Attending Provider ID | Character | 10 | Required COS 06, 11, 12, 15, 28, 73, 85, 87 | The NPI of the attending provider for inpatient encounters and the servicing provider for non-Inpatient encounters. If the provider type is not recognized by NPI, then report the state Medicaid Id. |

| Record Positions | Data Element - Institutional | Format | Field Length | Submission Status | Description |
|---|---|---|---|---|---|
| 1868-1870 | Surgeon Profession Code | Character | 3 | Required: COS 11 | The profession code issued by the State Department of Education that identifies the type of license of the surgeon performing the primary procedure or the surgery. |
| 1871-1878 | Surgeon License Number | Character | 8 | Required: COS 11 | The professional license number, issued by the State Department of Education that identifies the surgeon. |
| 1879-1888 | Surgeon Provider ID | Character | 10 | Required: COS 11 | The NPI number of the surgeon. |
| 1889-1896 | Admission Date | Date CCYYMMDD | 8 | Required: COS 11, 12, 28 | The admit date for the institutional stay. |
| 1897-1904 | Discharge Date | Date CCYYMMDD | 8 | Required: COS 11,12,28 | The date of discharge from an inpatient stay at a hospital. |
| 1905-3000 | FILLER | Character | 1096 | Required | Space-fill positions 1905 to 3000. |

**Pharmacy Segment**

| Record Positions | Data Element - Pharmacy | Format | Field Length | Submission Status | Description |
|---|---|---|---|---|---|
| 258 | Prescription Origin Code | Character | 1 | Required: COS 14 | A one (1) digit indicator that identifies the method which the provider used to transmit the prescription or order to the pharmacy. |
| 259-270 | Prescription Number | Character | 12 | Required: COS 14 | The prescription number assigned by the pharmacy. |
| 271-273 | Prescribing Provider Profession Code | Character | 3 | Required: COS 14 | The profession code issued by the State Department of Education that identifies the type of license of the prescribing provider. |
| 274-281 | Prescribing Provider License Number | Character | 8 | Required: COS 14 | The professional license number, issued by the State Department of Education that identifies the prescribing provider. |
| 282-291 | Prescribing Provider ID | Character | 10 | Required: COS 14 | The NPI number of the prescribing provider. |
| 292-299 | Prescription Ordered Date | Date CCYYMMDD | 8 | Required: COS 14 | The date the prescription was issued by the referring provider. |
| 300-307 | Date Filled | Date CCYYMMDD | 8 | Required: COS 14 | The date the prescription was filled. |

| Record Positions | Data Element - Pharmacy | Format | Field Length | Submission Status | Description |
|---|---|---|---|---|---|
| 308-310 | Drug Days Supply Count | Numeric | 3 | Required: COS 14 | Represents the number of days supply currently dispensed with this prescription service. |
| 311-321<br>357-367<br>403-413<br>449-459<br>495-505<br>541-551<br>587-597<br>633-643<br>679-689<br>725-735<br>771-781<br>817-827<br>863-873<br>909-919<br>955-965<br>1001-1011<br>1047-1057<br>1093-1103<br>1139-1149<br>1185-1195<br>1231-1241<br>1277-1287<br>1323-1333<br>1369-1379<br>1415-1425 | National Drug Code (NDC) or Product Code [up to 25] | Character | 11 | Required: COS 14 | An 11-digit national drug identification number assigned by the Federal Drug Administration (or the HCPCS code) used to identify Durable Medical Equipment, Hearing Aids, OTC medications or other pharmacy products without an NDC code. |
| 322-333<br>368-379<br>414-425<br>460-471<br>506-517<br>552-563<br>598-609<br>644-655<br>690-701<br>736-747<br>782-793<br>828-839<br>874-885 | Quantity Dispensed [up to 25] | Numeric | 12 | Required: COS 14 | The dispensing quantity based upon the unit of measure as defined by the National Drug Code. |

| Record Positions | Data Element - Pharmacy | Format | Field Length | Submission Status | Description |
|---|---|---|---|---|---|
| 920-931<br>966-977<br>1012-1023<br>1058-1069<br>1104-1115<br>1150-1161<br>1196-1207<br>1242-1253<br>1288-1299<br>1334-1345<br>1380-1391<br>1426-1437 | | | | | |
| 334-344<br>380-390<br>426-436<br>472-482<br>518-528<br>564-574<br>610-620<br>656-666<br>702-712<br>748-758<br>794-804<br>840-850<br>886-896<br>932-942<br>978-988<br>1024-1034<br>1070-1080<br>1116-1126<br>1162-1172<br>1208-1218<br>1254-1264<br>1300-1310<br>1346-1356<br>1392-1402<br>1438-1448 | Amount Charged [up to 25] | Numeric | 11 | Required:<br>COS 14 | The amount charged for the prescription or ingredient. |
| 345-355<br>391-401<br>437-447 | Amount Paid [up to 25] | Numeric | 11 | Required:<br>COS 14 | The amount paid for the prescription or ingredient. |

| Record Positions | Data Element - Pharmacy | Format | Field Length | Submission Status | Description |
|---|---|---|---|---|---|
| 483-493<br>529-539<br>575-585<br>621-631<br>667-677<br>713-723<br>759-769<br>805-815<br>851-861<br>897-907<br>943-953<br>989-999<br>1035-1045<br>1081-1091<br>1127-1137<br>1173-1183<br>1219-1229<br>1265-1275<br>1311-1321<br>1357-1367<br>1403-1413<br>1449-1459 | | | | | |
| 356<br>402<br>448<br>494<br>540<br>586<br>632<br>678<br>724<br>770<br>816<br>862<br>908<br>954<br>1000<br>1046<br>1092<br>1138 | Pharmacy Claim/Encounter Indicator [up to 25] | Character | 1 | Required:<br>COS 14 | “E” = Capitated encounter;<br>“C” = Within plan claim;<br>“A” = Administratively denied service |

| Record Positions | Data Element - Pharmacy | Format | Field Length | Submission Status | Description |
|---|---|---|---|---|---|
| 1184<br>1230<br>1276<br>1322<br>1368<br>1414<br>1460 | | | | | |
| 1461-1462 | Refill Indicator | Character | 2 | Required: COS 14 | The number indicating whether the prescription is an original or refill. |
| 1463-1464 | Number of Refills Authorized | Character | 2 | Required: COS 14 | The number of refills authorized by the prescriber. |
| 1465 | Dispensed As Written | Character | 1 | Required: COS 14 | The code indicates whether or not a prescription is dispensed based on the prescriber's instructions. |
| 1466 | ICD Version Code | Character | 1 | Required: COS 14 | A one digit code to indicate whether the reported Diagnosis Code is ICD-9 or ICD-10. |
| 1467-1473 | Diagnosis Code | Character | 7 | Required: COS 14 | Diagnosis codes are to be recorded for diagnosed medical conditions for which the recipient receives services during the encounter or which may have been present at the time of the encounter and recorded by the provider. |
| 1474-1485 | Prescription Serial Number | Character | 12 | Required: COS 14 | The serial number on the official NYS Prescription Form. |
| 1486-1487 | Submission Clarification Code | Character | 2 | Required: COS 14 | Submission Clarification Code is the code indicating that the pharmacist is clarifying the submission |
| 1488-1498 | Dispensing Fee | Numeric | 11 | Required: COS 14 | Pharmacy Dispensing Fee is that portion of the claim payment amount that is directly related to cost of dispensing the drug. |
| 1499 | Mail Order Pharmacy Indicator | Character | 1 | Required: COS 14 | A one digit indicator of whether or not the script was from a mail order pharmacy. |
| 1500-3000 | FILLER | Character | 1501 | Required | Space-fill record positions 1500 to 3000. |

**Dental Segment**

| Record Positions | Data Element-Dental | Format | Field Length | Submission Status | Description |
|---|---|---|---|---|---|
| 258-260 | Provider Specialty Code | Character | 3 | Required: COS 13 | A provider's specialty code identifies a provider's medical, dental, clinic or program type specialty. |
| 261-268<br>339-346<br>417-424<br>495-502<br>573-580<br>651-658<br>729-736<br>807-814<br>885-892<br>963-970 | Service Start Date [up to 10] | Date CCYYMMDD | 8 | Required: COS 13 | The date the service began. |
| 269-276<br>347-354<br>425-432<br>503-510<br>581-588<br>659-666<br>737-744<br>815-822<br>893-900<br>971-978 | Service End Date [up to 10] | Date CCYYMMDD | 8 | Required: COS 13 | The date the service ended. |
| 277-278 | | Character | 2 | | Indicates where the dental service took place. |

| Record Positions | Data Element-Dental | Format | Field Length | Submission Status | Description |
|---|---|---|---|---|---|
| 355-356<br>433-434<br>511-512<br>589-590<br>667-668<br>745-746<br>823-824<br>901-902<br>979-980 | Place of Service/Place of Treatment [up to 10] | | | Required: COS 13 | |
| 279-283<br>357-361<br>435-439<br>513-517<br>591-595<br>669-673<br>747-751<br>825-829<br>903-907<br>981-985 | Procedure Codes [up to 10] | Character | 5 | Required: COS 13 | Procedure Codes identifying the procedures performed during the dental visit. |
| 284-285<br>362-363<br>440-441<br>518-519<br>596-597<br>674-675<br>752-753<br>830-831<br>908-909<br>986-987 | Procedure Modifier Code 1 [up to 10] | Character | 2 | Required: COS 13 | Procedure Modifier Codes are used in conjunction with the CPT procedure code to uniquely describe the service(s) rendered by a provider during an encounter. Fields for reporting a single modifier on each of the up to ten procedures or services are available. |
| 286-287 | Procedure Modifier Code 2 [up to 10] | Character | 2 | | |

| Record Positions | Data Element-Dental | Format | Field Length | Submission Status | Description |
|---|---|---|---|---|---|
| 364-365<br>442-443<br>520-521<br>598-599<br>676-677<br>754-755<br>832-833<br>910-911<br>988-989 | | | | Required:<br>COS 13 | Procedure Modifier Codes are used in conjunction with the CPT procedure code to uniquely describe the service(s) rendered by a provider during an encounter. Fields for reporting a single modifier on each of the up to ten procedures or services are available. |
| 288-289<br>366-367<br>444-445<br>522-523<br>600-601<br>678-679<br>756-757<br>834-835<br>912-913<br>990-991 | Procedure Modifier Code 3 [up to 10] | Character | 2 | Required:<br>COS 13 | Procedure Modifier Codes are used in conjunction with the CPT procedure code to uniquely describe the service(s) rendered by a provider during an encounter. Fields for reporting a single modifier on each of the up to ten procedures or services are available. |
| 290-291<br>368-369<br>446-447<br>524-525<br>602-603<br>680-681<br>758-759<br>836-837<br>914-915<br>992-993 | Procedure Modifier Code 4 [up to 10] | Character | 2 | Required:<br>COS 13 | Procedure Modifier Codes are used in conjunction with the CPT procedure code to uniquely describe the service(s) rendered by a provider during an encounter. Fields for reporting a single modifier on each of the up to ten procedures or services are available. |
| 292-293 | Tooth Number or Letter [up to 10] | Character | 2 | | The tooth that the service was performed on. |

| Record Positions | Data Element-Dental | Format | Field Length | Submission Status | Description |
|---|---|---|---|---|---|
| 370-371<br>448-449<br>526-527<br>604-605<br>682-683<br>760-761<br>838-839<br>916-917<br>994-995 | | | | Required:<br>COS 13 | |
| 294-304<br>372-382<br>450-460<br>528-538<br>606-616<br>684-694<br>762-772<br>840-850<br>918-928<br>996-1006 | Dental Number of Units/Visits [up to 10] | Numeric | 11 | Required:<br>COS 13 | The number of times a procedure or service was provided during the encounter; or the number of units, visits, or days a procedure or service was rendered during an episode of care defined by Service Start and End Dates. |
| 305-315<br>383-393<br>461-471<br>539-549<br>617-627<br>695-705<br>773-783<br>851-861<br>929-939<br>1007-1017 | Charged Amount [up to 10] | Numeric | 11 | Required:<br>COS 13 | The Amount Charged for each listed service. |

| Record Positions | Data Element-Dental | Format | Field Length | Submission Status | Description |
|---|---|---|---|---|---|
| 316-326<br>394-404<br>472-482<br>550-560<br>628-638<br>706-716<br>784-794<br>862-872<br>940-950<br>1018-1028 | Medicare Paid Amount | Numeric | 11 | Required: COS 13 | The amount Medicare paid for each listed service line that is received by dual eligible Medicaid/Medicare enrollees or beneficiaries. A service line is identified through either CPT/HCPCS procedure codes or revenue codes. This is the Medicare Paid Amount on the service line. |
| 327-337<br>405-415<br>483-493<br>561-571<br>639-649<br>717-727<br>795-805<br>873-883<br>951-961<br>1029-1039 | Paid Amount [up to 10] | Numeric | 11 | Required: COS 13 | The amount paid by Medicaid for each listed service. |
| 338<br>416<br>494<br>572<br>650<br>728<br>806<br>884 | Dental Claim/Encounter Indicator [up to 10] | Character | 1 | Required: COS 13 | Indicates whether the service provided was a capitated service within the health organization's contract ("E"); a within plan claim ("C") or an administratively denied service ("A"). |

| Record Positions | Data Element-Dental | Format | Field Length | Submission Status | Description |
|---|---|---|---|---|---|
| 962<br>1040 | | | | | |
| 1041-3000 | FILLER | Character | 1960 | Required | Space-fill positions 1041 to 3000. |

**Professional Segment**

| Record Positions | Data Element-Professional | Format | Field Length | Submission Status | Description |
|---|---|---|---|---|---|
| 258-260 | Provider Specialty Code | Character | 3 | Required: COS 01, 03, 04, 05, 07, 16, 22, 41, 75 | The code identifying a provider's medical, dental, clinic or program type specialty. |
| 261 | ICD Version Code | Character | 1 | Required: COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75 | A one-digit code to indicate whether the reported diagnosis is ICD-9 or ICD-10. |
| 262-268<br>269-275<br>276-282<br>283-289 | Diagnosis Codes [up to 4] | Character | 7 | Required: COS 01, 03, 04, 05, 07, 16, 22, 41, 75 | Up to four diagnosis codes are to be recorded for diagnosed medical conditions for which the recipient receives services during the encounter or which may have been present at the time of the encounter and recorded by the provider. |
| 290-291<br>388-389<br>486-487<br>584-585<br>682-683<br>780-781<br>878-879<br>976-977<br>1074-1075<br>1172-1173 | Place of Service/Place of Treatment [up to 10] | Character | 2 | Required: COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75 | Indicates location where service occurred. |
| 292-299 | Service Start Date [up to 10] | | 8 | | The date the service began. |

| Record Positions | Data Element-Professional | Format | Field Length | Submission Status | Description |
|---|---|---|---|---|---|
| 390-397<br>488-495<br>586-593<br>684-691<br>782-789<br>880-887<br>978-985<br>1076-1083<br>1174-1181 | | Date CCYYMMDD | | Required: COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75 | |
| 300-307<br>398-405<br>496-503<br>594-601<br>692-699<br>790-797<br>888-895<br>986-993<br>1084-1091<br>1182-1189 | Service End Date [up to 10] | Date CCYYMMDD | 8 | Required: COS 01, 03, 04, 05, 07, 16, 19, 22, 28, 41, 73, 75 | The date the service ended. |
| 308-312<br>406-410<br>504-508<br>602-606<br>700-704<br>798-802<br>896-900<br>994-998<br>1092-1096<br>1190-1194 | Procedure Codes [up to 10] | Character | 5 | Required: COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75 | The CPT/HCPCS procedure code that describes the service(s) rendered during the professional encounter(s). |

| Record Positions | Data Element-Professional | Format | Field Length | Submission Status | Description |
|---|---|---|---|---|---|
| 313-314<br>411-412<br>509-510<br>607-608<br>705-706<br>803-804<br>901-902<br>999-1000<br>1097-1098<br>1195-1196 | Procedure Modifier Code 1 [up to 10] | Character | 2 | Required: COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75 | Procedure Modifier Codes are used in conjunction with the CPT procedure code to uniquely describe the service(s) rendered by a provider during an encounter. Fields for reporting a single modifier on each of the up to ten procedures or services are available. |
| 315-316<br>413-414<br>511-512<br>609-610<br>707-708<br>805-806<br>903-904<br>1001-1002<br>1099-1100<br>1197-1198 | Procedure Modifier Code 2 [up to 10] | Character | 2 | Required: COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75 | Procedure Modifier Codes are used in conjunction with the CPT procedure code to uniquely describe the service(s) rendered by a provider during an encounter. Fields for reporting a single modifier on each of the up to ten procedures or services are available. |
| 317-318<br>415-416<br>513-514<br>611-612<br>709-710<br>807-808<br>905-906<br>1003-1004<br>1101-1102 | Procedure Modifier Code 3 [up to 10] | Character | 2 | Required: COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75 | Procedure Modifier Codes are used in conjunction with the CPT procedure code to uniquely describe the service(s) rendered by a provider during an encounter. Fields for reporting a single modifier on each of the up to ten procedures or services are available. |

| Record Positions | Data Element-Professional | Format | Field Length | Submission Status | Description |
|---|---|---|---|---|---|
| 1199-1200 | | | | | |
| 319-320<br>417-418<br>515-516<br>613-614<br>711-712<br>809-810<br>907-908<br>1005-1006<br>1103-1104<br>1201-1202 | Procedure Modifier Code 4 [up to 10] | Character | 2 | Required: COS 01 | Procedure Modifier Codes are used in conjunction with the CPT procedure code to uniquely describe the service(s) rendered by a provider during an encounter. Fields for reporting a single modifier on each of the up to ten procedures or services are available. |
| 321-331<br>419-429<br>517-527<br>615-625<br>713-723<br>811-821<br>909-919<br>1007-1017<br>1105-1115<br>1203-1213 | Professional Number of Units/Visits [up to 10] | Numeric | 11 | Required: COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75 | The number of times a procedure or service was provided during the encounter; or the number of units, visits, or days a procedure or service was rendered during an episode of care defined by Service Start and End Dates. |
| 332-342<br>430-440<br>528-538<br>626-636<br>724-734<br>822-832<br>920-930<br>1018-1028 | NDC (Formulary) Code [up to 10] | Character | 11 | Required: COS 01 | An 11-digit national drug identification number assigned by the Federal Drug Administration used to identify OTC medications. |

| Record Positions | Data Element-Professional | Format | Field Length | Submission Status | Description |
|---|---|---|---|---|---|
| 1116-1126<br>1214-1224 | | | | | |
| 343-353<br>441-451<br>539-549<br>637-647<br>735-745<br>833-843<br>931-941<br>1029-1039<br>1127-1137<br>1225-1235 | NDC (Formulary) Units [up to 10] | Numeric | 11 | Required: COS 01 | An 11-digit national drug identification number assigned by the Federal Drug Administration (or the HCPCS code) used to identify Durable Medical Equipment, Hearing Aids, OTC medications or other pharmacy products without an NDC code. |
| 354-364<br>452-462<br>550-560<br>648-658<br>746-756<br>844-854<br>942-952<br>1040-1050<br>1138-1148<br>1236-1246 | Charged Amount [up to 10] | Numeric | 11 | Required: COS 01, 03, 04, 05, 07, 16, 19, 22, 28, 41, 73, 75 | The amount charged for the reported claim line. |
| 365-375<br>463-473<br>561-571<br>659-669<br>757-767<br>855-865<br>953-963 | Medicare Paid Amount | Numeric | 11 | Required: COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75 | The amount Medicare paid for each listed service line that is received by dual eligible Medicaid/Medicare enrollees or beneficiaries. A service line is identified through either CPT/HCPCS procedure codes or revenue codes. This is the Medicare Paid Amount on the service line. |

| Record Positions | Data Element-Professional | Format | Field Length | Submission Status | Description |
|---|---|---|---|---|---|
| 1051-1061<br>1149-1159<br>1247-1257 | | | | | |
| 376-386<br>474-484<br>572-582<br>670-680<br>768-778<br>866-876<br>964-974<br>1062-1072<br>1160-1170<br>1258-1268 | Paid Amount [up to 10] | Numeric | 11 | Required: COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75 | The amount paid by Medicaid for each listed service. |
| 387<br>485<br>583<br>681<br>779<br>877<br>975<br>1073<br>1171<br>1269 | Professional Claim/Encounter Indicator [up to 10] | Character | 1 | Required: COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75 | Indicates whether the service provided was a capitated service within the health organization's contract ("E"); a within plan claim ("C") or an administratively denied service ("A"). |
| 1270-3000 | FILLER | Character | 1731 | Required | Space-fill positions 1270 to 3000. |

**Trailer Record**

| Record Positions | Data Element-Trailer | Format | Field Length | Submission Status | Description |
|---|---|---|---|---|---|
| 1-2 | Record Type | Character | 2 | Required | T1=Trailer |
| 3 | Submission Record Count | Numeric | 9 | Required | The total number of records in the file, including the header and trailer records. Zero fill and right justify. |
| Space-fill Record Positions 12 to 3000 | | | | | |

# IV.ENCOUNTER TYPE ASSIGNMENT BY COS: REQUIREMENTS BY MEDS III DATA ELEMENT

**R = Required for Reporting**

| | MEDS Category of Service (COS) | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 01 | 03 | 04 | 05 | 06 | 07 | 11 | 12 | 13 | 14 | 15 | 16 | 19 | 22 | 28 | 41 | 73 | 75 | 85 | 87 |
| **Encounter Type:** | P | P | P | P | I | P | I | I | T | D | I | P | P | P | I | P | I | P | I | I |
| **Institutional Transaction Segment (Encounter Type = "I")** | | | | | | | | | | | | | | | | | | | | |
| Provider Specialty Code | | | | | R | | | R | | | R | | | | R | | R | | R | R |
| Hosp Inpatient Claim/Encounter Indicator | | | | | | | R | | | | | | | | | | | | | |
| NYS DRG Code | | | | | | | R | | | | | | | | | | | | | |
| Type of Bill Digits 1 & 2 Code | | | | | R | | R | R | | | R | | | | R | | R | | R | R |
| Type of Bill Digit 3 Code | | | | | R | | R | R | | | R | | | | R | | R | | R | R |
| Statement Covers Period From | | | | | R | | | R | | | R | | | | R | | R | | R | R |
| Statement Covers Period Thru | | | | | R | | | R | | | R | | | | R | | R | | R | R |
| Type of Admission | | | | | | | R | | | | | | | | | | | | | |
| Source of Admission | | | | | | | R | | | | | | | | | | | | | |
| Patient Status or Disposition Code | | | | | | | R | R | | | | | | | R | | R | | | |
| Medical Record Number | | | | | | | R | | | | | | | | | | | | | |
| Neonate Birth Weight Value Code | | | | | | | R | | | | | | | | | | | | | |
| Neonate Birth Weight in Grams | | | | | | | R | | | | | | | | | | | | | |
| Service Date | | | | | R | | | R | | | R | | | | R | | R | | R | R |
| Revenue Code | | | | | R | | R | R | | | R | | | | R | | R | | R | R |
| CPT/HCPCS Code | | | | | R | | | R | | | R | | | | R | | R | | R | R |
| Procedure Modifier Code 1 | | | | | R | | | R | | | R | | | | R | | R | | R | R |
| Procedure Modifier Code 2 | | | | | R | | | R | | | R | | | | R | | R | | R | R |
| Procedure Modifier Code 3 | | | | | R | | | R | | | R | | | | R | | R | | R | R |
| Procedure Modifier Code 4 | | | | | R | | | R | | | R | | | | R | | R | | R | R |
| Quantity or Units Submitted | | | | | R | | | R | | | R | | | | R | | R | | R | R |
| NDC (Formulary) Code | | | | | R | | | R | | | R | | | | R | | R | | R | R |
| NDC (Formulary) Units | | | | | R | | | R | | | R | | | | R | | R | | R | R |
| Charged Amount | | | | | R | | | R | | | R | | | | R | | R | | R | R |

| | MEDS Category of Service (COS) | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 01 | 03 | 04 | 05 | 06 | 07 | 11 | 12 | 13 | 14 | 15 | 16 | 19 | 22 | 28 | 41 | 73 | 75 | 85 | 87 |
| **Encounter Type:** | P | P | P | P | I | P | I | I | T | D | I | P | P | P | I | P | I | P | I | I |
| Medicare Paid Amount | | | | | R | | | R | | | R | | | | R | | R | | R | R |
| Paid Amount | | | | | R | | | R | | | R | | | | R | | R | | R | R |
| Non-Inpatient Claim/Encounter Indicator | | | | | R | | | R | | | R | | | | R | | R | | R | R |
| ICD Version Code | | | | | R | | R | R | | | R | | | | R | | R | | R | R |
| Principal/Primary Diagnosis Code | | | | | R | | R | R | | | R | | | | R | | R | | R | R |
| Other Diagnosis Codes | | | | | R | | R | R | | | R | | | | R | | R | | R | R |
| Admit Diagnosis | | | | | | | R | | | | | | | | | | | | | |
| External Diagnosis Code (E Code) | | | | | | | R | | | | | | | | | | | | | |
| Present on Admission Code | | | | | | | R | | | | | | | | | | | | | |
| Principal Procedure Code | | | | | | | R | | | | | | | | | | | | | |
| Procedure Date | | | | | | | R | | | | | | | | | | | | | |
| Other Procedure Codes | | | | | | | R | | | | | | | | | | | | | |
| Attending Provider Profession Code | | | | | R | | R | R | | | R | | | | R | | R | | R | R |
| Attending Provider License Number | | | | | R | | R | R | | | R | | | | R | | R | | R | R |
| Attending Provider ID | | | | | R | | R | R | | | R | | | | R | | R | | R | R |
| Surgeon Profession Code | | | | | | | R | | | | | | | | | | | | | |
| Surgeon License Number | | | | | | | R | | | | | | | | | | | | | |
| Surgeon Provider ID | | | | | | | R | | | | | | | | | | | | | |
| Admission Date | | | | | | | R | R | | | | | | | R | | | | | |
| Discharge Date | | | | | | | R | R | | | | | | | R | | | | | |
| **Pharmacy Transaction Segment (Encounter Type = "D")** | | | | | | | | | | | | | | | | | | | | |
| Prescription Origin Code | | | | | | | | | | R | | | | | | | | | | |
| Prescription Number | | | | | | | | | | R | | | | | | | | | | |
| Prescribing Provider Profession Code | | | | | | | | | | R | | | | | | | | | | |
| Prescribing Provider License Code | | | | | | | | | | R | | | | | | | | | | |
| Prescribing Provider ID | | | | | | | | | | R | | | | | | | | | | |
| Prescription Ordered Date | | | | | | | | | | R | | | | | | | | | | |
| Date Filled | | | | | | | | | | R | | | | | | | | | | |
| Drug Days Supply Count | | | | | | | | | | R | | | | | | | | | | |

| | MEDS Category of Service (COS) | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 01 | 03 | 04 | 05 | 06 | 07 | 11 | 12 | 13 | 14 | 15 | 16 | 19 | 22 | 28 | 41 | 73 | 75 | 85 | 87 |
| **Encounter Type:** | P | P | P | P | I | P | I | I | T | D | I | P | P | P | I | P | I | P | I | I |
| National Drug Code (NDC) or Product Code | | | | | | | | | | R | | | | | | | | | | |
| Quantity Dispensed | | | | | | | | | | R | | | | | | | | | | |
| Amount Charged | | | | | | | | | | R | | | | | | | | | | |
| Amount Paid | | | | | | | | | | R | | | | | | | | | | |
| Pharmacy Claim/Encounter Indicator | | | | | | | | | | R | | | | | | | | | | |
| Refill Indicator | | | | | | | | | | R | | | | | | | | | | |
| Number of Refills Authorized | | | | | | | | | | R | | | | | | | | | | |
| Dispensed As Written | | | | | | | | | | R | | | | | | | | | | |
| ICD Version Code | | | | | | | | | | R | | | | | | | | | | |
| Diagnosis Code | | | | | | | | | | R | | | | | | | | | | |
| Prescription Serial Number | | | | | | | | | | R | | | | | | | | | | |
| Submission Clarification Code | | | | | | | | | | R | | | | | | | | | | |
| Dispensing Fee | | | | | | | | | | R | | | | | | | | | | |
| Mail Order Pharmacy Indicator | | | | | | | | | | R | | | | | | | | | | |
| **Dental Transaction Segment (Encounter Type = "T")** | | | | | | | | | | | | | | | | | | | | |
| Provider Specialty Code | | | | | | | | | R | | | | | | | | | | | |
| Service Start Date | | | | | | | | | R | | | | | | | | | | | |
| Service End Date | | | | | | | | | R | | | | | | | | | | | |
| Place of Service/Place of Treatment | | | | | | | | | R | | | | | | | | | | | |
| Procedure Codes | | | | | | | | | R | | | | | | | | | | | |
| Procedure Modifier Code 1 | | | | | | | | | R | | | | | | | | | | | |
| Procedure Modifier Code 2 | | | | | | | | | R | | | | | | | | | | | |
| Procedure Modifier Code 3 | | | | | | | | | R | | | | | | | | | | | |
| Procedure Modifier Code 4 | | | | | | | | | R | | | | | | | | | | | |
| Tooth Number or Letter | | | | | | | | | R | | | | | | | | | | | |
| Dental Number of Units/Visits | | | | | | | | | R | | | | | | | | | | | |
| Charged Amount | | | | | | | | | R | | | | | | | | | | | |
| Medicare Paid Amount | | | | | | | | | R | | | | | | | | | | | |
| Paid Amount | | | | | | | | | R | | | | | | | | | | | |

| | MEDS Category of Service (COS) | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 01 | 03 | 04 | 05 | 06 | 07 | 11 | 12 | 13 | 14 | 15 | 16 | 19 | 22 | 28 | 41 | 73 | 75 | 85 | 87 |
| **Encounter Type:** | P | P | P | P | I | P | I | I | T | D | I | P | P | P | I | P | I | P | I | I |
| Dental Claim/Encounter Indicator | | | | | | | | | R | | | | | | | | | | | |
| **Professional Transaction Segment (Encounter Type = "P")** | | | | | | | | | | | | | | | | | | | | |
| Provider Specialty Code | R | R | R | R | | R | | | | | | R | | R | | R | | R | | |
| ICD Version Code | R | R | R | R | | R | | | | | | R | R | R | | R | | R | | |
| Diagnosis Codes | R | R | R | R | | R | | | | | | R | | R | | R | | R | | |
| Place of Service/Place of Treatment | R | R | R | R | | R | | | | | | R | R | R | | R | | R | | |
| Service Start Date | R | R | R | R | | R | | | | | | R | R | R | | R | | R | | |
| Service End Date | R | R | R | R | | R | | | | | | R | R | R | | R | | R | | |
| Procedure Codes | R | R | R | R | | R | | | | | | R | R | R | | R | | R | | |
| Procedure Modifier Code 1 | R | R | R | R | | R | | | | | | R | R | R | | R | | R | | |
| Procedure Modifier Code 2 | R | R | R | R | | R | | | | | | R | R | R | | R | | R | | |
| Procedure Modifier Code 3 | R | R | R | R | | R | | | | | | R | R | R | | R | | R | | |
| Procedure Modifier Code 4 | R | R | R | R | | R | | | | | | R | R | R | | R | | R | | |
| Professional Number of Units/Visits | R | R | R | R | | R | | | | | | R | R | R | | R | | R | | |
| NDC (Formulary) Code | R | | | | | | | | | | | | | | | | | | | |
| NDC (Formulary) Units | R | | | | | | | | | | | | | | | | | | | |
| Charged Amount | R | R | R | R | | R | | | | | | R | R | R | R | R | R | R | | |
| Medicare Paid Amount | R | R | R | R | | R | | | | | | R | R | R | | R | | R | | |
| Paid Amount | R | R | R | R | | R | | | | | | R | R | R | | R | | R | | |
| Professional Claim/Encounter Indicator | R | R | R | R | | R | | | | | | R | R | R | | R | | R | | |

# V. HEADER RECORD

**MEDS III Transaction Segment: Header**

| **Data Element Name:** | **RECORD TYPE** |
|---|---|
| Submission Status: | Required for Header Record |
| Encounter Record Position(s): | 1-2 |
| Format - Length: | Character - 2 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | NA |

**Definition**: The Record Type identifies the data being submitted as either the header record, the detail section, or the trailer record.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

| ***Code*** | ***Value*** |
|---|---|
| H1 | Header |

**Edit Applications:**

- Must be a valid code of H1 for Header Record
- Tier One Edit

**MEDS III Transaction Segment: Header**

| **Data Element Name:** | **PROVIDER TRANSMISSION SUPPLIER NUMBER (TSN)** |
|---|---|
| Submission Status: | Required for Header Record |
| Encounter Record Position(s): | 3-6 |
| Format - Length: | Character - 4 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 4312/E4312 |

**Definition**: Provider Transmission Supplier Number (TSN) is a unique number assigned to the health organization submitting encounter records. The TSN should be left-justified and space-filled.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Left-justified and space-filled
- Unique to health plan reporting

**Edit Applications:**

- Must be a valid TSN/Plan Id combination

**MEDS III Transaction Segment: Header**

| **Data Element Name:** | **INPUT SERIAL NUMBER** |
|---|---|
| Submission Status: | Required for Header Record |
| Encounter Record Position(s): | 7-12 |
| Format - Length: | Character - 6 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | NA/E6203 |

**Definition**: This is a number assigned by the submitter for electronic submissions.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Left-justified and space-filled
- Unique to health plan reporting

**Edit Applications:**

- None

**MEDS III Transaction Segment: Header**

| **Data Element Name:** | **TSN CERTIFICATION** |
|---|---|
| Submission Status: | Required for Header Record |
| Encounter Record Position(s): | 13-21 |
| Format - Length: | Character - 9 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | NA/C110 |

**Definition**: This field must contain the word "CERTIFIED" (in UPPERCASE letters) to indicate the submitter is certified to submit electronically.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Left-justified
- "CERTIFIED" in UPPERCASE letters

**Edit Applications:**

- None

**MEDS III Transaction Segment: Header**

| **Data Element Name:** | **VENDOR SOFTWARE NUMBER** |
|---|---|
| Submission Status: | Optional |
| Encounter Record Position(s): | 22-26 |
| Format - Length: | Character - 5 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | NA/E2843 |

**Definition**: Vendor Software Number

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Optional Plan Reported Data Element

**Edit Applications:**

- None

**MEDS III Transaction Segment: Header**

| **Data Element Name:** | **VENDOR SOFTWARE UPDATE LEVEL** |
|---|---|
| Submission Status: | Optional |
| Encounter Record Position(s): | 27-28 |
| Format - Length: | Character - 2 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | NA/E2825 |

**Definition**: Vendor Software Update Level

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Optional Plan Reported Data Element

**Edit Applications:**

- None

**MEDS III Transaction Segment: Header**

| **Data Element Name:** | **TEST / PROD INDICATOR** |
|---|---|
| Submission Status: | Required for Header Record |
| Encounter Record Position(s): | 29-32 |
| Format - Length: | Character - 4 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | NA/NA |

**Definition**: This field must contain either the word "TEST" to direct your submission to the Provider Test Environment (PTE) or "PROD" for submitting files to production. If this field is left blank, the submission will not pass through our "Tier One" editing process and the entire file will reject.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Left-justified
- Must contain either the word "TEST" or "PROD"

**Edit Applications:**

- Tier One Edit: 'Specified mode "  " does not match' 'Test/Prod Indicator'

**MEDS III Transaction Segment: Header**

| **Data Element Name:** | **PLAN IDENTIFICATION NUMBER** |
|---|---|
| Submission Status: | Required for Header Record |
| Encounter Record Position(s): | 33-40 |
| Format - Length: | Character - 8 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 4397/H056 |

**Definition**: The health organization's MMIS Identification Number.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Left-justified with no embedded blanks and Space-filled
- Must be a valid MMIS Plan Identification Number

**Edit Applications:**

- 00423 MMIS Plan ID Missing
- 00424 MMIS Plan ID Not On File
- 00425 MMIS Plan ID Not MC Capitation Provider

**MEDS III Transaction Segment: Header**

| **Data Element Name:** | **SUBMITTER NAME** |
|---|---|
| Submission Status: | Required for Header Record |
| Encounter Record Position(s): | 41-61 |
| Format - Length: | Character - 21 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | NA/NA |

**Definition**: Name of submitting health organization.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Name Used on Official State Records

**Edit Applications:**

- None

**MEDS III Transaction Segment: Header**

| **Data Element Name:** | **SUBMITTER ADDRESS1** |
|---|---|
| Submission Status: | Required for Header Record |
| Encounter Record Position(s): | 62-79 |
| Format - Length: | Character - 18 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | NA/NA |

**Definition**: Street address for submitting health organization.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Valid Street Address

**Edit Applications:**

- None

**MEDS III Transaction Segment: Header**

| **Data Element Name:** | **SUBMITTER ADDRESS2** |
|---|---|
| Submission Status: | Required for Header Record |
| Encounter Record Position(s): | 80-97 |
| Format - Length: | Character - 18 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | NA/NA |

**Definition**: Street address for submitting health organization.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Left-justified
- Valid Street Address

**Edit Applications:**

- None

**MEDS III Transaction Segment: Header**

| **Data Element Name:** | **SUBMITTER CITY** |
|---|---|
| Submission Status: | Required for Header Record |
| Encounter Record Position(s): | 98-112 |
| Format - Length: | Character - 15 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | NA/NA |

**Definition**: City in which the submitting health organization correspondence should be sent.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Left-justified
- Valid City Name

**Edit Applications:**

- None

**MEDS III Transaction Segment: Header**

| **Data Element Name:** | **SUBMITTER STATE** |
|---|---|
| Submission Status: | Required for Header Record |
| Encounter Record Position(s): | 113-114 |
| Format - Length: | Character - 2 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | NA/NA |

**Definition**: Two-character standard state postal code in which the health organization does business.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Valid two character state abbreviation (e.g., “NY”)

**Edit Applications:**

- None

**MEDS III Transaction Segment: Header**

| **Data Element Name:** | **SUBMITTER ZIP** |
|---|---|
| Submission Status: | Required for Header Record |
| Encounter Record Position(s): | 115-123 |
| Format - Length: | Character - 9 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | NA/NA |

**Definition**: The health organizations geographic area denoted by the postal zip code.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Left-justified

**Edit Applications:**

- None

**MEDS III Transaction Segment: Header**

| **Data Element Name:** | **SUBMITTER FAX NUMBER** |
|---|---|
| Submission Status: | Required for Header Record |
| Encounter Record Position(s): | 124-134 |
| Format - Length: | Character - 11 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | NA/NA |

**Definition**: Facsimile number for the health organization.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Left-justified

**Edit Applications:**

- None

**MEDS III Transaction Segment: Header**

| **Data Element Name:** | **SUBMITTER PHONE NUMBER** |
|---|---|
| Submission Status: | Required for Header Record |
| Encounter Record Position(s): | 135-145 |
| Format - Length: | Character - 11 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | NA/NA |

**Definition**: Phone number for the health organization, including 1 and the area code and seven digit number.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Left-justified

**Edit Applications:**

- None

**MEDS III Transaction Segment: Header**

| **Data Element Name:** | **MEDS VERSION NUMBER** |
|---|---|
| Submission Status: | Required for Header Record |
| Encounter Record Position(s): | 146-148 |
| Format - Length: | Character - 3 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | NA/NA |

**Definition**: Version Number is “003”.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- 003

**Edit Applications:**

- None

# VI. COMMON DETAIL

**MEDS III Transaction Segment: Common Detail**

| **Data Element Name:** | **RECORD TYPE** |
|---|---|
| Submission Status: | Required: All COS |
| Encounter Record Position(s): | 1-2 |
| Format - Length: | Character - 2 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | NA |

**Definition**: The Record Type identifies the data being submitted as either the header record, the detail section, or the trailer record.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

| ***Code*** | ***Value*** |
|---|---|
| H1 | Header |
| D1 | Detail |
| T1 | Trailer |

**Edit Applications:**

- Must be a valid code of D1 for Common Detail Segment
- Tier One Edit

**MEDS III Transaction Segment: Common Detail**

| **Data Element Name:** | **ENCOUNTER TYPE INDICATOR (ETI)** |
|---|---|
| Submission Status: | Required: All COS |
| Encounter Record Position(s): | 3 |
| Format - Length: | Character - 1 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 2764/H054 |

**Definition**: The Encounter Type Indicator (ETI) is a one-digit code indicating the type of encounter being reported. The ETI follows the four paper and electronic forms for institutional, pharmacy, dental and professional transactions.

Each of the four encounter types to be reported has different required data element sets and formats.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Code must be valid or the encounter file will reject and no further editing will occur.

| ***Code*** | ***Value*** |
|---|---|
| I | Institutional |
| D | Pharmacy |
| T | Dental |
| P | Professional |

Note: Institutional includes inpatient (COS 11) and other Categories of Service. Refer to Section II, Encounter Type Assignment by Category of Service, for more information on proper assignment.

**Edit Applications:**

- Must be a valid code.
- The combination of Encounter Type and Category of Service must be valid.
- 00901 Claim Type Unknown

**MEDS III Transaction Segment: Common Detail**

| **Data Element Name:** | **ENCOUNTER CONTROL NUMBER (ECN)** |
|---|---|
| Submission Status: | Required: All COS |
| Encounter Record Position(s): | 4-14 |
| Format - Length: | Character - 11 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1121/H073 |

**Definition**: Encounter Control Number (ECN) is the health organization assigned number used to uniquely identify an encounter transaction. CSC will include the ECN on edit feedback reports to health organizations. Other than editing the ECN for its presence on the encounter record and special characters, the assignment, composition, and validity of the ECN is the responsibility of the health organization.

The ECN is returned to the plan on the response report file so the plan is able to reconcile the status of the encounter with the original file submitted.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Must be left-justified with no embedded blanks and space-filled
- Cannot equal zero or blanks
- Must be numeric (0-9) and/or alphabetic (A-Z). Special Characters are invalid entries.

**Edit Applications:**

- 00400 Encounter Control Number Missing

**MEDS III Transaction Segment: Common Detail**

| **Data Element Name:** | **PREVIOUS TRANSACTION CONTROL NUMBER (TCN)** |
|---|---|
| Submission Status: | Situational |
| Encounter Record Position(s): | 15-30 |
| Format - Length: | Character/Numeric – 16 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 0537/H055 (TCN) H075 (Prev TCN) |

**Definition**: This data element was formerly called the Previous Encounter Reference Number (ERN).

Transaction Control Number (TCN) is a unique identifier assigned by Computer Sciences Corporation (CSC) to each encounter transaction received. The TCN is used for internal control purposes and by plans to adjust or void records identified as failing edits. Records failing soft edits will be identified to the plans by the assigned TCN and unique, plan-assigned Encounter Control Number (ECN). The previous TCN and appropriate Transaction Status Code are used only to properly adjust or void a previously submitted record. When submitting a second adjustment of a record, use the TCN assigned to the adjustment record (i.e. not the original record).

Additionally, if the encounter record passes through the system without hitting any edits, the plan should store the associated TCN and the "Accepted" status in their internal data system.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Space-filled if the previous ERN is not recorded (i.e. the record is not being adjusted or voided).

**Edit Applications:**

- 00103 Adj / Void Fields Incomplete
- 00725 Hist Record Not Found Adjus/Void

**MEDS III Transaction Segment: Common Detail**

| **Data Element Name:** | **TRANSACTION STATUS CODE** |
|---|---|
| Submission Status: | Required: All COS |
| Encounter Record Position(s): | 31 |
| Format - Length: | Number – 1 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 0705/H066 |

**Definition**: The Transaction Status Code identifies an encounter transaction as an original encounter, a void or a replacement to a previously accepted encounter. This data element was formerly called the Adjustment/Void Code.

Health organizations may use the adjustment/void process to update previously submitted information, to correct data elements that had previously failed soft edits or to delete records that should not have been submitted.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

| ***Code*** | ***Value*** |
|---|---|
| 0 | ORIGINAL ENCOUNTER |
| 7 | ADJUSTMENT ENCOUNTER - REPLACEMENT RECORD |
| 8 | VOID ENCOUNTER – DELETION RECORD |

- All new encounters will be submitted with a value of "0"
- For adjustments, resubmit entire record, with the "7" code and Previous Transaction Control Number
- For Voids, resubmit entire record with an "8" code and Previous TCN
- To resubmit rejected records, resubmit the entire record with a value of "0", with the same Encounter Control Number, but without the TCN

**Edit Applications:**

- 00103 Adj / Void fields incomplete

**MEDS III Transaction Segment: Common Detail**

| **Data Element Name:** | **CLIENT IDENTIFICATION NUMBER (CIN)** |
|---|---|
| Submission Status: | Required: All COS |
| Encounter Record Position(s): | 32-39 |
| Format - Length: | Character - 8 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 0535/1010 |

**Definition**: The CIN is assigned to an enrollee upon determination that an individual is eligible for Medicaid services. All encounter records must contain a valid CIN. Newborn encounters should not be reported under the maternal CIN.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #60 |
| Institutional | UB-04 | #60 |
| Pharmacy | UCF | ID |
| Dental | ADA | #15 |
| Professional | CMS-1500 | #1A |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Code | Page No. |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2010BA | NM1<br>NM1 | 08<br>09 | 66<br>67 | MI | 110 |
| Dental | 837D | 2010CA | NM1 | 08<br>09 | 66<br>67 | MI | 137-138 |
| Professional | 837P | 2010CA | NM1 | 08<br>09 | 66<br>67 | MI | 159 |

| Encounter Type | NCPDP Format |
|---|---|
| Pharmacy/DME | 302-C2 |

**Codes and Values**:

- The Medicaid CIN format consists of 2 letters, followed by 5 numbers, and ending with 1 letter (e.g. XY12345Z). CHPlus CIN is 8 numbers.

**Edit Applications:**

- 00074 Recipient ID Number Invalid
- 00140 Recipient ID Not On File
- 00689 Recipient Not Enrolled in Plan on Date of Service
- 00693 Recipient Never Enrolled in Managed Care
- 00694 Recipient Not Enrolled in MC on Date of Service
- 00696 Recipient Enrolled in Another MC Plan on Date of Service

**MEDS III Transaction Segment: Common Detail**

| **Data Element Name:** | **BENEFICIARY IDENTIFICATION NUMBER** |
|---|---|
| Submission Status: | Optional |
| Encounter Record Position(s): | 40-64 |
| Format - Length: | Character - 25 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 2767/H072 |

**Definition**: The Beneficiary Identification Number is a unique identification number assigned by the health organization to the member. The Beneficiary Identification Number may also be known as the subscriber identification number or a health insurance card identification number. The Beneficiary Identification Number should be identical to the Policy Number used for hospital claims and the Insured's Identification Number used in Professional service claims.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #60 |
| Institutional | UB-04 | #60 |
| Pharmacy | UCF | ID |
| Dental | ADA | #15 |
| Professional | CMS-1500 | #1A |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Page No. |
|---|---|---|---|---|---|---|
| Institutional | 837I | 2300 | CLM | 01 | 1028 | 158 |
| Dental | 837D | 2300 | CLM | 01 | 1028 | 150 |
| Professional | 837P | 2300 | CLM | 01 | 1028 | 171 |

| Encounter Type | NCPDP Format |
|---|---|
| Pharmacy/DME | ID |

**Codes and Values**:

- Left-justified
- Space-fill if not applicable

**Edit Applications:**

- None

**MEDS III Transaction Segment: Common Detail**

| **Data Element Name:** | **PROVIDER PROFESSION CODE** |
|---|---|
| Submission Status: | Required: 01, 03, 04, 05, 06, 07, 13, 41, 75 |
| Encounter Record Position(s): | 65-67 |
| Format - Length: | Character - 3 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 2165/2165_3 |

**Definition**: Provider Profession Code specifies the three-digit profession of a provider on the State Education Department (SED) license file. The Profession Code is used in conjunction with the provider license number to identify providers licensed by SED.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Provider Profession Codes and Values are contained within Appendix A. These codes are also available for download on the MEDS Home Page on the HCS.
- Space-fill if not applicable.

**Edit Applications:**

- Must be a valid code

***Important Note:***

Plans are now receiving the SED profession code for every provider on their Provider Network Data Submission. Please contact the Department's Provider Network and MEDS Compliance Unit at pnds@health.ny.gov if you have any questions or need more information.

For up to date information on provider profession codes, plans can also visit the State Education Department website at http://www.nysed.gov/.

**MEDS III Transaction Segment: Common Detail**

| **Data Element Name:** | **PROVIDER LICENSE NUMBER** |
|---|---|
| Submission Status: | Required: 01, 03, 04, 05, 06, 07, 13, 41, 75 |
| Encounter Record Position(s): | 68-75 |
| Format - Length: | Character - 8 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1570/W047 |

**Definition**: The Provider License Number, issued by the New York State Department of Education, is used to identify the health care provider rendering services or primarily responsible for the care provided during the encounter.

**Mapping**:

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Code | Page No. |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2010AA | REF | 01<br>02 | 128<br>127 | 0B | 83-84 |
| Dental | 837D | 2010AA | REF | 01<br>02 | 128<br>127 | 0B | 84 |
| Professional | 837P | 2010AA | REF | 01<br>02 | 128<br>127 | 0B | 92 |

**Codes and Values**:

- Right-justified
- Do not zero fill – Space-fill if not applicable
- Must be a valid professional license number issued by the New York State Department of Education

**Edit Applications:**

- Must be a valid entry
- Soft edit failures will be recorded if license number is not provided
- 00416 License Number Is Missing

***Important Note:***

There is a lookup tool for SED License status on the Provider Network Data System homepage on the HCS. This application supplements the SED license site lookup but gives plans more features and search flexibility. This lookup also returns SED profession code for those needing this information for MEDS submission purposes.
The direct link for this lookup tool is:
https://commerce.health.state.ny.us/hpn/cgi-bin/applinks/omcdata/lic_lookup.cgi.

**MEDS III Transaction Segment: Common Detail**

| **Data Element Name:** | **PROVIDER IDENTIFICATION NUMBER** |
|---|---|
| Submission Status: | Required: All COS |
| Encounter Record Position(s): | 76-85 |
| Format - Length: | Character - 10 |
| Effective Date: | 9/1/2008 |
| Version Number - Date: | 2.7 - August 2008 |
| MEDS III DE# / DW#: | 1563/2001 |

**Definition**: Provider Identification Number is a unique National Provider ID (NPI) assigned to each health care provider that sees recipients. If the provider type is non-health care related the Provider Identification Number is a unique MMIS provider ID assigned to each provider that sees Medicaid recipients. This number is the primary way of identifying a provider.

| Encounter Type | Provider Type |
|---|---|
| Professional | Servicing Provider |
| Dental | Servicing Provider |
| Institutional | Billing (Referring) Provider |
| Pharmacy/DME | Dispensing (Referring) Provider |

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #51 |
| Institutional | UB-04 | #56- 57 |
| Pharmacy | UCF | Service Provider ID |
| Dental | ADA | #54 |
| Professional | CMS-1500 | #33 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Code | Page No. |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2010AA | NM1 | 08<br>09 | 66<br>67 | XX | 77 |
| Dental | 837D | 2010AA | NM1 | 08<br>09 | 66<br>67 | XX | 78 |
| Professional | 837P | 2010AA | NM1 | 08<br>09 | 66<br>67 | XX | 86 |

| Encounter Type | NCPDP Format |
|---|---|
| Pharmacy/DME | 202-B2<br>201-B1 |

**Codes and Values**:

- NPI should be left-justified with no embedded blanks.

- MMIS Id should be left-justified with two (2) trailing spaces.
- Space-fill if not applicable.

- The following Generic Provider IDs should be used to report encounters involving out-of-network providers (in state or out-of-state) when Provider IDs are unknown.

| *COS* | *COS Description* | *Generic Provider ID* |
|---|---|---|
| 01 | Provider Services | 01666119 |
| 03 | Podiatry | 01666119 |
| 04 | Psychology | 01666119 |
| 05 | Eye Care/Vision | 01666119 |
| 06 | Rehabilitation Therapy | 01666119 |
| 07 | Nursing | 01666119 |
| 11 | Inpatient | 01666086 |
| 12 | Institutional Long Term Care | 01666119 |
| 13 | Dental | 01666119 |
| 14 | Pharmacy | 01666137 |
| 15 | Home Health Care / Non-Institutional Long Term Care | 01666119 |
| 16 | Laboratories | 01666100 |
| 19 | Transportation | 01666077 |
| 22 | DME and Hearing Aids | 01666137 |
| 28 | Intermediate Care Facilities | 01666119 |
| 41 | Nurse Providers/Midwives | 01666119 |
| 73 | Hospice | 01666119 |
| 75 | Clinical Social Worker | 01666119 |
| 85 | Freestanding Clinic | 01666095 |
| 87 | Non-Inpatient/Emergency Room | 01666128 |

**Edit Applications:**

- Must be a valid entry
- 00409 Inpatient MMIS Provider ID Is Not A Hospital (COS 11 Only)
- 00175 Servicing Provider Id Not on File (Professional and Dental)
- 00078 Referring Provider Identification Number Invalid (Institutional and Pharmacy)
- 02022 Missing Referring NPI (Institutional and Pharmacy)
- 02025 Missing Rendering NPI (Professional and Dental)
- 02032 Invalid Referring NPI (Institutional and Pharmacy)
- 02035 Invalid Rendering NPI (Professional and Dental)
- Tier One Edit – Provider Check Digit

**MEDS III Transaction Segment: Common Detail**

| **Data Element Name:** | **PROVIDER SERVICE LOCATION** |
|---|---|
| Submission Status: | Required: ALL COS |
| Encounter Record Position(s): | 86-94 |
| Format - Length: | Zip+4 - 9 |
| Effective Date: | 4/1/2012 |
| Version Number – Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | E9805/9805 |

**Definition**: Provider Service Location is the Zip+4 U.S. address postal code or an international postal code related to the address for the Provider ID and Locator Code.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-04 | #1 |
| Pharmacy | UCF | Zip Code |
| Dental | ADA | #56 |
| Professional | CMS-1500 | #32 |

- **Electronic**:

| Mapping Electronic Claim Element | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **X12 Mapping Loop** | **X12 Mapping Segment** | **Seg. Ele. (Ref)** | **Element ID** | **X12 Mapping Loop** | **X12 Mapping Segment** | **Seg. Ele. (Ref)** | **Element ID** | **Page No.** |
| **837I** | 2310E | N4 | 03 | 116 | 2010AA | N4 | 03 | 116 | 81 |
| **837D** | 2310C | N4 | 03 | 116 | 2010AA | N4 | 03 | 116 | 90 |
| **NCPDC** | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| **837P** | 2310C | N4 | 03 | 116 | 2010AA | N4 | 03 | 116 | 82 |
| Primary Zip code loop | | | | | Secondary Zip code loop – used when Primary loop not present | | | | |

**Codes and Values**:

- Left-justified
- Zip+4 codes are U. S. address postal codes
- Must be valid U.S postal codes with the format 123456789
- Zero filled for non U.S address location

**Edit Applications:**

- Tier One Edit – Provider Zip Code

**MEDS III Transaction Segment: Common Detail**

| **Data Element Name:** | **CATEGORY OF SERVICE** |
|---|---|
| Submission Status: | Required: All COS |
| Encounter Record Position(s): | 95-96 |
| Format - Length: | Numeric - 2 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 2694/H001_7 |

**Definition**: Category of Service is a two-digit alpha-numeric code which indicates the type of service being provided and/or the provider rendering the service.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**: Category of Service must be applicable to the encounter type being reported.

| ***Category of Service*** | | ***Encounter Type*** | |
|---|---|---|---|
| ***Code*** | ***Value*** | ***Code*** | ***Value*** |
| 01 | Physician Services | P | Professional |
| 03 | Podiatry | P | Professional |
| 04 | Psychology | P | Professional |
| 05 | Eye Care / Vision | P | Professional |
| 06 | Rehabilitation Therapy | I | Institutional |
| 07 | Nursing | P | Professional |
| 11 | Inpatient | I | Institutional |
| 12 | Institutional LTC | I | Institutional |
| 13 | Dental | T | Dental |
| 14 | Pharmacy | D | Pharmacy/DME |
| 15 | Home Health Care/Non-Institutional LTC | I | Institutional |
| 16 | Laboratories | P | Professional |
| 19 | Transportation | P | Professional |
| 22 | DME and Hearing Aids | P | Professional |
| 28 | Intermediate Care Facilities | I | Institutional |
| 41 | NPs/Midwives | P | Professional |
| 73 | Hospice | I | Institutional |
| 75 | Clinical Social Worker | P | Professional |
| 85 | Freestanding Clinic | I | Institutional |
| 87 | Hospital OP/ER Room | I | Institutional |

**Edit Applications:**

- Must be a valid code
- 00408 Category Of Service Missing
- 00901 Claim Type Unknown

**MEDS III Transaction Segment: Common Detail**

| **Data Element Name:** | **TOTAL CHARGED AMOUNT** |
|---|---|
| Submission Status: | Required: ALL COS |
| Encounter Record Position(s): | 97-107 |
| Format - Length: | Numeric - 11 |
| Effective Date: | 4/1/2012 |
| Version Number – Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | E1025/1025 |

**Definition**: The total amount charged for each listed service.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-04 | #47 |
| Pharmacy | UCF | Net Amount Due |
| Dental | ADA | #33 |
| Professional | CMS-1500 | #28 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Page No. |
|---|---|---|---|---|---|---|
| Institutional | 837I | 2300 | CLM | 02 | 782 | 159 |
| Dental | 837D | 2300 | CLM | 02 | 782 | 151 |
| Professional | 837P | 2300 | CLM | 02 | 782 | 172 |

| Encounter Type | NCPDP Format |
|---|---|
| Pharmacy/DME | 430-DU |

**Codes and Values**:

- Right-justified and zero filled
- This amount is defined with two implied decimal places (e.g., $1,000.00 is reported as 100000)

**Edit Applications:**

- Must be a valid format
- Must be entered as a positive number
- 00036 M/I Usual and Customary

**MEDS III Transaction Segment: Common Detail**

| **Data Element Name:** | **TOTAL PAID AMOUNT** |
|---|---|
| Submission Status: | Required: All COS |
| Encounter Record Position(s): | 108-118 |
| Format - Length: | Numeric - 11 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1028/E1028 |

**Definition**: The total amount Medicaid paid for all listed services. The Total Amount Paid includes the sum of all plan claims (Claim/Encounter Indicator="C") and proxy encounters (Claim/Encounter Indicator="E").

Total Amount Paid should be calculated from the service lines reported. If the record submitted in a continuation encounter, the Total Paid Amount on the first encounter record would be for service lines 1 through 10 and the Total Paid Amount on the second encounter record would be for service lines 11 – 20, etc.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Right-justified and zero filled
- This amount is defined with two implied decimal places (e.g., $1,000.00 is reported as 100000)

**Edit Applications:**

- Must be a valid format
- Must be entered as a positive number

**MEDS III Transaction Segment: Common Detail**

| **Data Element Name:** | **MEDICARE TOTAL PAID AMOUNT** |
|---|---|
| Submission Status: | Situational:<br>Required if member enrolled in Medicare. |
| Encounter Record Position(s): | 119-129 |
| Format - Length: | Numeric - 11 |
| Effective Date: | 2/18/2010 |
| Version Number - Date: | 2.9 - April 2010 |
| MEDSIII DE# / DW#: | 1085/H3033_2 |

**Definition**: The total amount Medicare paid for listed services that are received by dual eligible Medicaid/Medicare enrollees or beneficiaries. This is the Medicare Total Paid Amount on the "Header Level".

Medicare Total Amount Paid should be calculated from the Medicare Paid Amount service lines reported. If the record submitted in a continuation encounter, the Medicare Total Paid Amount on the first encounter record would be for service lines 1 through 10 and the Medicare Total Paid Amount on the second encounter record would be for service lines 11 – 20, etc.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Right-justified and zero filled
- This amount is defined with two implied decimal places (e.g., $1,000.00 is reported as 100000)

**Edit Applications:**

- Must be a valid format
- Must be entered as a positive number

***Important Note:***

This data element will be used to identify the first 20 days of a nursing home stay in which Medicare pays 100% of the cost. If the enrollee is not discharged within the first 20 days, then the remainder of the month would be reported as a separate encounter.

**MEDS III Transaction Segment: Common Detail**

| **Data Element Name:** | **OTHER INSURANCE TOTAL PAID AMOUNT** |
|---|---|
| Submission Status: | Situational |
| Encounter Record Position(s): | 130-140 |
| Format - Length: | Numeric - 11 |
| Effective Date: | 3/1/2005 |
| Version Number – Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1085/3031 |

**Definition**: The total amount paid by insurance other than Medicaid.
Medicare cost data should be reported the Medicare paid amount data fields.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Right-justified and zero-filled
- This amount is defined with two implied decimal places

**Edit Applications:**

- Must be a valid format
- Must be entered as a positive number

**MEDS III Transaction Segment: Common Detail**

| **Data Element Name:** | **OTHER PAYER NAME** |
|---|---|
| Submission Status: | Situational |
| Encounter Record Position(s): | 141-175 |
| Format - Length: | Character - 35 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1589/E1589 |

**Definition**: Other Payer Name identifies the secondary payer on the encounter. Medicare data should be reported the Medicare data fields.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #50B |
| Institutional | UB-04 | #50B |
| Pharmacy | UCF | |
| Dental | ADA | #11 |
| Professional | CMS-1500 | |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Page No. |
|---|---|---|---|---|---|---|
| Institutional | 837I | 2010BC | NM1 | 03 | 1035 | 127 |
| Dental | 837D | 2010BB | NM1 | 03 | 1035 | 118 |
| Professional | 837P | 2010BB | NM1 | 03 | 1035 | 131 |

**Codes and Values**:

- Free-form description of secondary payer
- Space-fill if not applicable

**Edit Applications:**

- None

**MEDS III Transaction Segment: Common Detail**

| **Data Element Name:** | **OTHER INSURANCE TYPE CODE** |
|---|---|
| Submission Status: | Situational |
| Encounter Record Position(s): | 176-177 |
| Format - Length: | Character - 2 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1455/E1455_2 |

**Definition**: The Other Insurance Type Code indicates payers other than Medicaid.

**Mapping**:

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Page No. |
|---|---|---|---|---|---|---|
| Institutional | 837I | 2000B | SBR | 09 | 1032 | 104 |
| Dental | 837D | 2000B | SBR | 09 | 1032 | 101 |
| Professional | 837P | 2000B | SBR | 09 | 1032 | 112 |

**Codes and Values**:

| *Code* | *Value* |
|---|---|
| 09 | Self-Pay |
| 10 | Central Certification |
| 11 | Other Non-Federal Programs |
| 12 | Preferred Provider Organizations (PPO) |
| 13 | Point of Service (POS) |
| 14 | Exclusive Provider Organization (EPO) |
| 15 | Indemnity Insurance |
| 16 | HMO Medicare Risk |
| AM | Automobile Medical |
| BL | Blue Cross/Blue Shield |
| CA | Capitated |
| CH | Champus |
| CI | Commercial Insurance Company |
| DS | Disability |
| HM | Health Maintenance Organization |
| LI | Liability |
| LM | Liability Medical |
| MA | Medicare; Part A |
| MB | Medicare; Part B |
| MC | Medicaid |
| OF | Other Federal Program |
| OI | Other Insurance |
| SC | Sub-Capitated |

| *Code* | *Value* |
|---|---|
| TV | Title V |
| VA | Veteran's Administration Plan |
| WC | Workers Compensation Health Plan |
| ZZ | Mutually Defined |

- Space-fill if not applicable

**Edit Applications:**

- Must be a valid code

**MEDS III Transaction Segment: Common Detail**

| **Data Element Name:** | **MEDICARE TOTAL DEDUCTIBLE PAID** |
|---|---|
| Submission Status: | Situational<br>Required if member enrolled in Medicare. |
| Encounter Record Position(s): | 178-188 |
| Format - Length: | Numeric - 11 |
| Effective Date: | 4/1/2012 |
| Version Number – Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | 3034/4141 |

**Definition**: The amount the beneficiary is required to pay for health care or prescriptions before Medicaid paid for the treatment.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Right-justified and zero filled
- This amount is defined with two implied decimal places (e.g., $1,000.00 is reported as 100000)

**Edit Applications:**

- Must be a valid format
- Must be entered as a positive number

**MEDS III Transaction Segment: Common Detail**

| **Data Element Name:** | **MEDICARE TOTAL CO-INSURANCE PAID** |
|---|---|
| Submission Status: | Situational<br>Required if member enrolled in Medicare. |
| Encounter Record Position(s): | 189-199 |
| Format - Length: | Numeric - 11 |
| Effective Date: | 4/1/2012 |
| Version Number – Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | F445/2735 |

**Definition**: The amount the beneficiary is required to pay for healthcare services which is a set percentage of the covered costs after the deductible has been paid before Medicare paid for the treatment.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Right-justified and zero filled
- This amount is defined with two implied decimal places (e.g., $1,000.00 is reported as 100000)

**Edit Applications:**

- Must be a valid format
- Must be entered as a positive number

**MEDS III Transaction Segment: Common Detail**

| **Data Element Name:** | **MEDICARE TOTAL COPAY PAID** |
|---|---|
| Submission Status: | Situational<br>Required if member enrolled in Medicare |
| Encounter Record Position(s): | 200-210 |
| Format - Length: | Numeric - 11 |
| Effective Date: | 4/1/2012 |
| Version Number – Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | S040 |

**Definition**: The specified amount the beneficiary is required to pay out-of-pocket for healthcare services at the time the service is rendered before Medicare paid for the treatment.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Right-justified and zero filled
- This amount is defined with two implied decimal places (e.g., $1,000.00 is reported as 100000)

**Edit Applications:**

- Must be a valid format
- Must be entered as a positive number

**MEDS III Transaction Segment: Common Detail**

| **Data Element Name:** | **OTHER INSURANCE TOTAL DEDUCTIBLE PAID** |
|---|---|
| Submission Status: | Situational |
| Encounter Record Position(s): | 211-221 |
| Format - Length: | Numeric - 11 |
| Effective Date: | 4/1/2012 |
| Version Number – Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | E0482/0482 |

**Definition**: The amount the beneficiary is required to pay for health care or prescriptions before the Other Payer paid for the treatment.

**Mapping**:

- New York State Specific data element

**Codes and Values**:

- Right-justified and zero filled
- This amount is defined with two implied decimal places (e.g., $1,000.00 is reported as 100000)

**Edit Applications:**

- Must be a valid format
- Must be entered as a positive number

**MEDS III Transaction Segment: Common Detail**

| **Data Element Name:** | **OTHER INSURANCE TOTAL CO-INSURANCE PAID** |
|---|---|
| Submission Status: | Situational |
| Encounter Record Position(s): | 222-232 |
| Format - Length: | Numeric - 11 |
| Effective Date: | 4/1/2012 |
| Version Number – Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | E1013/1033 |

**Definition**: The amount the beneficiary is required to pay for healthcare services which is a set percentage of the covered costs after the deductible has been paid before the Other Payer paid for the treatment.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Right-justified and zero filled
- This amount is defined with two implied decimal places (e.g., $1,000.00 is reported as 100000)

**Edit Applications:**

- Must be a valid format
- Must be entered as a positive number

**MEDS III Transaction Segment: Common Detail**

| **Data Element Name:** | **OTHER INSURANCE TOTAL COPAY PAID** |
|---|---|
| Submission Status: | Situational |
| Encounter Record Position(s): | 233-243 |
| Format - Length: | Numeric - 11 |
| Effective Date: | 4/1/2012 |
| Version Number – Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | E0481/0481 |

**Definition**: The specified amount the beneficiary is required to pay out-of-pocket for healthcare services at the time the service is rendered before the Other Payer paid for the treatment.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Right-justified and zero filled
- This amount is defined with two implied decimal places (e.g., $1,000.00 is reported as 100000)

**Edit Applications:**

- Must be a valid format
- Must be entered as a positive number

**MEDS III Transaction Segment: Common Detail**

| **Data Element Name:** | **FILLER** |
|---|---|
| Submission Status: | Situational |
| Encounter Record Position(s): | 244-257 |
| Format - Length: | Character - 14 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |

**Definition**: Space-fill positions 244 to 257.

**Mapping**:

- New York State Specific data element

**Codes and Values:**

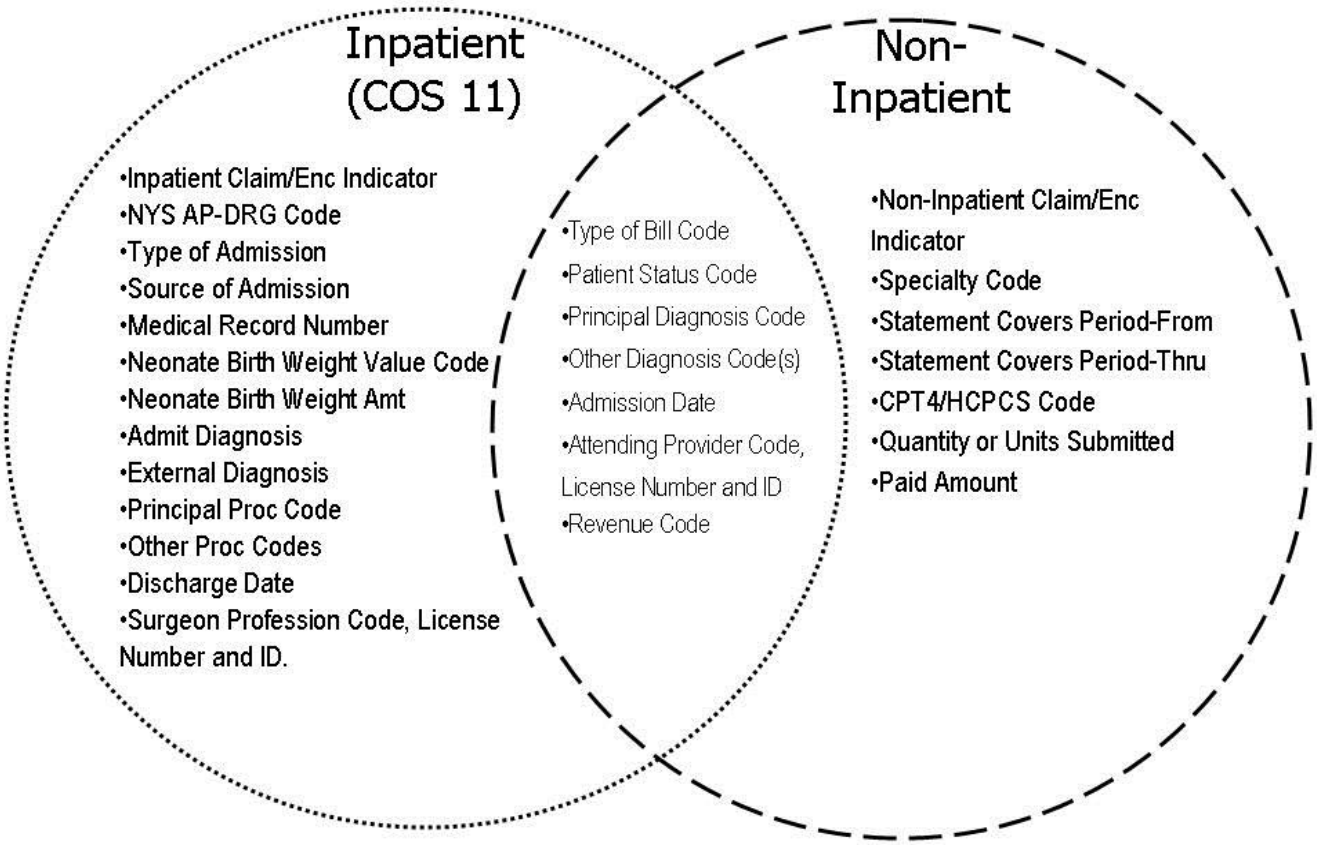
- Left-justified and space-filled

**Edit Applications:**

- Tier One Edit – Record is not 3000 bytes.

# VII. INSTITUTIONAL

Inpatient and Non-Inpatient Reporting Requirements
By Data Element




There are two components to the Institutional segment of MEDS III reporting requirements: inpatient and non-inpatient. As the diagram above indicates, many of the Institutional data elements are required for inpatient COS 11 only. The intersection of the diagram above indicates the data elements that are required for both inpatient and non-inpatient reporting.

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **PROVIDER SPECIALTY CODE** |
|---|---|
| Submission Status: | Required for COS 06, 12, 15, 28, 73, 85, 87 |
| Encounter Record Position(s): | 258-260 |
| Format - Length: | Character - 3 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1499/2048 |

**Definition**: The Provider Specialty Code identifies a provider's medical, dental, clinic or program type specialty.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Refer to Appendix B for valid codes and values
- Where applicable, specialty codes must be a valid three-digit MMIS specialty code
- Space-fill if not applicable

**Edit Applications:**

- Must be a valid code
- 00404 Provider Specialty Missing
- 00413 Provider Specialty Not On File

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **HOSPITAL INPATIENT CLAIM/ENCOUNTER INDICATOR** |
|---|---|
| Submission Status: | Required for COS 11 |
| Encounter Record Position(s): | 261 |
| Format - Length: | Character - 1 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1983/E1983 |

**Definition**: Indicates whether the inpatient service provided was a capitated service within the health organization's contract ("E"); a within plan claim ("C") or an administratively denied service ("A").

Administratively denied encounters are those encounters, which reflect services normally paid for, but were denied due to failure of at least one requirement of the agreement between provider and plan. An example could be that encounters must be submitted within 60 days of service date. A well-child encounter submitted 63 days after date of service would be administrative denied. (Claim received too late).

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

| Code | Value |
|---|---|
| E | Capitated Encounter or service not paid directly by the health organization |
| C | Within Plan Claim |
| A | Administrative Denial |

- Space-fill if not applicable

**Edit Applications:**

- Must be a valid code
- 00437 Claim Encounter Ind Invalid

***Please Note:***
Sub-capitation vendor relationships should be reported as encounters.

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **NYS DIAGNOSIS RELATED GROUP CODE** |
|---|---|
| Submission Status: | Required for COS 11 |
| Encounter Record Position(s): | 262-265 |
| Format - Length: | Character – 4 |
| Effective Date: | 12/01/2009 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 2053/3336 |

**Definition**: The NYS Diagnosis Related Group (APR-DRG) Code specifies the group of services received by a recipient during an inpatient stay. The APR-DRG data element is a four digits character field. The APR-DRG code is three digits and should be reported first (left justified). The **Severity of illness (SOI)** indicator is the last digit within the data element.

This code is generated by the NYS APR-DRG grouper module during claims processing and is derived using recipient information, diagnosis codes and procedure codes.

In instances where a plan-derived DRG differs from the provider submitted DRG, submit the plan-derived DRG.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #11, #39-41, #78, #84 |
| Institutional | UB-04 | #39-41, #78, #80 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Code | Page No. |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2300 | HI | 01 | 1 | | 230 |
| | | | HI | 01 | 2 | | |

**Codes and Values**:

- Follow the guidelines for APR-DRG codes
- Values for Severity of Illness:

| *Code* | *Value* |
|---|---|
| 1 | Minor |
| 2 | Moderate |
| 3 | Major |
| 4 | Severe |

- Left-justified
- If there is no DRG to report, a plan must report “0000” for the DRG

**Edit Applications:**

- Must be a valid code
- 00410 DRG Code Missing

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **TYPE OF BILL DIGITS 1 & 2 CODE** |
|---|---|
| Submission Status: | Required for COS 06, 11, 12, 15, 28, 73, 85, 87 |
| Encounter Record Position(s): | 266-267 |
| Format - Length: | Character - 2 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 0394 / E0394 |

**Definition**: Type of Bill Digits 1 & 2 Code is the first two digits of a three digit numeric code which identifies the specific type of bill (inpatient, outpatient, adjustments, voids, etc.). The first digit represents the Type of Facility; the second digit is the Bill Classification.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #4 |
| Institutional | UB-04 | #4 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Composite | Element ID | Page No. |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2300 | CLM | 05 | C023-1<br>C023-2 | 1331<br>1332 | 159 |

**Codes and Values**:

| *Code* | *Value* |
|---|---|
| 11 | HOSP-INP INCL MED PART A |
| 12 | HOSP-INP MED PART B ONLY |
| 13 | HOSP-OUT |
| 14 | HOSP-OTHER |
| 15 | HOSP-INTER CARE LEVEL I |
| 16 | HOSP-INTER CARE LEVEL II |
| 17 | HOSP-SUBACUTE INP |
| 18 | HOSP-SWING BEDS |
| 21 | SNF-INP INCL MED PART A |
| 22 | SNF-INP MED PART B ONLY |
| 23 | SNF-OUT |
| 24 | SNF-OTHER |
| 25 | SNF-INTER CARE LEVEL I |
| 26 | SNF-INTER CARE LEVEL II |
| 27 | SNF-SUBACUTE INP |
| 28 | SNF-SWING BEDS |

| *Code* | *Value* |
|---|---|
| 32 | HOME HLTH-INP MED PART B ONLY |
| 33 | HOME HLTH-OUTPATIENT |
| 34 | HOME HLTH-OTHER |
| 41 | NON-MED HCI-HOSP INP-INP INCL MED PART A |
| 42 | NON-MED HCI-HOSP INP-INP MED PART B ONLY |
| 43 | NON-MED HCI-HOSP INP-OUT |
| 44 | NON-MED HCI-HOSP INP-OTHER |
| 45 | NON-MED HCI-HOSP INP-INTER CARE LEVEL I |
| 46 | NON-MED HCI-HOSP INP-INTER CARE LEVEL II |
| 47 | NON-MED HCI-HOSP INP-SUBACUTE INP |
| 48 | NON-MED HCI-HOSP INP-SWING BEDS |
| 51 | NON-MED HCI-POST-HOSP EXT CS-INP INCL MED PART A |
| 52 | NON-MED HCI-POST-HOSP EXT CS-INP MED PART B ONLY |
| 53 | NON-MED HCI-POST-HOSP EXT CS-OUT |
| 54 | NON-MED HCI-POST-HOSP EXT CS-OTHER |
| 55 | NON-MED HCI-POST-HOSP EXT CS-INTER CARE LEVEL I |
| 56 | NON-MED HCI-POST-HOSP EXT CS-INTER CARE LEVEL II |
| 57 | NON-MED HCI-POST-HOSP EXT CS-SUBACUTE INP |
| 58 | NON-MED HCI-POST-HOSP EXT CS-SWING BEDS |
| 61 | INTER CARE-INP INCL MED PART A |
| 62 | INTER CARE-INP MED PART B ONLY |
| 63 | INTER CARE-OUT |
| 64 | INTER CARE-OTHER |
| 65 | INTER CARE-INTER CARE LEVEL I |
| 66 | INTER CARE-INTER CARE LEVEL II |
| 67 | INTER CARE-SUBACUTE INP |
| 68 | INTER CARE-SWING BEDS |
| 71 | CLINIC-RURAL HLTH |
| 72 | CLINIC-HOSP/INDEP DIALYSIS CNTR |
| 73 | CLINIC-FREE STANDING |
| 74 | CLINIC-ORF |
| 75 | CLINIC-CORF |
| 76 | CLINIC-COMMUNITY MENTAL HLTH CENTER |
| 79 | CLINIC-OTHER |
| 81 | SPEC FACI-HOSPICE (NON-HOSP BASED) |
| 82 | SPEC FACI-HOSPICE (HOSP BASED) |
| 83 | SPEC FACI-AMB SURG CNTR |
| 84 | SPEC FACI-FREE STANDING BIRTHING CENTER |
| 85 | SPEC FACI-CRITICAL ACCESS HOSP |
| 86 | SPEC FACI-RESIDENTIAL FACILITY |
| 89 | SPEC FACI-OTHER |

**Edit Applications:**

- Must be a valid code.
- 01718 Type of Bill is Invalid

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **TYPE OF BILL CODE DIGIT 3 CODE** |
|---|---|
| Submission Status: | Required for COS 06, 11, 12, 15, 28, 73, 85, 87 |
| Encounter Record Position(s): | 268 |
| Format - Length: | Character – 1 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 0395/ E0395 |

**Definition**: Type of Bill Digit 3 Code is the last digit of the three Character Type of Bill code. It represents the frequency of the bill.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #4 |
| Institutional | UB-04 | #4 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Composite | Element ID | Page No. |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2300 | CLM | 05 | C023-3 | 1325 | 159 |

**Codes and Values**:

| *Code* | *Value* |
|---|---|
| 0 | NON-PAYMENT/ZERO CLAIM |
| 1 | ADMIT THRU DISCHARGE CLAIM |
| 2 | INTERIM - FIRST CLAIM (NOT VALID FOR COS 11 ENCOUNTERS) |
| 3 | INTERIM - CONTINUING CLAIM (NOT VALID FOR COS 11 ENCOUNTERS) |
| 4 | INTERIM - LAST CLAIM (NOT VALID FOR COS 11 ENCOUNTERS) |
| 5 | LATE CHARGE(S) ONLY CLAIM |
| 6 | RESERVED |
| 7 | REPLACEMENT OF PRIOR CLAIM |
| 8 | VOID/CANCEL OF PRIOR CLAIM |
| 9 | FINAL CLAIM FOR A HOME HEALTH PPS EPISODE |
| A | ADMISSION/ELECTION NOTICE (A) |

**Edit Applications:**

- Must be a valid code
- 00436 Type of Bill Digit 3 Invalid

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **STATEMENT COVERS PERIOD FROM** |
|---|---|
| Submission Status: | Required for COS 06, 12, 15, 28, 73, 85, 87 |
| Encounter Record Position(s): | 269-276 |
| Format - Length: | Date – CCYYMMDD |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1022/3013 |

**Definition**: Statement Covers Period From date is the first date that a service on an encounter was rendered.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #6 |
| Institutional | UB-04 | #6 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Code | Pg No |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2300 | DTP | 01<br>02<br>03 | 374<br>1250<br>1251 | 434<br>D8&RD8 | 167 |

**Codes and Values**:

- Must be a valid date format CCYYMMDD

| Valid Century (CC) | Valid Year (YY) |
|---|---|
| 20 | >=04 |

| Valid Month Code (MM) | Valid Day Code (DD) |
|---|---|
| 01, 03, 05, 07, 08, 10, 12 | Greater than 00 and less than 32 |
| 04, 06, 09, 11 | Greater than 00 and less than 31 |
| 02 | Greater than 00 and less than 29 (less than 30 on a leap year) |

- Must be spaced-filled when not applicable (i.e., COS 06, 12, 15, 28, 73, 85, 87)

**Edit Applications:**

- Must be on or before the Statement Covers Period – Thru Date
- 00018 Date Of Service/Fill Date Invalid
- 001292 Date of Service Two Years Prior to Date Received

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **STATEMENT COVERS PERIOD THRU** |
|---|---|
| Submission Status: | Required for COS 06, 12, 15, 28, 73, 85, 87 |
| Encounter Record Position(s): | 277-284 |
| Format - Length: | Date - CCYYMMDD |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1023/3015 |

**Definition**: Statement Covers Period Thru date is the last date that a service on an encounter was rendered.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #6 |
| Institutional | UB-04 | #6 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Code | Pg No |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2300 | DTP | 01<br>02<br>03 | 374<br>1250<br>1251 | 434<br>D8&RD8 | 167 |

**Codes and Values**:

- Must be a valid date format CCYYMMDD

| Valid Century (CC) | Valid Year (YY) |
|---|---|
| 20 | >=04 |

| Valid Month Code (MM) | Valid Day Code (DD) |
|---|---|
| 01, 03, 05, 07, 08, 10, 12 | Greater than 00 and less than 32 |
| 04, 06, 09, 11 | Greater than 00 and less than 31 |
| 02 | Greater than 00 and less than 29 (less than 30 on a leap year) |

- Must be spaced-filled when not applicable (i.e., COS 06, 12, 15, 28, 73, 85, 87)

**Edit Applications:**

- Must be on or after the Statement Covers Period – From Date
- Must be on or after the Admission Date
- 00655 Discharge Date Different Than Statement Thru Date
- 01004 Thru Service Date Invalid
- 01006 Thru Service Prior to From Service Date

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **TYPE OF ADMISSION** |
|---|---|
| Submission Status: | Required for COS 11 |
| Encounter Record Position(s): | 285 |
| Format - Length: | Character - 1 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 4151/3101 |

**Definition**: One-digit alpha-numeric code indicating priority of the admission to a hospital.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #19 |
| Institutional | UB-04 | #14 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Composite | Element ID | Page No. |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2300 | CL1 | 01 | n/a | 1315 | 171 |

**Codes and Values**:

| *Code* | *Value* |
|---|---|
| 1 | Emergency: The patient requires immediate medical intervention as a result of severe, life threatening, or potentially disabling conditions. |
| 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 admission based on the availability of a suitable accommodation. |
| 4 | Newborn: Use of this code necessitates the use of special codes in the Source of Admission |
| 5 | Trauma Center |

- Space-fill if not applicable

**Edit Applications:**

- Must be a valid entry.
- 00603 Admission Type Code Invalid

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **SOURCE OF ADMISSION** |
|---|---|
| Submission Status: | Required for COS 11 |
| Encounter Record Position(s): | 286 |
| Format - Length: | Character - 1 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 0138/E0138 |

**Definition**: Source of Admission specifies the source of an admission into a hospital.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #20 |
| Institutional | UB-04 | #15 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Composite | Element ID | Page No. |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2300 | CL1 | 02 | n/a | 1314 | 172 |

**Codes and Values**:

| *Code* | *Value* |
|---|---|
| 1 | Non Health Care Facility Point of Origin |
| 2 | Clinic Referral |
| 4 | Transfer from a Hospital |
| 5 | Transfer from a Skilled Nursing Facility or Intermediate Care Facility |
| 6 | Transfer from Another Health Care Facility |
| 7 | Emergency Room |
| 8 | Court/Law Enforcement |
| 9 | Information Not Available |
| B | Transfer from Another Home Health Agency |
| C | Readmission to Same Home Health Agency |
| D | Transfer from One Distinct Unit of the Hospital to another Distinct Unit of the same hospital |
| E | Transfer from Ambulatory Surgery Center |
| F | Transfer from Hospice and is Under a Hospice Plan of Care |

If the Type of Admission is a Newborn, "4", the following coding scheme must be used for Source of Admission.

| *Code* | *Value* |
|---|---|
| 5 | Born Inside this Hospital |
| 6 | Born Outside this Hospital |

- Space-fill if not applicable

**Edit Applications:**

- Must be a valid entry
- 00435 Source of Admission Code Invalid

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **PATIENT STATUS OR DISPOSITION CODE** |
|---|---|
| Submission Status: | Required for COS 11, 12, 28, 73 |
| Encounter Record Position(s): | 287-288 |
| Format - Length: | Character - 2 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 0168/3291 |

**Definition**: Patient Status Code describes a specific condition or status of an enrollee as of the last date of service on the encounter.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #22 |
| Institutional | UB-04 | #17 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Composite | Element ID | Page No. |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2300 | CL1 | 03 | n/a | 1352 | 172 |

**Codes and Values**:

- Right-justified and zero-filled.
- Must be a valid code in accordance with Patient Status or Disposition Codes

| *Code* | *Value* |
|---|---|
| 01 | DISCHARGE / TRANSFER TO HOME/SELF CARE |
| 02 | TRANSFER TO A DRG HOSPITAL |
| 03 | DISCHARGE / TRANSFER TO SKILLED NURSING FACILITY |
| 04 | DISCHARGE/TRANSFER TO INTER CARE FACILITY/HRF |
| 05 | TRANSFERRED TO A NON-DRG HOSPITAL |
| 06 | DISCHARGE TO HOME UNDER CARE OF HOME HEALTH ORG. |
| 07 | LEFT AGAINST MEDICAL ADVICE |
| 08 | DISCHARGED TO HOME IV THERAPY |
| 09 | ADMITTED TO INPATIENT HOSPITAL |
| 20 | EXPIRED |
| 21 | DISCHARGE/TRANSFER TO COURT/LAW ENFORCEMENT |
| 30 | STILL A PATIENT/RESIDENT (NOT VALID FOR COS 11 ENCOUNTERS) |
| 40 | EXPIRED AT HOME |
| 41 | EXPIRED AT MEDICAL FACILITY |
| 42 | EXPIRED - PLACE UNKNOWN |

| *Code* | *Value* |
|---|---|
| 43 | DISCHARGED TO FEDERAL HOSPITAL |
| 50 | HOSPICE – HOME |
| 51 | HOSPICE - MEDICAL FACILITY |
| 61 | DISCHARGE/TRANSFER TO ALC |
| 62 | DISCHARGE/TRANSFER TO INPATIENT REHAB FACILITY |
| 63 | DISCHARGE/TRANSFER TO MCARE LTC HOSPITAL |
| 64 | DISCHARGE/TRANSFER TO SNF CERTIFIED UNDER MCAID |
| 65 | DISCHAGE /TRANSFER TO PSYCHIATRIC HOSPITAL |
| 66 | DISCHARGE/ TRANSFER TO A CRITICAL ACCESS HOSPITAL |
| 70 | DISCHARGE/ TRANSFER TO ANOTHER TYPE OF HEALTH CARE INSTITUTION |

- Space-fill if not applicable

**Edit Applications:**

- Must be a valid entry
- 00021 Patient Status Code Invalid

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **MEDICAL RECORD NUMBER** |
|---|---|
| Submission Status: | Required for COS 11 |
| Encounter Record Position(s): | 289-308 |
| Format - Length: | Character – 20 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1016/3253 |

**Definition**: Patient Medical Record Number is an identifier assigned by a provider to a client for the purposes of tracking, accounting or reference. The number used by the Medical Records Department to identify the patient's permanent medical/health record file.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #23 |
| Institutional | UB-04 | #3-B |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Composite | Element ID | Page No. |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2300 | REF | 01<br>02 | n/a | 128<br>127 | 200-201 |

**Codes and Values**:

- Left-justified with no embedded blanks
- Space-fill if not applicable
- Must not equal zero or blanks
- Must be numeric (0-9) and/or alphabetic (A-Z); special characters are invalid

**Edit Applications:**

- Must be a valid entry

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **NEONATE BIRTH WEIGHT CODE [up to 2]** |
|---|---|
| Submission Status: | Required for COS 11 |
| Encounter Record Position(s): | 309-310; 318-319 |
| Format - Length: | Character – 2 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1093/3321 |

**Definition**: The MEDS III layout allows for up to two Value Codes and up to two Value Code Amounts. At this time, only neonatal birth weight will be using the Value Codes. All newborn encounters must have a value code of 54.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #39-41 |
| Institutional | UB-04 | #39-41 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Composite | Element ID | Page No. |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2300 | HI | 01 | C022 - 2 | 1271 | 281 |

**Codes and Values**:

| *Code* | *Value* |
|---|---|
| 54 | Newborn Birth Weight In Grams |

- Space-fill if not applicable

**Edit Applications:**

- If applicable, must be a valid code
- 00431 Neonate Brth Weight Cd Invalid

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **NEONATE BIRTH WEIGHT IN GRAMS (VALUE CODE AMOUNT) [up to 2]** |
|---|---|
| Submission Status: | Required for COS 11 |
| Encounter Record Position(s): | 311-317; 320-326 |
| Format - Length: | Numeric – 7 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1094/3367 |

**Definition**: The birth weight of the neonate in grams.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #39-41 |
| Institutional | UB-04 | #39-41 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Composite | Element ID | Page No. |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2300 | HI | 01 | C022-5 | 782 | 280 |

**Codes and Values**:

- Right-justified and zero-filled
- Must be a valid number greater than "0099" and less than "8000"
- Birth Weights of "0099" grams or less should be reported as "0100" grams
- If this field is not applicable it must contain zeroes

**Edit Applications:**

- Must be a valid entry
- 00434 Birthweight Not Reasonable

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **SERVICE DATE [up to 10]** |
|---|---|
| Submission Status: | Required for COS 06, 12, 15, 28, 73, 85, 87 |
| Encounter Record Position(s): | 327-334; 420-427; 513-520; 606-613; 699-706; 792-799; 885-892; 978-985; 1071-1078; 1164-1171 |
| Format - Length: | Date CCYYMMDD - 8 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | 3013/1080 |

**Definition**: The associated Service Date for the reported CPT/HCPCS or Revenue code(s) describing non-inpatient procedure(s) performed.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #17 |
| Institutional | UB-04 | #45 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Page No. |
|---|---|---|---|---|---|---|
| Institutional | 837I | 2400 | DTP | 03 | 1251 | 457 |

**Codes and Values**:

- Must be a valid date format CCYYMMDD

| Valid Century (CC) | Valid Year (YY) |
|---|---|
| 20 | >=04 |

| Valid Month Code (MM) | Valid Day Code (DD) |
|---|---|
| 01, 03, 05, 07, 08, 10, 12 | Greater than 00 and less than 32 |
| 04, 06, 09, 11 | Greater than 00 and less than 31 |
| 02 | Greater than 00 and less than 29 (less than 30 on a leap year) |

**Edit Applications:**

- Must be a valid, properly formatted date

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **REVENUE CODE [up to 10]** |
|---|---|
| Submission Status: | Required for COS 06, 11, 12, 15, 28, 73, 85, 87 |
| Encounter Record Position(s): | 335-338; 428-431; 521-524; 614-617; 707-710; 800-803; 893-896; 986-989;1079-1082;1172-1175 |
| Format - Length: | Character - 4 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 0442/0442 |

**Definition**: Revenue Codes uniquely identify a provider's cost center.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #42 |
| Institutional | UB-04 | #42 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Composite | Element ID | Page No. |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2400 | SV2 | 01 | n/a | 234 | 446 |

**Codes and Values**:

- Right-justified
- Space-fill if not applicable
- Valid values are assigned by the National Uniform Billing Committee (NUBC)
- If this field is not applicable it must be space-filled

**Edit Applications:**

- Must be a valid code
- 01705 Revenue Code Not On File

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **CPT/HCPCS CODE [up to 10]** |
|---|---|
| Submission Status: | Required for COS 06, 12, 15, 28, 73, 85, 87 |
| Encounter Record Position(s): | 339-343;432-436;525-529;618-622;711-715;804-808;897-901;990-994;1083-1087;1176-1180 |
| Format - Length: | Character - 5 |
| Effective Date: | 1/1/2009 |
| Version Number - Date: | 2.8 - January 2009 |
| MEDS III DE# / DW#: | 2042/5055 |

**Definition**: The American Medical Association's Current Procedural Terminology 4th Edition (CPT-4) Code or the Healthcare Common Procedure Coding System (HCPCS) code, which applies to the non-inpatient procedure performed and associated with each line of service.

Procedure Codes uniquely describe the service(s) rendered by a provider during an encounter. Fields for reporting up to ten procedures or services are available. If more than ten procedures were performed during the encounter, submit a second encounter record with the additional procedures listed and using the same Encounter Control Number and identical information on all other elements that were included in the first record.

Injections and immunizations administered or DME provided during the encounter should be recorded using the appropriate procedure codes. Diagnostic tests performed during the encounter should be reported. Diagnostic testing performed on subsequent days should be reported as separate encounters.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #44 |
| Institutional | UB-04 | #44 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Composite | Element ID | Page No. |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2400 | SV2 | 02 | C0003-1<br>C0003-2 | 235<br>234 | 446 |

**Codes and Values**:

- Space-fill if not applicable
- Entered exactly as shown in the American Medical Association's Current Procedural Terminology - 4th Edition (CPT-4) or the Centers for Medicare and Medicaid Services HCPCS code for ambulatory surgery and emergency department procedures performed.
- Not applicable for inpatient encounters

**Edit Applications:**

- Must be a valid code
- 00070 Procedure Code Invalid
- 00170 Procedure Code Not On File
- 00710 Procedure Exceeds Service Limits

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **PROCEDURE MODIFIER CODE 1 [up to 10]** |
|---|---|
| Submission Status: | Required for COS 06, 12, 15, 28, 73, 85, |
| Encounter Record Position(s): | 344-345; 437-438;530-531;623-624;716-717;809-810;902-903;995-996;1088-1089;1181-1182 |
| Format - Length: | Character - 2 |
| Effective Date: | 1/1/2009 |
| Version Number - Date: | 2.8 - January 2009 |
| MEDS III DE# / DW#: | 3227_1 |

**Definition**: Procedure Modifier Codes are used in conjunction with the CPT procedure code to uniquely describe the service(s) rendered by a provider during an encounter. Fields for reporting a single modifier on each of the up to ten procedures or services are available.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #44 |
| Institutional | UB-04 | #44 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Composite | Element ID | Page No. |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2400 | SV2 | 02 | 3 | 1339 | 447 |

**Codes and Values**:

- Space-fill if not applicable
- Entered exactly as shown in the American Medical Association's Current Procedural Terminology - 4th Edition (CPT-4)
- Not applicable for inpatient encounters

**Edit Applications:**

- 00927 Modifier Invalid For Procedure Code

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **PROCEDURE MODIFIER CODE 2 [up to 10]** |
|---|---|
| Submission Status: | Required for COS 06, 12, 15, 28, 73, 85, 87 |
| Encounter Record Position(s): | 346-347;439-440;532-533;625-626;718-719;811-812;904-905;997-998;1090-1091;1183-1184 |
| Format - Length: | Character - 2 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2- April 2012 |
| MEDS III DE# / DW#: | 3227_1 |

**Definition**: Procedure Modifier Codes are used in conjunction with the CPT procedure code to uniquely describe the service(s) rendered by a provider during an encounter. Fields for reporting a single modifier on each of the up to ten procedures or services are available.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #44 |
| Institutional | UB-04 | #44 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Composite | Element ID | Page No. |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2400 | SV2 | 02 | 4 | 1339 | 447 |

**Codes and Values**:

- Space-fill if not applicable
- Entered exactly as shown in the American Medical Association's Current Procedural Terminology - 4th Edition (CPT-4).
- Not applicable for inpatient encounters

**Edit Applications:**

- 00927 Modifier Invalid For Procedure Code

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **PROCEDURE MODIFIER CODE 3 [up to 10]** |
|---|---|
| Submission Status: | Required for COS 06, 12, 15, 28, 73, 85, 87 |
| Encounter Record Position(s): | 348-349;441-442;534-535;627-628;720-721;813-814;906-907;999-1000;1092-1093;1185-1186 |
| Format - Length: | Character - 2 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | 3227_1 |

**Definition**: Procedure Modifier Codes are used in conjunction with the CPT procedure code to uniquely describe the service(s) rendered by a provider during an encounter. Fields for reporting a single modifier on each of the up to ten procedures or services are available.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #44 |
| Institutional | UB-04 | #44 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Composite | Element ID | Page No. |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2400 | SV2 | 02 | 5 | 1339 | 448 |

**Codes and Values**:

- Space-fill if not applicable
- Entered exactly as shown in the American Medical Association's Current Procedural Terminology - 4th Edition (CPT-4).
- Not applicable for inpatient encounters

**Edit Applications:**

- 00927 Modifier Invalid For Procedure Code

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **PROCEDURE MODIFIER CODE 4 [up to 10]** |
|---|---|
| Submission Status: | Required for COS 06, 12, 15, 28, 73, 85, 87 |
| Encounter Record Position(s): | 350-351;443-444;536-537;629-630;722-723;815-816;908-909;1001-1002;1094-1095;1187-1188 |
| Format - Length: | Character - 2 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | 3227_1 |

**Definition**: Procedure Modifier Codes are used in conjunction with the CPT procedure code to uniquely describe the service(s) rendered by a provider during an encounter. Fields for reporting a single modifier on each of the up to ten procedures or services are available.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #44 |
| Institutional | UB-04 | #44 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Composite | Element ID | Page No. |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2400 | SV2 | 02 | 6 | 1339 | 448 |

**Codes and Values**:

- Space-fill if not applicable
- Entered exactly as shown in the American Medical Association's Current Procedural Terminology - 4th Edition (CPT-4).
- Not applicable for inpatient encounters

**Edit Applications:**

- 00927 Modifier Invalid For Procedure Code

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **QUANTITY OR UNITS SUBMITTED [up to 10]** |
|---|---|
| Submission Status: | Required for COS 06, 12, 15, 28, 73, 85, 87, |
| Encounter Record Position(s): | 352-362;445-455;538-548;631-641;724-734;817-827;910-920;1003-1013;1096-1106;1189-1199 |
| Format - Length: | Numeric – 11 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1092/3029 |

**Definition**: Quantity or Units Submitted is the total number of units or quantity submitted by a provider for the service rendered. This element may contain days, metric units, visits, miles, injections, etc. Format and size may vary based on encounter type and nature of the quantity specified.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #46 |
| Institutional | UB-04 | #46 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Composite | Element ID | Page No. |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2400 | SV2 | 04<br>05 | | 355<br>380 | 448 |

**Codes and Values**:

Right-justified and zero-filled with 2 implied decimal points (i.e. '1' would be reported as '00000000001'

**Edit Applications:**

- 00094 Number of Units Not Greater Than Zero
- 00180 Units Greater Than Maximum
- 00710 Procedure Code Exceeds Service Limits

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **NDC (FORMULARY) CODE [up to 10]** |
|---|---|
| Submission Status: | Required for COS 06, 12, 15, 28, 73, 85, 87 |
| Encounter Record Position(s): | 363-373;456-466;549-559;642-652;735-745;828-838;921-931;1014-1024;1107-1117;1200-1210 |
| Format - Length: | Character - 11 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | 1856/E1856 |

**Definition**: National Drug Code (NDC) is an 11-digit national drug identification number assigned by the Federal Drug Administration used to identify OTC medications. The NDC uniquely identifies a drug and includes information on the manufacturer, product code, and package size.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #43 |
| Institutional | UB-04 | #43 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Page No. |
|---|---|---|---|---|---|---|
| Institutional | 837I | 2400 | SV2 | 04 | 355 | 448 |

**Codes and Values**:

- Right-justified and zero filled.
- Valid values for this data element are defined and maintained by First DataBank.

**Edit Applications:**

- 00544 NDC Code Non-Numeric
- 00561 Drug Code Not On file
- 01610 Missing or Invalid Alternate Product Code
- 02066 Drug Code Missing

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **NDC (FORMULARY) UNITS [up to 10]** |
|---|---|
| Submission Status: | Required for COS 06, 12, 15, 28, 73, 85 |
| Encounter Record Position(s): | 374-385;467-478;560-571;653-664;746-757;839-850;932-943;1025-1036;1118-1129;1211-1222 |
| Format - Length: | Numeric - 12 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | 4217/3251 |

**Definition**: NDC (Formulary) Unit is the dispensed quantity of a drug as submitted on a claim form. The dispensing quantity is based upon the unit of measure as defined by the National Drug Code. Quantity Dispensed was formerly called NDC Units.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #46 |
| Institutional | UB-04 | #46 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Composite | Element ID | Page No. |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2410 | CTP | 04 | | 380 | 449 |

**Codes and Values**:

- Must be entered if a National Drug Code has been entered
- Right-justified and zero filled with 3 implied decimal points
- Must be a positive numeric value
- Fractions must be reported to the nearest 1000$^{th}$ (.001)

**Edit Applications:**

- Must be a valid entry
- 00528 Missing Or Invalid Quantity Dispensed

Examples:
2.755 units = 000000002755
2.5 units = 000000002500
25 units = 000000025000
250 units = 000000250000

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **CHARGED AMOUNT [up to 10]** |
|---|---|
| Submission Status: | Required for COS 06, 12, 15, 28, 73, 85, 87 |
| Encounter Record Position(s): | 386-396;479-489;572-582;665-675;758-768;851-861;944-954;1037-1047;1130-1140;1223-1233 |
| Format - Length: | Numeric - 11 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | 3199/3199 |

**Definition**: The amount charged for each listed service corresponding to the procedures defined in the CPT/HCPCS data element.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #47 |
| Institutional | UB-04 | #47 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Page No. |
|---|---|---|---|---|---|---|
| Institutional | 837I | 2400 | SV2 | 02 | 782 | 159 |

**Codes and Values**:

- Right-justified and zero filled
- The amount is defined with two implied decimal places
- Must be entered as a positive number

**Edit Applications:**

- Must be a valid format
- Must be entered as a positive number
- 00036 M/I Usual and Customary

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **MEDICARE PAID AMOUNT** |
|---|---|
| Submission Status: | Required for COS 06, 12, 15, 28, 73, 85, 87 |
| Encounter Record Position(s): | 397-407;490-500;583-593;676-686;769-779;862-872;955-965;1048-1058;1141-1151;1234-1244 |
| Format - Length: | Numeric - 11 |
| Effective Date: | 2/18/2010 |
| Version Number - Date: | 2.9 – April 2010 |
| MEDS III DE# / DW#: | 1085/L3033_2 |

**Definition**: The amount Medicare paid for each listed service line that is received by dual eligible Medicaid/Medicare enrollees or beneficiaries. A service line is identified through either HCPCS/CPT procedure codes or revenue codes. This is the Medicare Paid Amount on the service line.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Right-justified and zero filled
- The amount is defined with two implied decimal places
- Must be entered as a positive number

**Edit Applications:**

- Must be a valid entry

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **PAID AMOUNT** |
|---|---|
| Submission Status: | Required for COS 06, 12, 15, 28, 73, 85, 87 |
| Encounter Record Position(s): | 408-418;501-511;594-604;687-697;780-790;873-883;966-976;1059-1069;1152-1162;1245-1255 |
| Format - Length: | Numeric - 11 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1028/3157 |

**Definition**: The amount Medicaid paid for each listed service, corresponding to the procedures defined in the data element HCPCS Code.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Right-justified and zero filled
- The amount is defined with two implied decimal places
- Must be entered as a positive number
- On the service line level the paid amount by Claim/Encounter Indicator should be as follows:

| Claim/Encounter Indicator | Total Paid Amount |
|---|---|
| "E" – Encounter | Proxy Cost Amount |
| "C" – Within Plan Claim | Actual Cost Amount |
| "A" – Administrative Denial | Zero Dollars |

**Edit Applications:**

- Must be a valid entry

***Important Note:***
Plans should use internal proxy fee schedules when determining the proxy cost amount.

**MEDS III Transaction Segment: Institutional**

**Data Element Name: NON-INPATIENT CLAIM/ENCOUNTER INDICATOR**

Submission Status: Required for COS 06, 12, 15, 28, 73, 85, 87
Encounter Record Position(s): 419;512;605;698;791;884;977;1070;1163; 1256
Format - Length: Character - 1
Effective Date: 3/1/2005
Version Number - Date: 2.6 - July 2008
MEDS III DE# / DW#: 1983/1983

**Definition**: Indicates whether the non-inpatient service provided was a capitated service within the health organization's contract ("E"); a within plan claim ("C") or an administratively denied service ("A").

Administratively denied encounters are those encounters which reflect services performed normally paid for, but were denied due to failure of at least one requirement of the agreement between provider and plan. An example could be where a contract requires that encounters must be submitted within 60 days of service date. A well-child encounter submitted 63 days after date of service would be administrative denied. (Claim received too late).

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

| *Code* | *Value* |
|---|---|
| E | Capitated Encounter, or service not paid directly by health organization. |
| C | Within Plan Claim |
| A | Administrative Denial |

- Space-fill if not applicable

**Edit Applications:**

- Must be a valid code
- 00437 Claim Encounter Ind Invalid

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **ICD VERSION CODE** |
|---|---|
| Submission Status: | Required for COS 06, 11, 12, 15, 28, 73, 85, 87 |
| Encounter Record Position(s): | 1257 |
| Format - Length: | Character - 1 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | E2498/2498 |

**Definition**: A one-digit code to indicate whether the reported diagnosis codes are ICD-9 or ICD-10.

**Mapping**:

- New York State specific data element

**Codes and Values:**

- If no diagnosis, leave blank (see below table).

| Code | Description |
|---|---|
| | Not Available |
| 1 | ICD-9 Version |
| 2 | ICD-10 Version |

**Edit Applications:**

- Must be a valid value
- 02174 Version Code Not Valid

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **PRINCIPAL/PRIMARY DIAGNOSIS CODE** |
|---|---|
| Submission Status: | Required for COS 06, 11, 12, 15, 28, 73, 85, 87 |
| Encounter Record Position(s): | 1258-1264 |
| Format - Length: | Character - 7 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 4183/3006 |

**Definition**: The ICD-9-CM or ICD-10-CM Principal Diagnosis Code uniquely specifies the condition established after study to be chiefly responsible for admission to an institution.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #67 |
| Institutional | UB-04 | #67 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Composite | Element ID | Code | Page No. |
|---|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2300 | HI | 01 | C022-1<br>C022-2 | 1270<br>1271 | BK | 228 |

NOTE: The Principal/Primary Diagnosis Code is coded in the first occurrence of C022 Composite for the Principal/Primary Diagnosis Information HI segment.

**Codes and Values**:

- Must be Left-justified and entered exactly as shown in the ICD-9-CM coding reference, excluding the decimal point, and Space-filled. The decimal point is implied because each ICD-9-CM or ICD-10-CM code is unique.
- Record the appropriate ICD-9-CM or ICD-10-CM code exactly as it appears in the manual. The diagnosis code must be the most specific/precise 3-digit, 4-digit or 5-digit code allowed for in the ICD-9-CM or ICD-10-CM coding format.
- Leading and trailing zeros in a diagnostic code must be recorded (i.e. do not use blanks in place of zeros for any reason). In addition, zeros should not be added to a diagnostic code to fill in blank spaces.
- External diagnosis codes (E Codes) are not valid as Principal Diagnosis Codes.

**Edit Applications:**

- Must be a valid code
- 00039 Primary Diagnosis Code Blank
- 00146 Primary Diagnosis not on File

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **OTHER DIAGNOSIS CODES [up to 8]** |
|---|---|
| Submission Status: | Required for COS 06, 11, 12, 15, 28, 73, 85, 87 |
| Encounter Record Position(s): | 1265-1271;1272-1278;1279-1285;1286-1292;1293-1299;1300-1306;1307-1313;1314-1320 |
| Format - Length: | Character - 7 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 4157/W657 |

**Definition**: Other Diagnosis Codes indicate additional significant condition(s) during an encounter.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #68-75 |
| Institutional | UB-04 | #67A- 67Q |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Composite | Element ID | Code | Page No. |
|---|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2300 | HI | 01 | C022-1<br>C022-2 | 1270<br>1271 | BF | 232 |

NOTE: The Other Diagnosis codes are coded in two iterations of C022 Composite for the Other Diagnosis Information HI segment.

**Codes and Values**:

- Left-justified and entered exactly as shown in the ICD-9-CM or ICD-10-CM coding reference, excluding the decimal point, and Space-filled. The decimal point is implied because each ICD-9-CM or ICD-10-CM code is unique.
- Record the appropriate ICD-9-CM or ICD-10-CM code exactly as it appears in the manual. The diagnosis code must be the most specific/precise 3-digit, 4-digit or 5-digit code allowed for in the ICD-9-CM or ICD-10-CM coding format.
- Leading and trailing zeros in a diagnostic code must be recorded (i.e. do not use blanks in place of zeros for any reason). In addition, zeros should not be added to a diagnostic code to fill in blank spaces.

**Edit Applications:**

- Must be a valid code
- If this field is not coded it must contain blanks
- 00412 Diagnosis Code Not On File

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **OTHER DIAGNOSIS CODES [9 TO 24]** |
|---|---|
| Submission Status: | Required for COS 06, 11, 12, 15, 28, 73, 85, 87 |
| Encounter Record Position(s): | 1321-1327;1328-1334;1335-1341;1342-1348;1349-1355;1356-1362;1363-1369;1370-1376;1377-1383;1384-1390;1391-1397;1398-1404;1405-1411;1412-1418;1419-1425;1426-1432 |
| Format - Length: | Character - 7 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 4157/W657 |

**Definition**: Other Diagnosis Codes indicate additional significant condition(s) during an encounter.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #68-75 |
| Institutional | UB-04 | #67A- 67Q |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Composite | Element ID | Code | Page No. |
|---|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2300 | HI | 01 | C022-1<br>C022-2 | 1270<br>1271 | BF | 232 |

NOTE: The Other Diagnosis codes are coded in two iterations of C022 Composite for the Other Diagnosis Information HI segment.

**Codes and Values**:

- Left-justified and entered exactly as shown in the ICD-9-CM or ICD-10-CM coding reference, excluding the decimal point, and Space-filled. The decimal point is implied because each ICD-9-CM or ICD-10-CM code is unique.
- Record the appropriate ICD-9-CM or ICD-10-CM code exactly as it appears in the manual. The diagnosis code must be the most specific/precise 3-digit, 4-digit or 5-digit code allowed for in the ICD-9-CM or ICD-10-CM coding format.
- Leading and trailing zeros in a diagnostic code must be recorded (i.e. do not use blanks in place of zeros for any reason). In addition, zeros should not be added to a diagnostic code to fill in blank spaces.

**Edit Applications:**

- Must be a valid code
- If this field is not coded it must contain blanks
- 00412 Diagnosis Code Not On File

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **ADMIT DIAGNOSIS** |
|---|---|
| Submission Status: | Required for COS 11 |
| Encounter Record Position(s): | 1433-1439 |
| Format - Length: | Character - 7 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 0411/3187 |

**Definition**: The diagnosis made by the Provider at the time of admission that describes the patient's condition upon admission to an institution. Since the Admitting Diagnosis is formulated before all tests and examinations are complete, it may have been stated in the form of a problem or symptom and it may differ from any of the final diagnoses recorded in the medical record.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #76 |
| Institutional | UB-04 | #69 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Comp-osite | Elem-ent ID | Code | Page No. |
|---|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2300 | HI | 02 | C022-1<br>C022-2 | 1270<br>1271 | BJ/PR | 228 |

NOTE: The Admitting Diagnosis Code is coded in the second occurrence of C022 Composite for the Principal Diagnosis Information HI segment.

**Codes and Values**:

- Left-justified and entered exactly as shown in the ICD-9-CM or ICD-10-CM coding reference, excluding the decimal point, and Space-filled.
- Must have been a valid ICD-9-CM or ICD-10-CM code excluding the decimal point. To be valid, ICD-9-CM or ICD-10-CM codes must have been entered at the most specific level to which they are classified in the ICD-9-CM or ICD-10-CM Tabular List. Three-digit codes further divided at the four-digit level must have been entered using all four digits. Four-digit codes further sub-classified at the five-digit level must be entered using all five digits.
- E-codes are not valid as Admitting Diagnosis Codes.

**Edit Applications:**

- 00604 Admitting Diagnosis Code Missing
- 00412 Diagnosis Code Not On File

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **EXTERNAL DIAGNOSIS CODE (E Code)** |
|---|---|
| Submission Status: | Required for COS 11 |
| Encounter Record Position(s): | 1440-1446 |
| Format - Length: | Character - 7 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 0411/5004 |

**Definition**: The External Diagnosis Code indicates the external cause of an injury, poisoning, or adverse effect.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #77 |
| Institutional | UB-04 | #70 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Composite | Element ID | Code | Page No. |
|---|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2300 | HI | 03 | C022-1<br>C022-2 | 1270<br>1271 | BN | 229 |

NOTE: The External Cause-of-Injury Code is coded in the third occurrence of C022 Composite for the Principal Diagnosis Information HI segment.

**Codes and Values**:

- Left-justified including the prefix letter “E” and all digits exactly as shown in the ICD-9-CM coding reference excluding the decimal point, and Space-filled.
- Must have been a valid ICD-9-CM or ICD-10-CM “E” code excluding the decimal point. To be valid, the code must have been entered at the most specific level classified in the ICD-9-CM Tabular List. Three-digit codes further divided to the four-digit level must have been entered using all four digits plus the prefix letter “E”. Failure to enter the prefix “E” and all required digits will cause the record to reject.
- If this field is not applicable it must contain blanks.

**Edit Applications:**

- Must contain a valid code
- 00412 Diagnosis Code Not On File

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **PRESENT ON ADMISSION CODE (POA) [up to 25]** |
|---|---|
| Submission Status: | Required for COS 11 |
| Encounter Record Position(s): | 1447;1448;1449;1450;1451;1452;1453;1454;1455;1456;1457;1458;1459;1460;1461;1462;1463;1464;1465;1466;1467;1468;1469;1470;<br>1471 |
| Format - Length: | Character - 1 |
| Effective Date: | 7/17/2008 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | E2254_1 – E2254_9 |

**Definition**: The POA code is a one-digit indicator for the inpatient diagnoses that denotes whether or not the diagnosis was present at the time of admission. Position one would be used for the primary diagnosis and positions two through twenty-five are used for the twenty-four other diagnoses.

**Mapping**:

- **Paper Form**:
  No mapping from paper form

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Code | Pg No |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2300 | K3 | 01 | 449 | | 204 |

**Codes and Values**:

- Blanks are not permitted
- Must be a valid code

| ***Code*** | ***Value*** |
|---|---|
| Y | Diagnosis was POA |
| N | Diagnosis was not POA |
| U | Documentation insufficient to determine POA or not |
| W | Provider unable to determine whether POA or not |
| 1 | Exempt/ Diagnosis not on applicable list |

**Edit Applications:**

- Edit 02079 Missing or Invalid POA code

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **PRINCIPAL PROCEDURE CODE** |
|---|---|
| Submission Status: | Required for COS 11 |
| Encounter Record Position(s): | 1472-1478 |
| Format - Length: | Character - 7 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 1.2 - May 96 |
| MEDS III DE# / DW#: | 0606/5055 |

**Definition**: The ICD-9-CM or ICD-10-CM Principal Procedure Code is the primary procedure code on a claim reported to the health organization by the providing inpatient facility.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #80 |
| Institutional | UB-04 | #74 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Composite | Element ID | Code | Page No. |
|---|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2300 | HI | 01 | C022-1<br>C022-2 | 1270<br>1271 | BR | 242 |

NOTE: The Principal Procedure Code is coded in the first occurrence of the C022 Composite for the Principal Procedure Information HI segment.

**Codes and Values**:

- Left-justified and Space-filled
- Enter exactly as shown in the ICD-9-CM coding reference, excluding the decimal point
- If this field is not coded it must be Space-filled

**Edit Applications:**

- Must contain a valid code if a procedure was performed
- 00405 Principal Procedure Code Missing
- 00170 Procedure Code Not on File

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **OTHER PROCEDURE CODES [up to 5]** |
|---|---|
| Submission Status: | Required for COS 11 |
| Encounter Record Position(s): | 1487-1493;1502-1508;1517-1523;1532-1538;1547-1553 |
| Format - Length: | Character - 7 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 4159/5055 |

**Definition**: Procedure Codes uniquely identify the procedures performed. All significant procedures other than the Principal Procedure Code are to be reported here. They are reported in order of significance, starting with the most significant.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #80 |
| Institutional | UB-04 | #74A- 74E |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Composite | Element ID | Code | Page No. |
|---|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2300 | HI | 01 | C022-1<br>C022-2 | 1270<br>1271 | BQ | 244 |

NOTE: The Other Procedure codes and dates are coded in two iterations of C022 Composite for the Other Procedure Information HI segment.

**Codes and Values**:

- Left-justified and Space-filled
- Enter exactly as shown in the ICD-9-CM or ICD-10-CM coding reference, excluding decimal points
- If this field is not applicable it must be Space-filled

**Edit Applications:**

- ICD-9-CM or ICD-10-CM procedure codes only
- 00170 Procedure Code Not on File

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **OTHER PROCEDURE CODES [6 TO 24]** |
|---|---|
| Submission Status: | Required for COS 11 |
| Encounter Record Position(s): | 1562-1568;1577-1583;1592-1598;1607-1613;1622-1628;1637-1643;1652-1658;1667-1673;1682-1688;1697-1703;1712-1718;1727-1733;1742-1748;1757-1763;1772-1778;1787-1793;1802-1808;1817-1823;1832-1838 |
| Format - Length: | Character - 7 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | 4159/5055 |

**Definition**: Procedure Codes uniquely identify the procedures performed. All significant procedures other than the Principal Procedure Code are to be reported here. They are reported in order of significance, starting with the most significant.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #80 |
| Institutional | UB-04 | #74A- 74E |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Composite | Element ID | Code | Page No. |
|---|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2300 | HI | 01 | C022-1<br>C022-2 | 1270<br>1271 | BQ | 244 |

**Codes and Values**:

- Left-justified and Space-filled
- Enter exactly as shown in the ICD-9-CM or ICD-10-CM coding reference, excluding decimal points
- If this field is not applicable it must be space-filled

**Edit Applications:**

- ICD-9-CM or ICD-10-CM procedure codes only

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **PROCEDURE DATE [up to 25]** |
|---|---|
| Submission Status: | Required for COS 11 |
| Encounter Record Position(s): | 1479-1486;1494-1501;1509-1516;1524-1531;1539-1546;1554-1561;1569-1576;1584-1591;1599-1606;1614-1621;1629-1636;1644-1651;1659-1666;1674-1681;1689-1696;1704-1711;1719-1726;1734-1741;1749-1756;1764-1771;1779-1786;1794-1801;1809-1816;1824-1831;1839-1846 |
| Format - Length: | Date CCYYMMDD - 8 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | |

**Definition**: The associated Procedure Date for the reported ICD-9 or ICD-10 code(s) describing inpatient procedure(s) performed.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-04 | #74 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Composite | Element ID | Page No. |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2300 | HI | 01 | 4 | 1251 | 244 |

**Codes and Values**:

- Blanks and characters are not permitted.
- Must be a valid date format CCYYMMDD

| Valid Century (CC) | Valid Year (YY) |
|---|---|
| 20 | >=04 |

| Valid Month Code (MM) | Valid Day Code (DD) |
|---|---|
| 01, 03, 05, 07, 08, 10, 12 | Greater than 00 and less than 32 |
| 04, 06, 09, 11 | Greater than 00 and less than 31 |
| 02 | Greater than 00 and less than 29 (less than 30 on a leap year) |

**Edit Applications:**

- Must be a valid, properly formatted date
- 00600 Admission/Service Date Invalid
- 02210 ICD-9 Procedure Date After Service Date
- 02211 ICD-9 Procedure Without ICD-9 Date
- 00613 Principal Procedure Date Is Invalid

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **ATTENDING PROVIDER PROFESSION CODE** |
|---|---|
| Submission Status: | Required for COS 06, 11, 12, 15, 28, 73, 85, 87 |
| Encounter Record Position(s): | 1847-1849 |
| Format - Length: | Character - 3 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 2165/2165_5 |

**Definition**: The NYS profession code of the attending provider for inpatient encounters (COS 11) and the servicing provider for non-inpatient encounters.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Provider Profession Codes and Values are contained within Appendix A
- Space-fill if not applicable

**Edit Applications:**

- Must be a valid code

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **ATTENDING PROVIDER LICENSE NUMBER** |
|---|---|
| Submission Status: | Required for COS 06, 11, 12, 15, 28, 73, 85, 87 |
| Encounter Record Position(s): | 1850-1857 |
| Format - Length: | Character – 8 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1570/3003_2 |

**Definition:** The NY professional license number of the attending provider for inpatient encounters (COS 11) and the servicing provider for non-inpatient encounters.

**Mapping:**

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Code | Page No. |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2420A | REF | 01<br>02 | 128<br>127 | 0B | 467 |

**Codes and Values**:

- Right-justified
- Do not zero fill – space-fill if not applicable
- Must be a valid professional license number issued by the New York State Department of Education

**Edit Applications:**

- Must be a valid entry
- 00416 License Number is Missing
- 00664 Attending Physician License Number Missing

**MEDS III Transaction Segment: Institutional**

**Data Element Name: ATTENDING PROVIDER IDENTIFICATION NUMBER**

Submission Status: Required for COS 06, 11, 12, 15, 28, 73, 85, 87
Encounter Record Position(s): 1858-1867
Format - Length: Character – 10
Effective Date: 9/1/2008
Version Number - Date: 2.7 - August 2008
MEDS III DE# / DW#: 1563/W039

**Definition**: The National Provider Identification (NPI) number of the attending provider for inpatient encounters and the servicing provider for non-inpatient encounters. If the servicing provider is a non-healthcare provider, you should report the state MMIS ID.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #82 |
| Institutional | UB-04 | #76 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Code | Page No. |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2420A | NM1 | 01 | 98 | 71 | 463 |
| | | | | 02 | 1065 | 1 | 463 |
| | | | | 08 | 66 | XX | 464 |
| | | | | 09 | 67 | | 464 |

**Codes and Values**:

- NPI should be left-justified with no embedded blanks.
- MMIS ID should be left-justified with two (2) trailing blanks.
- Space-fill if not applicable.

**Edit Applications:**

- Must be a valid entry
- 00432 Attend Prov Id Not on File
- 02023 Missing Attending NPI
- 02033 Invalid Attending NPI

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **SURGEON PROFESSION CODE** |
|---|---|
| Submission Status: | Required for COS 11 |
| Encounter Record Position(s): | 1868-1870 |
| Format - Length: | Character - 3 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 2165/2165_6 |

**Definition**: The profession code issued by the State Department of Education that identifies the type of license of the surgeon.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Provider Profession Codes and Values are contained within Appendix A
- Space-fill if not applicable.

**Edit Applications:**

- Must be a valid code.

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **SURGEON LICENSE NUMBER** |
|---|---|
| Submission Status: | Required for COS 11 |
| Encounter Record Position(s): | 1871-1878 |
| Format - Length: | Character - 8 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1570/3100 |

**Definition**: The professional license number, issued by the NYS Department of Education, used to identify the surgeon.

**Mapping:**

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Code | Page No. |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2420C | REF | 01<br>02 | 128<br>127 | 0B | 481<br>482 |

**Codes and Values**:

- Right-justified
- Do not zero fill, space-fill if not applicable
- Must be a valid professional license number issued by the NYS Department of Education.

**Edit Applications:**

- If a surgery was performed, must be a valid entry
- 00416 License Number Is Missing

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **SURGEON PROVIDER IDENTIFICATION NUMBER** |
|---|---|
| Submission Status: | Required for COS 11 |
| Encounter Record Position(s): | 1879-1888 |
| Format - Length: | Character - 10 |
| Effective Date: | 9/1/2008 |
| Version Number - Date: | 2.7 - August 2008 |
| MEDS III DE# / DW#: | 1563/W042 |

**Definition**: The National Provider Identification (NPI) number of the surgeon who performed the surgery.

**Mapping**:

- **Paper Form**: (Other identification Number)

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #83 |
| Institutional | UB-04 | #77 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Code | Page No. |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2420C | NM1 | 01 | 98 | 73 | 477 |
| | | | | 02 | 1065 | 1 | 477 |
| | | | | 08 | 66 | XX | 478 |
| | | | | 09 | 67 | | 478 |

**Codes and Values**:

- NPI must be left-justified with no embedded blanks.
- Space-fill if not applicable

**Edit Applications:**

- If a surgery was performed, must be a valid entry
- 00433 Oper Prov Id Not on File
- 02024 Missing Operating NPI
- 02034 Invalid Operating NPI

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **ADMISSION DATE** |
|---|---|
| Submission Status: | Required for COS 11, 12, 28 |
| Encounter Record Position(s): | 1889-1896 |
| Format - Length: | Date CCYYMMDD - 8 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1033/3011 |

**Definition**: The date of the patient's admission to the institution or facility.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #17 |
| Institutional | UB-04 | #12 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Code | Page No. |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2300 | DTP | 02 | 1250<br>1251 | DT | 169 |

**Codes and Values**:

- Blanks and characters are not permitted
- Must be a valid date format CCYYMMDD

| Valid Century (CC) | Valid Year (YY) |
|---|---|
| 20 | >=04 |

| Valid Month Code (MM) | Valid Day Code (DD) |
|---|---|
| 01, 03, 05, 07, 08, 10, 12 | Greater than 00 and less than 32 |
| 04, 06, 09, 11 | Greater than 00 and less than 31 |
| 02 | Greater than 00 and less than 29 (less than 30 on a leap year) |

**Edit Applications:**

- Must be on or before the Statement Covers Thru Date
- Must be a valid, properly formatted date
- 00600 Admission Date Invalid

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **DISCHARGE DATE** |
|---|---|
| Submission Status: | Required for COS 11, 12, 28 |
| Encounter Record Position(s): | 1897-1904 |
| Format - Length: | Date CCYYMMDD - 8 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1185/3108 |

**Definition**: The date of discharge from a stay in an inpatient hospital.

Inpatient encounters should be reported only after the patient is discharged. The entire inpatient stay, identified by actual admission and discharge dates should be reported as one encounter even if there are payers in addition to Medicaid managed care involved.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Institutional | UB-92 | #6 |
| Institutional | UB-04 | #6 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Code | Pg No |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2300 | DTP | 01<br>02<br>03 | 374<br>1250<br>1251 | 434<br>D8&RD8 | 167 |

**Codes and Values**:

- Blanks and characters are not permitted.
- Must be a valid date format CCYYMMDD

| Valid Century (CC) | Valid Year (YY) |
|---|---|
| 20 | >=04 |
| **Valid Month Code (MM)** | **Valid Day Code (DD)** |
| 01, 03, 05, 07, 08, 10, 12 | Greater than 00 and less than 32 |
| 04, 06, 09, 11 | Greater than 00 and less than 31 |
| 02 | Greater than 00 and less than 29 (less than 30 on a leap year) |

**Edit Applications:**

- Must be a valid, properly formatted date
- 00625 Discharge Date Illogical
- 00652 Discharge Date Prior To Admission Date
- 00655 Discharge Date Different Than Statement Thru Date

**MEDS III Transaction Segment: Institutional**

| **Data Element Name:** | **FILLER** |
|---|---|
| Submission Status: | Required |
| Encounter Record Position(s): | 1905-3000 |
| Format - Length: | Character - 1096 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |

**Definition**: Space-fill positions 1905 to 3000.

**Mapping**:

- New York State specific element

**Codes and Values**:

- Left-justified and space-filled

**Edit Applications:**

- Tier One Error – Record is not 3000 bytes

# VIII. PHARMACY SEGMENT

**MEDS III Transaction Segment: Pharmacy**

| **Data Element Name:** | **PRESCRIPTION ORIGIN CODE** |
|---|---|
| Submission Status: | Required for COS 14 |
| Encounter Record Position(s): | 258 |
| Format - Length: | Character - 1 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | E2371/2371 |

**Definition**: The Prescription Origin Code holds a value representing the medium used for submitting the prescription. It is a one-digit indicator that identifies the method in which the prescription was transmitted electronically to the pharmacy.

**Mapping**:

| **Encounter Type** | **Paper** | | **Electronic** | |
|---|---|---|---|---|
| | **Form** | **Element** | **Format** | **Element** |
| Pharmacy | UCF | N/A | NCPDP | 419-DJ |

**Codes and Values**:

| Code | Description |
|---|---|
| 0 | NOT SPECIFIED OR AVAILABLE |
| 1 | WRITTEN |
| 2 | TELEPHONE |
| 3 | ELECTRONIC |
| 4 | FACSIMILE |

**Edit Applications:**

- Must be a valid value
- 02116 Missing Prescription Origin Code
- 02117 Invalid Prescription Origin Code
- 02193 Controlled Substance Limit Exceeded

**MEDS III Transaction Segment: Pharmacy**

| **Data Element Name:** | **PRESCRIPTION NUMBER** |
|---|---|
| Submission Status: | Required for COS 14 |
| Encounter Record Position(s): | 259-270 |
| Format - Length: | Character - 12 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | 3099/3099 |

**Definition**: Prescription Number is assigned to a prescription by the pharmacy when it is filled.

**Mapping**:

| **Encounter Type** | **Paper** | | **Electronic** | |
|---|---|---|---|---|
| | **Form** | **Element** | **Format** | **Element** |
| Pharmacy | UCF | Prescription/ Service Reference # | NCPDP | 402-D2 |

**Codes and Values**:

- Must be right-justified and zero filled.
- Cannot equal zero or blanks.
- Must be numeric (0-9). Special Characters and Spaces are invalid entries.

**Edit Applications:**

- 00526 Missing or Invalid Prescription Number

**MEDS III Transaction Segment: Pharmacy**

| **Data Element Name:** | **PRESCRIBING PROVIDER PROFESSION CODE** |
|---|---|
| Submission Status: | Required for COS 14 |
| Encounter Record Position(s): | 271-273 |
| Format - Length: | Character - 3 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 2165/2165_2 |

**Definition**: The profession code, issued by the NYS Department of Education, is used to identify the type of license of individual health care professionals providing the services or primarily responsible for the care provided during the encounter. The prescribing Provider profession code relates to the Provider who signed the prescription form.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Provider Profession Codes and Values are contained within Appendix A
- Space-fill if not applicable

**Edit Applications:**

- Must be a valid code

**MEDS III Transaction Segment: Pharmacy**

| **Data Element Name:** | **PRESCRIBING PROVIDER LICENSE NUMBER** |
|---|---|
| Submission Status: | Required for COS 14 |
| Encounter Record Position(s): | 274-281 |
| Format - Length: | Character - 8 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1570/3005 |

**Definition**: The State issued provider license number of the prescribing provider. Health organizations must submit the State license number or the MMIS identification number on all prescriptions written for Medicaid recipients. When a prescription is written by an unlicensed intern or resident, the supervising physician's NYS MMIS number or State license number must be provided.

**Mapping**:

| **Common Detail Section** | **Paper** | | **Electronic** | |
|---|---|---|---|---|
| | **Form** | **Element** | **Format** | **Element** |
| Pharmacy | UCF | Prescriber ID | NCPDP | 466-EZ* 411-DB |

** Element 466-EZ is a prescriber ID qualifier and will always equal 08.*

**Codes and Values**:

- Right-justified
- Do not zero fill – space-fill if not applicable
- Must be a valid professional license number issued by the New York State Department of Education.
- Plans should not report a prescriber Drug Enforcement Agency (DEA) number in this field.

**Applicable Edit Codes:**

- Must be a valid entry
- 00525 Prescribing License Number Missing

**MEDS III Transaction Segment: Pharmacy**

| **Data Element Name:** | **PRESCRIBING PROVIDER IDENTIFICATION NUMBER** |
|---|---|
| Submission Status: | Required for COS 14 |
| Encounter Record Position(s): | 282-291 |
| Format - Length: | Character - 10 |
| Effective Date: | 9/1/2008 |
| Version Number - Date: | 2.7 - August 2008 |
| MEDS III DE# / DW#: | 1563/W048 |

**Definition**: The National Provider Identification number of the prescribing Provider. Health organizations must submit the State license number or the NPI on all prescriptions written for Medicaid recipients. When a prescription is written by an unlicensed intern or resident, the supervising physician's NPI number or State license number must be provided.

**Mapping**:

| **Common Detail Section** | **Paper** | | **Electronic** | |
|---|---|---|---|---|
| | **Form** | **Element** | **Format** | **Element** |
| Pharmacy | UCF | Service Provider ID | NCPDP | 466-EZ* 411-DB |

** The NCPDP qualifier (466-EZ) will always be equal to 05*

**Codes and Values**:

- NPI must be left-justified with no embedded spaces
- Space-fill if not applicable

**Applicable Edit Codes:**

- Must be a valid entry
- 00897 Prescriber Id Not on File
- 02029 Missing Prescribing NPI
- 02039 Invalid Prescribing NPI

**MEDS III Transaction Segment: Pharmacy**

| **Data Element Name:** | **PRESCRIPTION ORDERED DATE** |
|---|---|
| Submission Status: | Required for COS 14 |
| Encounter Record Position(s): | 292-299 |
| Format - Length: | Date – CCYYMMDD |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 0860/3247 |

**Definition**: Prescription Ordered Date is the date that a service was ordered or a prescription was written. (Formerly called Date Prescribed/Ordered)

**Mapping**:

| **Encounter Type** | **Paper** | | **Electronic** | |
|---|---|---|---|---|
| | **Form** | **Element** | **Format** | **Element** |
| Pharmacy | UCF | Date Written | NCPDP | 414-DE |

**Codes and Values**:

- Must be a valid date format CCYYMMDD

| **Valid Century (CC)** | **Valid Year (YY)** |
|---|---|
| 20 | >=04 |

| **Valid Month Code (MM)** | **Valid Day Code (DD)** |
|---|---|
| 01, 03, 05, 07, 08, 10, 12 | Greater than 00 and less than 32 |
| 04, 06, 09, 11 | Greater than 00 and less than 31 |
| 02 | Greater than 00 and less than 29 (less than 30 on a leap year) |

**Edit Applications:**

- Must be a valid date
- 00534 Date Ordered Invalid
- 00548 Fill Date Precedes Order Date

**MEDS III Transaction Segment: Pharmacy**

| **Data Element Name:** | **DATE FILLED** |
|---|---|
| Submission Status: | Required for COS 14 |
| Encounter Record Position(s): | 300-307 |
| Format - Length: | Date – CCYYMMDD |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1022/3013 |

**Definition**: Date Filled is the date a prescription or order was filled.

**Mapping**:

| **Encounter Type** | **Paper** | | **Electronic** | |
|---|---|---|---|---|
| | **Form** | **Element** | **Format** | **Element** |
| Pharmacy | UCF | Date of Service | NCPDP | 401-D1 |

**Codes and Values**:

- Must be a valid date format CCYYMMDD

| Valid Century (CC) | Valid Year (YY) |
|---|---|
| 20 | >=04 |

| **Valid Month Code (MM)** | **Valid Day Code (DD)** |
|---|---|
| 01, 03, 05, 07, 08, 10, 12 | Greater than 00 and less than 32 |
| 04, 06, 09, 11 | Greater than 00 and less than 31 |
| 02 | Greater than 00 and less than 29 (less than 30 on a leap year) |

**Edit Applications:**

- Must be a valid date
- 00018 Date Of Service/Fill Date Invalid
- 00020 Service/Fill Date Later Than Receipt Date
- 00548 Fill Date Precedes Order Date
- 001292 Date of Service Two Years Prior to Date Received

**MEDS III Transaction Segment: Pharmacy**

| **Data Element Name:** | **DRUG DAYS SUPPLY COUNT** |
|---|---|
| Submission Status: | Required for COS 14 |
| Encounter Record Position(s): | 308-310 |
| Format - Length: | Numeric - 3 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 0819/3232 |

**Definition**: Drug Days Supply Count specifies the number of days supply dispensed with the prescription service.

**Mapping**:

| **Encounter Type** | **Paper** | | **Electronic** | |
|---|---|---|---|---|
| | **Form** | **Element** | **Format** | **Element** |
| Pharmacy | UCF | Days Supply | NCPDP | 405-D5 |

**Codes and Values**:

- Must be entered if a National Drug Code has been entered.
- Must be a positive whole number.
- Right-justified and zero filled.
- Leave blank when reporting DME/Hearing aid and alternate product encounter records.

**Edit Applications:**

- Must be a valid entry.
- 00540 Number of Days Supply Invalid

**MEDS III Transaction Segment: Pharmacy**

| **Data Element Name:** | **NATIONAL DRUG CODE (NDC) / PRODUCT CODE** |
|---|---|
| Submission Status: | Required for COS 14 |
| Encounter Record Position(s): | 311-321; 357-367; 403-413; 449-459; 495-505; 541-551; 587-597; 633-643; 679-689; 725-735; 771-781; 817-827; 863-873; 909-919; 955-965; 1001-1011; 1047-1057; 1093-1103; 1139-1149; 1185-1195; 1231-1241; 1277-1287; 1323-1333; 1369-1379; 1415-1425 |
| Format - Length: | Character - 11 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | NDC: 1856/E1856<br>Product Code: 1856/E1856 |

**Definition**: National Drug Code (NDC) uniquely identifies a drug and includes information on the manufacturer, product code, and package size.

The Product Code is the HCPCS Code used to identify Durable Medical Equipment, Hearing Aids, Over the Counter medications or other pharmacy products without an NDC code.

**Mapping**:

NDC Code:

| **Encounter Type** | **Paper** | | **Electronic** | |
|---|---|---|---|---|
| | **Form** | **Element** | **Format** | **Element** |
| Pharmacy | UCF | Product ID | NCPDP | 436-E1<br>407-D7 |

**Codes and Values**:

- Right-justified and zero filled
- Valid values for this data element are defined and maintained by First DataBank.

**Edit Applications:**

- 00544 NDC Code Non-Numeric
- 00561 Drug Code Not On file
- 01610 Missing or Invalid Alternate Product Code
- 02171 NDC Occurs More Than Once On The Compound

**MEDS III Transaction Segment: Pharmacy**

| **Data Element Name:** | **QUANTITY DISPENSED** |
|---|---|
| Submission Status: | Required for COS 14 |
| Encounter Record Position(s): | 322-333; 368-379; 414-425; 460-471; 506-517; 552-563; 598-609; 644-655; 690-701; 736-747; 782-793; 828-839; 874-885; 920-931; 966-977; 1012-1023; 1058-1069; 1104-1115; 1150-1161; 1196-1207; 1242-1253; 1288-1299; 1334-1345; 1380-1391; 1426-1437 |
| Format - Length: | Numeric – 12 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 4217/3251 |

**Definition**: Quantity Dispensed is the quantity of a drug as submitted on a claim form. The dispensing quantity is based upon the unit of measure as defined by the National Drug Code. Quantity Dispensed was formerly called NDC Units.

**Mapping**:

| **Encounter Type** | **Paper** | | **Electronic** | |
|---|---|---|---|---|
| | **Form** | **Element** | **Format** | **Element** |
| Pharmacy | UCF | Quantity Dispensed | NCPDP | 442-E7 |

**Codes and Values**:

- Must be entered if a National Drug Code has been entered
- Right-justified and zero filled with 3 implied decimal points
- Must be a positive numeric value
- Fractions must be reported to the nearest 1000$^{th}$ (.001)

**Edit Applications:**

- Must be a valid entry
- 00528 Missing Or Invalid Quantity Dispensed

Examples:
2.755 units = 000000002755
2.5 units = 000000002500
25 units = 000000025000
250 units = 000000250000

**MEDS III Transaction Segment: Pharmacy**

| **Data Element Name:** | **AMOUNT CHARGED [up to 25]** |
|---|---|
| Submission Status: | Required for COS 14 |
| Encounter Record Position(s): | 334-344; 380-390; 426-436; 472-482; 518-528; 564-574; 610-620; 656-666; 702-712; 748-758; 794-804; 840-850; 886-896; 932-942; 978-988; 1024-1034; 1070-1080; 1116-1126; 1162-1172; 1208-1218; 1254-1264; 1300-1310; 1346-1356; 1392-1402; 1438-1448 |
| Format - Length: | Numeric - 11 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | 3199/3199 |

**Definition**: The amount charged for the prescription or ingredient.

**Mapping**:

| **Encounter Type** | **Paper** | | **Electronic** | |
|---|---|---|---|---|
| | **Form** | **Element** | **Format** | **Element** |
| Pharmacy | UCF | Ingredient Cost Submitted | NCPDP | 409-D9 |

**Codes and Values**:

- Right-justified and zero filled
- This amount is defined with two implied decimal places (e.g., $1,000.00 is reported as 100000)

**Edit Applications:**

- Must be a valid format
- Must be entered as a positive number

**MEDS III Transaction Segment: Pharmacy**

| **Data Element Name:** | **AMOUNT PAID [up to 25]** |
|---|---|
| Submission Status: | Required for COS 14 |
| Encounter Record Position(s): | 345-355; 391-401; 437-447; 483-493; 529-539; 575-585; 621-631; 667-677; 713-723; 759-769; 805-815; 851-861; 897-907; 943-953; 989-999; 1035-1045; 1081-1091; 1127-1137; 1173-1183; 1219-1229; 1265-1275; 1311-1321; 1357-1367; 1403-1413; 1449-1459 |
| Format - Length: | Numeric - 11 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | 3157/1028 |

**Definition**: The amount paid for the prescription or ingredient.

**Mapping**:

- New York State specific element

**Codes and Values**:

- Right-justified and zero filled
- This amount is defined with two implied decimal places (e.g., $1,000.00 is reported as 100000)

**Edit Applications:**

- Must be a valid format
- Must be entered as a positive number

**MEDS III Transaction Segment: Pharmacy**

| **Data Element Name:** | **PHARMACY CLAIM/ENCOUNTER INDICATOR [up to 25]** |
|---|---|
| Submission Status: | Required for COS 14 |
| Encounter Record Position(s): | 356; 402; 448; 494; 540; 586; 632; 678; 724; 770; 816; 862; 908; 954; 1000; 1046; 1092; 1138; 1184; 1230; 1276; 1322; 1368; 1414; 1460 |
| Format - Length: | Character - 1 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1983/E1983 |

**Definition**: Indicates whether the service provided was a capitated service within the health organization's contract ("E"); a within plan claim ("C") or an administratively denied service ("A").

Administratively denied encounters are those encounters which reflect services performed normally paid for, but were denied due to failure of at least one requirement of the agreement between provider and plan.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

| ***Code*** | ***Value*** |
|---|---|
| E | Capitated Encounter, or service not paid directly by the health organization |
| C | Within Plan Claim |
| A | Administrative Denial |

**Edit Applications:**

- Must be a valid code
- 00437 Claim Encounter Ind Invalid

**MEDS III Transaction Segment: Pharmacy**

| **Data Element Name:** | **REFILL INDICATOR** |
|---|---|
| Submission Status: | Required for COS 14 |
| Encounter Record Position(s): | 1461-1462 |
| Format - Length: | Character - 2 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | 3233/4237 |

**Definition**: The number indicating whether the prescription is an original or refill.

**Mapping**:

| **Encounter Type** | **Paper** | | **Electronic** | |
|---|---|---|---|---|
| | **Form** | **Element** | **Format** | **Element** |
| Pharmacy | UCF | Fill Number | NCPDP | 403-D3 |

**Codes and Values**:

| **Code** | **Description** |
|---|---|
| 00 | ORIGINAL |
| 01 | 1ST REFILL |
| 02 | 2ND REFILL |
| 03 | 3RD REFILL |
| 04 | 4TH REFILL |
| 05 | 5TH REFILL |

**Edit Applications:**

- Must be a valid value
- 00530 New/Refill Number Invalid

**MEDS III Transaction Segment: Pharmacy**

| **Data Element Name:** | **NUMBER OF REFILLS AUTHORIZED** |
|---|---|
| Submission Status: | Required for COS 14 |
| Encounter Record Position(s): | 1463-1464 |
| Format - Length: | Number - 2 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | 3018/0851 |

**Definition**: The number of refills that have been authorized for a prescription by the provider beyond the original prescription. This number should be consistent for all encounters within the same prescribed period.

**Mapping**:

| **Encounter Type** | **Paper** | | **Electronic** | |
|---|---|---|---|---|
| | **Form** | **Element** | **Format** | **Element** |
| Pharmacy | UCF | N/A | NCPDP | 415-DF |

**Codes and Values**:

- Must be numeric; alphabetic and special characters are invalid

**Edit Applications:**

- Must be a valid value
- 00531 Authorized Refills Number Invalid

| **Data Element Name:** | **DISPENSED AS WRITTEN** |
|---|---|
| Submission Status: | Required for COS 14 |
| Encounter Record Position(s): | 1465 |
| Format - Length: | Number - 1 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | XXXX/3234 |

**Definition**: Dispensed As Written (DAW) product selection codes provide important information to the New York State Department of Health as to whether or not a prescription is dispensed based on the prescriber's instructions. The specific codes being used (see below) have been taken from the National Council on
Prescription Drug Programs (NCPDP) Version 5.1 Data Dictionary, Field 408-D8 Product Selection Codes. It is important that plans report the appropriate selections as submitted or reported on the prescription form with prescriber's signature.

**Mapping**:

| **Encounter Type** | **Paper** | | **Electronic** | |
|---|---|---|---|---|
| | **Form** | **Element** | **Format** | **Element** |
| Pharmacy | UCF | DAW Code | NCPDP | 408-D8 |

**Codes and Values**:

| **Codes** | **Description** |
|---|---|
| 0 | No product selection indicated |
| 1 | Substitution not allowed by provider |
| 2 | Substitution allowed- patient requested product dispensed |
| 3 | Substitution allowed- pharmacist selected product dispensed |
| 4 | Substitution allowed- generic drug not in stock |
| 5 | Substitution allowed- brand drug dispensed as generic |
| 6 | Override |
| 7 | Substitution not allowed- brand drug mandated by law |
| 8 | Substitution allowed- generic drug not available in marketplace |
| 9 | Other (Not Allowed) |

**Edit Applications:**

- Must be a valid entry
- Code '9' is not a valid entry

**MEDS III Transaction Segment: Pharmacy**

| **Data Element Name:** | **ICD VERSION CODE** |
|---|---|
| Submission Status: | Required for COS 14 |
| Encounter Record Position(s): | 1466 |
| Format - Length: | Character - 1 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | E2498/2498 |

**Definition**: A one digit code to indicate whether the reported diagnoses are ICD-9 or ICD-10.

**Mapping**:

- New York State specific element

**Codes and Values:**

- If no diagnosis, leave blank (see below table).

| Code | Description |
|---|---|
| | Not Available |
| 1 | ICD-9 Version |
| 2 | ICD-10 Version |

**Edit Applications:**

- Must be a valid value
- 02174 Version Not Valid

**MEDS III Transaction Segment: Pharmacy**

| **Data Element Name:** | **DIAGNOSIS CODE** |
|---|---|
| Submission Status: | Required for COS 14 |
| Encounter Record Position(s): | 1467-1473 |
| Format - Length: | Character - 7 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | 4157/W657 |

**Definition**: Diagnosis codes are to be recorded for diagnosed medical conditions for which the recipient receives services during the encounter or which may have been present at the time of the encounter and recorded by the provider.

**Mapping**:

| **Encounter Type** | **Paper** | | **Electronic** | |
|---|---|---|---|---|
| | **Form** | **Element** | **Format** | **Element** |
| Pharmacy | UCF | Diagnosis Code | NCPDP | 424-DO |

**Codes and Values:**

- Filled or zero filled
- Left-justified and entered exactly as shown in the ICD-9-CM or ICD-10-CM coding reference, excluding the decimal point, and Space-filled. The decimal point is implied because each ICD-9-CM or ICD-10-CM code is unique.
- Record the appropriate ICD-9-CM or ICD-10-CM code exactly as it appears in the manual. The diagnosis code must be the most specific/precise 3-digit, 4-digit or 5-digit code allowed for in the ICD-9-CM or ICD-10-CM coding format.
- Leading and trailing zeros in a diagnostic code must be recorded. In addition, zeros should not be added to a diagnostic code to fill in blank spaces.

**Edit Applications:**

- Must be a valid code
- If this field is not coded it must contain blanks

**MEDS III Transaction Segment: Pharmacy**

| **Data Element Name:** | **PRESCRIPTION SERIAL NUMBER** |
|---|---|
| Submission Status: | Required for COS 14 |
| Encounter Record Position(s): | 1474-1485 |
| Format - Length: | Character - 12 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | E2011/2011 |

**Definition**: Prescription Serial Number is the number on the official New York State Prescription Form. It is a unique number used to identify an individual prescription sheet within a prescription pad.

Some valid Prescriptions can be dispensed when not written on Official Prescription Forms. For these specific situations, in lieu of the Prescription Serial Number, use the codes below.

**Mapping**:

| **Encounter Type** | **Paper** | | **Electronic** | |
|---|---|---|---|---|
| | **Form** | **Element** | **Format** | **Element** |
| Pharmacy | UCF | N/A | NCPDP | 454-EK |

**Codes and Values:**

- Blanks are not permitted
- Must be a valid code

| ***Code*** | ***Value*** |
|---|---|
| HHHHHHHHHHHH | Prescriptions on Hospital and their affiliated Clinics Prescription Pads |
| ZZZZZZZZZZZZ | Prescriptions written by Out of State prescribers |
| EEEEEEEEEEE | Prescriptions submitted via fax or electronically |
| NNNNNNNNNNN | Prescriptions for carve-out drugs for nursing home patients |
| 888888888888 | Unknown/Documentation insufficient to determine Serial Number |
| 999999999999 | Oral Prescriptions |

**Edit Applications:**

- 02002 Prescription Serial Number Missing

**MEDS III Transaction Segment: Pharmacy**

| **Data Element Name:** | **SUBMISSION CLARIFICATION CODE** |
|---|---|
| Submission Status: | Required for COS 14 |
| Encounter Record Position(s): | 1486-1487 |
| Format - Length: | Character - 2 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | |

**Definition**: Submission Clarification Code is used to indicate whether or not the code indicating that the pharmacist is clarifying the submission. This code is required if the Date of Service contains the subsequent payer coverage date, the Submission Clarification Code is required with value "19" (split billing indicates the quantity dispensed is the remainder billed to a subsequent payer when Medicare Part A expires. It is used only in long-term care settings) for individual unit of use of medications.

**Mapping:**

- New York State Specific data element

**Codes and Values:**

- Blanks are not permitted
- Must be a valid code

| ***Code*** | ***Value*** |
|---|---|
| 01 | No Override |
| 02 | Other Override |
| 05 | Therapy Change |
| 06 | Starter Dose |
| 07 | Medically Necessary |
| 08 | Process Compound For Approved Ingredients |
| 09 | Encounters |
| 19 | Split Billing – Medicare Part A Expiration |
| 20 | 340B - Indicates that prior to providing service, the pharmacy has determined the product to be billed was purchased pursuant to the rights available under Section 340B of the Public Health Act of 1992. |
| 99 | Other |

**Edit Applications:**

NONE

**MEDS III Transaction Segment: Pharmacy**

| **Data Element Name:** | **DISPENSING FEE** |
|---|---|
| Submission Status: | Required for COS 14 |
| Encounter Record Position(s): | 1488-1498 |
| Format - Length: | Numeric - 11 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | E0817/0817 |

**Definition**: Pharmacy Dispensing Fee is that portion of the cost to dispense the claim payment amount that is directly related to drug by the dispensing fee of the provider pharmacy.

**Mapping**:

- New York State specific data element

**Codes and Values**:

- Right-justified and zero filled
- This amount is defined with two implied decimal places (e.g., $1,000.00 is reported as 100000)

**Edit Applications:**

- Must be a valid format
- Must be entered as a positive number

**MEDS III Transaction Segment: Pharmacy**

| **Data Element Name:** | **MAIL ORDER PHARMACY INDICATOR** |
|---|---|
| Submission Status: | Required |
| Encounter Record Position(s): | 1499 |
| Format - Length: | Character - 1 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | |

**Definition**: Mail Order Pharmacy Indicator is a one digit code to indicate whether or not the script was order either by telephone or online and delivered through the mail and not picked up directly from the neighborhood pharmacy.

**Mapping**:

- New York State specific data element

**Codes and Values**:

| ***Code*** | ***Value*** |
|---|---|
| 1 | Online Order |
| 2 | Telephone Order |
| 3 | Non Online/Telephone Order |

**Edit Applications:**

- Must be a valid code

**MEDS III Transaction Segment: Pharmacy**

| **Data Element Name:** | **FILLER** |
|---|---|
| Submission Status: | Required |
| Encounter Record Position(s): | 1500-3000 |
| Format - Length: | Character - 1501 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |

**Definition**: Space-fill positions 1500 to 3000.

**Mapping**:

- New York State Specific data element

**Codes and Values:**

- Left-justified and space-filled

**Edit Applications:**

- Tier One Edit – Record is not 3000 bytes.

# IX. DENTAL SEGMENT

**MEDS III Transaction Segment: Dental**

| **Data Element Name:** | **PROVIDER SPECIALTY CODE** |
|---|---|
| Submission Status: | Required for COS 13 |
| Encounter Record Position(s): | 258-260 |
| Format - Length: | Character - 3 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1499/2048 |

**Definition**: The Provider Specialty Code designates the State classification of provider specialties. It is based on a provider's certified medical specialty.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- See Appendix B for Valid Codes and Values

**Edit Applications:**

- Must be a valid code
- 00404 Provider Specialty Missing
- 00413 Provider Specialty Not On File

**MEDS III Transaction Segment: Dental**

| **Data Element Name:** | **SERVICE START DATE** |
|---|---|
| Submission Status: | Required for COS 13 |
| Encounter Record Position(s): | 261-268; 339-346; 417-424;495-502;573-580;651-658;729-736;807-814;885-892;963-970 |
| Format - Length: | Date - CCYYMMDD |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1022/3013 |

**Definition**: The date the dental service was received or initiated.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Dental | ADA | #24 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Code | Page No. |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2300 | DTP | 02 | 1250 | D8 & RD8 | 167 |
| | | | | 03 | 1251 | | 168 |
| Dental | 837D | 2300 | DTP | 02 | 1250 | D8 & RD8 | 164 |
| | | | | 03 | 1251 | | 165 |

**Codes and Values**:

- Must be a valid date format CCYYMMDD

| Valid Century (CC) | Valid Year (YY) |
|---|---|
| 20 | >=04 |

| Valid Month Code (MM) | Valid Day Code (DD) |
|---|---|
| 01, 03, 05, 07, 08, 10, 12 | Greater than 00 and less than 32 |
| 04, 06, 09, 11 | Greater than 00 and less than 31 |
| 02 | Greater than 00 and less than 29 (less than 30 on a leap year) |

**Edit Applications**:

- 00018 Date Of Service/Fill Date Invalid
- 00020 Service/Fill Date Later Than Receipt Date
- 01006 Thru Service Prior to From Service Date
- 001292 Date of Service Two Years Prior to Date Received

**MEDS III Transaction Segment: Dental**

| **Data Element Name:** | **SERVICE END DATE** |
|---|---|
| Submission on Status: | Required for COS 13 |
| Encounter Record Position(s): | 269-276; 347-354; 425-432;503-510;581-588;659-666;737-744;815-822;893-900;971-978 |
| Format - Length: | Date - CCYYMMDD |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1023/3015 |

**Definition**: The date the dental service ended.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Dental | ADA | #24 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Code | Page No. |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2300 | DTP | 02<br>03 | 1250<br>1251 | D8 & RD8 | 167<br>168 |
| Dental | 837D | 2300 | DTP | 02<br>03 | 1250<br>1251 | D8 & RD8 | 164<br>165 |

**Codes and Values**:

- Must be a valid date format CCYYMMDD

| Valid Century (CC) | Valid Year (YY) |
|---|---|
| 20 | >=04 |

| Valid Month Code (MM) | Valid Day Code (DD) |
|---|---|
| 01, 03, 05, 07, 08, 10, 12 | Greater than 00 and less than 32 |
| 04, 06, 09, 11 | Greater than 00 and less than 31 |
| 02 | Greater than 00 and less than 29 (less than 30 on a leap year) |

**Edit Applications:**

- 01004 Thru Service Date Invalid
- 01006 Thru Service Prior to From Service Date

**MEDS III Transaction Segment: Dental**

| **Data Element Name:** | **PLACE OF SERVICE/PLACE OF TREATMENT** |
|---|---|
| Submission Status: | Required for COS 13 |
| Encounter Record Position(s): | 277-278; 355-356; 433-434;511-512;589-590;667-668;745-746;823-824;901-902;979-980 |
| Format - Length: | Character - 2 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 4178/3016 |

**Definition**: Place of Service/Place of Treatment Code identifies the place(s) where a service was rendered by a provider.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Dental | ADA | #38 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Page No. |
|---|---|---|---|---|---|---|
| Institutional | 837I | 2300 | CLM | 05-1 | 1331 | 159 |
| Dental | 837D | 2300 | CLM | 05-1 | 1331 | 151 |

**Codes and Values**:

| *Code* | *Value* |
|---|---|
| 03 | SCHOOL |
| 04 | HOMELESS SHELTER |
| 05 | INDN HLTH FREE STND |
| 06 | INDN HLTH PROV BSD |
| 07 | TRIB 638 FREE STND |
| 08 | TRIB 638 PROV BSD |
| 11 | OFFICE |
| 12 | CLIENT'S HOME |
| 13 | ASSISTD LIVING FCLTY |
| 14 | GROUP HOME |
| 15 | MOBILE UNIT |
| 16 | HOSP-INTERCARE LVLII |
| 17 | HOSP-SUBACUTE INP |
| 18 | HOSP-SWING BEDS |
| 20 | URGENT CARE FACILITY |
| 21 | INPATIENT HOSPITAL |
| 22 | OUTPATIENT HOSPITAL |

| *Code* | *Value* |
|---|---|
| 23 | HOSP ER |
| 24 | AMB SURG CTR |
| 25 | BIRTHING CENTER |
| 26 | MILITARY TRTMNT FLTY |
| 27 | SNF-SUBACUTE INP |
| 28 | SNF-SWING BEDS |
| 31 | SNF |
| 32 | NURSING FACILITY |
| 33 | CUSTODIAL CARE FCLTY |
| 34 | HOSPICE |
| 41 | AMBULANCE - LAND |
| 42 | AMBLNCE AIR OR WATER |
| 43 | NON-MED HCI-HOSP I-O |
| 44 | NON-MED HCIHOSP OTHR |
| 45 | NON-MED HCIHOSP IC I |
| 46 | NON-MED HCIHOSP ICII |
| 47 | NON-MED HCIHOSP SUBA |
| 48 | NON-MED HCIHOSP SWNG |
| 49 | INDP CLINIC |
| 50 | FQHC |
| 51 | INPAT PSYCH FCLTY |
| 52 | PSYCH FCLTY PRT HSP |
| 53 | COMM MH CTR |
| 54 | ICF/MR |
| 55 | RES SUB AB TREAT FAC |
| 56 | PSYCH RES TREAT FAC |
| 57 | NO RES SUB ABS FCLTY |
| 58 | NO MED HCI POST HOSP |
| 60 | MASS IMMUN |
| 61 | CIRF |
| 62 | CORF |
| 63 | INTER CARE-OUT |
| 64 | INTER CARE-OTHR |
| 65 | ES RNAL DIS TRT FAC |
| 66 | INTER CARE-IC LVL II |
| 67 | INTER CARE-SUBAC INP |
| 68 | INTER CARE-SWING BED |
| 71 | ST OR LCL PHC |
| 72 | RRL HLTH CLNC |
| 73 | CLINIC-FREE STANDING |
| 74 | CLINIC-ORF |
| 75 | CLINIC-CORF |
| 76 | CLINIC-COMM MH |

| *Code* | *Value* |
|---|---|
| 79 | CLINIC-OTHER |
| 81 | IND LAB |
| 82 | SPC FAC-HOSPICE HB |
| 83 | SPC FAC-AMB SURG CTR |
| 84 | SPC FAC-FS BIRTH CTR |
| 85 | SPC FAC-CRITIC AH |
| 86 | SPC FAC-RES FAC |
| 88 | HMO |
| 89 | SPEC FACI-OTHER |
| 99 | OTHER |

**Edit Applications:**

- Must be a valid entry
- 00071 Place Of Service Code Invalid

**MEDS III Transaction Segment: Dental**

| **Data Element Name:** | **PROCEDURE CODE [up to 10]** |
|---|---|
| Submission Status: | Required for COS 13 |
| Encounter Record Position(s): | 279-283; 357-361; 435-439;513-517;591-595;669-673;747-751;825-829;903-907;981-985 |
| Format - Length: | Character - 5 |
| Effective Date: | 1/1/2009 |
| Version Number - Date: | 2.8 - January 2009 |
| MEDS III DE# / DW#: | 4159/5055 |

**Definition**: Procedure Codes identifying the procedures performed during the dental visit. Fields for reporting of up to ten procedures or services are available. If more than ten procedures were performed during the encounter, submit a second encounter record with the additional procedures listed and using a different Encounter Control Number and identical information on all other elements that were included in the first record (with the exception of Total Amount Paid).

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Dental | ADA | #29 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Code | Page No. |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2400 | SV2 | 02-1<br>02-2 | 235<br>234 | HC | 446<br>447 |
| Dental | 837D | 2400 | SV3 | 01-1<br>01-2 | 235<br>234 | | 266-267 |

**Codes and Values**:

- Per the 837D, American Dental Association (i.e., CDT) codes may be used to report dental procedures. If CDT2 codes are used, the leading zero of the 5 digit ADA code must be replaced with a 'D" so that the code will conform to the HCPCS coding convention. CDT3 codes conform with HCPCS D codes.
- Left-justified and entered exactly as shown in the CPT coding reference.

**Edit Applications:**

- Must be a valid code
- 00070 Procedure Code Invalid
- 00170 Procedure Code Not On File
- 00710 Procedure Code Exceeds Service Limits

**MEDS III Transaction Segment: Dental**

| **Data Element Name:** | **PROCEDURE MODIFIER CODE 1 [up to 10]** |
|---|---|
| Submission Status: | Required for COS 13 |
| Encounter Record Position(s): | 284-285; 362-363; 440-441;518-519;596-597;674-675;752-753;830-831;908-909;986-987 |
| Format - Length: | Character - 2 |
| Effective Date: | 1/1/2009 |
| Version Number - Date: | 2.8 - January 2009 |
| MEDS III DE# / DW#: | 3227_1 |

**Definition**: Procedure Modifier Codes are used in conjunction with the CDT procedure code to uniquely describe the service(s) rendered by a provider during an encounter. Fields for reporting a single modifier on each of the up to ten procedures or services are available.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Dental | ADA | #29 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Composite | Element ID | Page No. |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2400 | SV2 | 02-3 | 1339 | HC | 447 |
| Dental | 837D | 2400 | SV3 | 01 | 3 | 1339 | 267 |

**Codes and Values**:

- Space-fill if not applicable
- Entered exactly as shown in the American Medical Association's Current Procedural Terminology - 4th Edition (CPT-4).
- Not applicable for inpatient encounters

**Edit Applications:**

- 00927 Modifier Invalid For Procedure Code

**MEDS III Transaction Segment: Dental**

| **Data Element Name:** | **PROCEDURE MODIFIER CODE 2 [up to 10]** |
|---|---|
| Submission Status: | Required for COS 13 |
| Encounter Record Position(s): | 286-287; 364-365; 442-443;520-521;598-599;676-677;754-755;832-833;910-911;988-989 |
| Format - Length: | Character - 2 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | 3227_1 |

**Definition**: Procedure Modifier Codes are used in conjunction with the CDT procedure code to uniquely describe the service(s) rendered by a provider during an encounter. Fields for reporting a single modifier on each of the up to ten procedures or services are available.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Dental | ADA | #29 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Composite | Element ID | Page No. |
|---|---|---|---|---|---|---|---|
| Dental | 837D | 2400 | SV3 | 01 | 4 | 1339 | 267 |

**Codes and Values**:

- Space-fill if not applicable
- Entered exactly as shown in the American Medical Association's Current Procedural Terminology - 4th Edition (CPT-4).
- Not applicable for inpatient encounters

**Edit Applications:**

- 00927 Modifier Invalid For Procedure Code

**MEDS III Transaction Segment: Dental**

| **Data Element Name:** | **PROCEDURE MODIFIER CODE 3 [up to 10]** |
|---|---|
| Submission Status: | Required for COS 13 |
| Encounter Record Position(s): | 288-289; 366-367; 444-445;522-523;600-601;678-679;756-757;834-835;912-913;990-991 |
| Format - Length: | Character - 2 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | 3227_1 |

**Definition**: Procedure Modifier Codes are used in conjunction with the CDT procedure code to uniquely describe the service(s) rendered by a provider during an encounter. Fields for reporting a single modifier on each of the up to ten procedures or services are available.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Dental | ADA | #29 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Composite | Element ID | Page No. |
|---|---|---|---|---|---|---|---|
| Dental | 837D | 2400 | SV3 | 01 | 5 | 1339 | 267 |

**Codes and Values**:

- Space-fill if not applicable
- Entered exactly as shown in the American Medical Association's Current Procedural Terminology - 4th Edition (CPT-4).
- Not applicable for inpatient encounters

**Edit Applications:**

- 00927 Modifier Invalid For Procedure Code

**MEDS III Transaction Segment: Dental**

| **Data Element Name:** | **PROCEDURE MODIFIER CODE 4 [up to 10]** |
|---|---|
| Submission Status: | Required for COS 13 |
| Encounter Record Position(s): | 290-291; 368-369; 446-447; 524-525;602-603;680-681;758-759;836-837;914-915;992-993 |
| Format - Length: | Character - 2 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | 3227_1 |

**Definition**: Procedure Modifier Codes are used in conjunction with the CDT procedure code to uniquely describe the service(s) rendered by a provider during an encounter. Fields for reporting a single modifier on each of the up to ten procedures or services are available.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Dental | ADA | #29 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Composite | Element ID | Page No. |
|---|---|---|---|---|---|---|---|
| Dental | 837D | 2400 | SV3 | 01 | 6 | 1339 | 267 |

**Codes and Values**:

- Space-fill if not applicable
- Entered exactly as shown in the American Medical Association's Current Procedural Terminology - 4th Edition (CPT-4).
- Not applicable for inpatient encounters

**Edit Applications:**

- 00927 Modifier Invalid For Procedure Code

**MEDS III Transaction Segment: Dental**

| **Data Element Name:** | **TOOTH NUMBER OR LETTER [up to 10]** |
|---|---|
| Submission Status: | Required for COS 13 |
| Encounter Record Position(s): | 292-293; 370-371;448-449;526-527;604-605;682-683;760-761;838-839;916-917;994-995 |
| Format - Length: | Character - 2 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1646/E4266 |

**Definition**: Dental Site Code specifies a tooth, oral cavity, quadrant, or arch.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Dental | ADA | #27 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Code | Page No. |
|---|---|---|---|---|---|---|---|
| Dental | 837D | 2400 | TOO | 01<br>02 | 1270<br>1271 | JP | 271<br>272 |

**Codes and Values**:

- See Appendix C for Valid Codes and Values
- Space-fill if not applicable

**Edit Applications:**

- Must be a valid entry
- 00931 Required Tooth For Procedure Invalid

**MEDS III Transaction Segment: Dental**

| **Data Element Name:** | **DENTAL NUMBER OF UNITS/VISITS [up to 10]** |
|---|---|
| Submission Status: | Required for COS 13 |
| Encounter Record Position(s): | 294-304; 372-382;450-460;528-538;606-616;684-694;762-772;840-850;918-928;996-1006 |
| Format - Length: | Numeric – 11 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1092/3029 |

**Definition**: A whole number indicating the number of times a procedure or service was provided during the dental encounter; or the number of units, visits, or days a procedure or service was rendered during an episode of care defined by Service Start and End Dates.

**Mapping**:

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Code | Page No. |
|---|---|---|---|---|---|---|---|
| Institutional | 837I | 2400 | SV2 | 04<br>05 | 355<br>380 | UN | 448 |
| Dental | 837D | 2400 | SV3 | 06 | 380 | | 270 |

**Codes and Values**:

- Right justified and zero filled with 2 implied decimal points ( i.e. '1' would be reported as '00000000001'

- Must contain a whole number

**Edit Applications:**

- Must be a valid entry
- 00094 Number of Units Not Greater than Zero
- 00180 Units Greater Than Maximum
- 00710 Procedure Code Exceeds Service Limits

**MEDS III Transaction Segment: Dental**

| **Data Element Name:** | **CHARGED AMOUNT [up to 10]** |
|---|---|
| Submission Status: | Required for COS 13 |
| Encounter Record Position(s): | 305-315; 383-393;461-471;539-549;617-627;695-705;773-783;851-861;929-939;1007-1017 |
| Format - Length: | Numeric - 11 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | |

**Definition**: Charged Amount is the line level charge amount submitted or billed by the provider. The total amount charged for each listed service corresponding to the procedures defined in the CPT data element.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Dental | ADA | #31 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Page No. |
|---|---|---|---|---|---|---|
| Dental | 837D | 2400 | SV3 | 02 | 782 | 268 |

**Codes and Values**:

- Right-justified and zero filled
- This amount is defined with two implied decimal places (e.g., $1,000.00 is reported as 100000)

**Edit Applications:**

- Must be a valid format
- Must be entered as a positive number
- 00036 M/I Usual and Customary

| | |
|---|---|
| **MEDS III Transaction Segment:** | **Dental** |
| **Data Element Name:** | **MEDICARE PAID AMOUNT [up to 10]** |
| Submission Status: | Required for COS 13 |
| Encounter Record Position(s): | 316-326; 394-404;472-482;550-560;628-638;706-716;784-794;863-872;940-950;1018-1028 |
| Format - Length: | Numeric - 11 |
| Effective Date: | 2/18/2010 |
| Version Number - Date: | 2.9 – April 2010 |
| MEDS III DE# / DW#: | 1085/L3033_2 |

**Definition**: The amount Medicare paid for each listed service line that is received by dual eligible Medicaid/Medicare enrollees or beneficiaries. A service line is identified through either HCPCS/CPT procedure codes or revenue codes. This is the Medicare Paid Amount on the service line.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Right-justified and zero filled
- The amount is defined with two implied decimal places
- Must be entered as a positive number

**Edit Applications:**

- Must be a valid entry

**MEDS III Transaction Segment: Dental**

| **Data Element Name:** | **PAID AMOUNT [up to 10]** |
|---|---|
| Submission Status: | Required for COS 13 |
| Encounter Record Position(s): | 327-337; 405-415;483-493;561-571;639-649;717-727;795-805;873-883;951-961;1029-1039 |
| Format - Length: | Numeric - 11 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1028/3157 |

**Definition**: The amount paid by Medicaid for each listed service.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Right-justified and zero-filled
- This amount is defined with two implied decimal places and must be entered as a positive number
- On the service line level the paid amount by Claim/Encounter Indicator should be as follows:

| **Claim/Encounter Indicator** | **Total Paid Amount** |
|---|---|
| "E" – Encounter | Proxy Cost Amount |
| "C" – Within Plan Claim | Actual Cost Amount |
| "A" – Administrative Denial | Zero Dollars |

**Edit Applications:**

- Must be a valid entry

***Important Note:***
Plans should use internal proxy fee schedules when determining the proxy cost amount.

**MEDS III Transaction Segment: Dental**

| **Data Element Name:** | **DENTAL CLAIM/ENCOUNTER INDICATOR** |
|---|---|
| Submission Status: | Required for COS 13 |
| Encounter Record Position(s): | 338; 416;494;572;650;728;806;884;962;1040 |
| Format - Length: | Character - 1 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1983/E1983 |

**Definition**: Indicates whether the dental service provided was a capitated service within the health organization's contract ("E"); a within plan claim ("C") or an administratively denied service ("A").

Administratively denied encounters are those encounters which reflect services performed normally paid for, but were denied due to failure of at least one requirement of the agreement between provider and plan.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

| ***Code*** | ***Value*** |
|---|---|
| E | Capitated Encounter, or service not paid directly by the health organization. |
| C | Within Plan Claim |
| A | Administrative Denial |

**Edit Applications:**

- Must be a valid code
- 00437 Claim Encounter Ind Invalid

**MEDS III Transaction Segment: Dental**

| **Data Element Name:** | **FILLER** |
|---|---|
| Submission Status: | Required |
| Encounter Record Position(s): | 1041-3000 |
| Format - Length: | Character - 1960 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |

**Definition**: Space-fill positions 1041 to 3000.

**Mapping**:

- New York State Specific data element

**Codes and Values:**

- Left-justified and space-filled

**Edit Applications:**

- Tier One Edit – Record is not 3000 bytes.

# X. PROFESSIONAL SEGMENT

**MEDS III Transaction Segment: Professional**

| **Data Element Name:** | **PROVIDER SPECIALTY CODE** |
|---|---|
| Submission Status: | Required for COS 01, 03, 04, 05, 07, 16, 22, 41, 75 |
| Encounter Record Position(s): | 258-260 |
| Format - Length: | Character - 3 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1499/2048 |

**Definition**: The provider's Specialty Code identifies a provider's medical, dental, clinic or program type specialty.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Refer to Appendix B for valid codes and values
- Provider Specialty Code for podiatrist (COS 03) is always 778
- Provider Specialty Code for laboratory (COS 16) is always 599
- Provider Specialty Code for DME (COS 22) is either 307 or 969
- Provider Specialty Code for non-emergency transportation services (COS 19) may be 671 Other Transportation

**Edit Applications:**

- Must be a valid code
- 00404 Provider Specialty Missing
- 00413 Provider Specialty Not On File

**MEDS III Transaction Segment: Professional**

| **Data Element Name:** | **ICD VERSION CODE** |
|---|---|
| Submission Status: | Required for COS 01, 03, 04, 05, 07, 16, 22, 41, 75 |
| Encounter Record Position(s): | 261 |
| Format - Length: | Character - 1 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | E2498/2498 |

**Definition**: A one-digit code to indicate whether the reported diagnoses are ICD-9 or ICD-10.

**Mapping**:

- New York State specific data element

**Codes and Values:**

- If no diagnosis, leave blank (see below table).

| Code | Description |
|---|---|
| | Not Available |
| 1 | ICD-9 Version |
| 2 | ICD-10 Version |

**Edit Applications:**

- Must be a valid value
- 02174 Version Code Not Valid

**MEDS III Transaction Segment: Professional**

| **Data Element Name:** | **DIAGNOSIS CODES [up to 4]** |
|---|---|
| Submission Status: | Required for COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75 |
| Encounter Record Position(s): | 262-268;269-275;276-282;283-289 |
| Format - Length: | Character - 7 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 4183/W657 |

**Definition**: Up to four diagnosis codes are to be recorded for diagnosed medical conditions for which the recipient receives services during the encounter or which may have been present at time of the encounter and recorded by the provider. V codes should be used to indicate well-child, routine check-ups and screening encounters where no diagnosed condition exists.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Professional | CMS-1500 | #21 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Composite | Code | Page No. |
|---|---|---|---|---|---|---|---|---|
| Professional | 837P | 2300 | H1 | 01-04 | 1270<br>1271 | C022-1<br>C022-2 | BK | 266-268 |

**Codes and Values**:

- Record the appropriate ICD-9-CM or ICD-10 code exactly as it appears in the manual. The diagnosis code must be the most specific/precise 3 digit, 4 digit, or 5 digit code allowed for in the ICD-9-CM or ICD-10coding format.
- Left-justified and entered exactly as shown in the ICD-9-CM or ICD-10coding reference, excluding the decimal point, and Space-filled. The decimal point is implied after third digit because each ICD-9-CM or ICD-10code is unique.
- Leading and trailing zeros in a diagnostic code must be recorded (i.e. do not use blanks in place of zeros for any reason). In addition, zeros should not be added to a diagnostic code to fill in blank spaces.
- For editing purposes, only the first four digits of the diagnostic code will be checked for validity against the ICD-9-CM or ICD-10 coding system.
- Managed Long Term Care (MLTC) and PACE plans may use V689 – Encounters for Unspecified Administrative Purposes when reporting services that do not have a diagnosis.

**Edit Applications:**

- 00406 Diagnosis Code Missing
- 00412 Diagnosis Code Not On File

**MEDS III Transaction Segment: Professional**

| **Data Element Name:** | **PLACE OF SERVICE/PLACE OF TREATMENT [UP TO 10]** |
|---|---|
| Submission Status: | Required for COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75 |
| Encounter Record Position(s): | 290-291;388-389;486-487;584-585;682-683;780-781;878-879;976-977;1074-1075;1172-1173 |
| Format - Length: | Character - 2 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 4178/3016 |

**Definition**: Place of Service/Place of Treatment Code identifies the place(s) where a service was rendered by a provider.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Professional | CMS-1500 | #24B |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Page No. |
|---|---|---|---|---|---|---|
| Professional | 837P | 2300 | CLM | 05-1 | 1331 | 173 |

**Codes and Values**:

| *Code* | *Value* |
|---|---|
| 03 | SCHOOL |
| 04 | HOMELESS SHELTER |
| 05 | INDIAN HLTH SVCS FR-STND FCLTY |
| 06 | INDIAN HLTH SVCS PR-BSD FCLTY |
| 07 | TRIBAL 638 FRE-STNDNG FACILITY |
| 08 | TRIBAL 638 PROV BASED FACILITY |
| 11 | OFFICE |
| 12 | CLIENT'S HOME |
| 13 | ASSISTED LIVING FACILITY |
| 14 | GROUP HOME |
| 15 | MOBILE UNIT |
| 20 | URGENT CARE FACILITY |
| 21 | INPATIENT HOSPITAL |
| 22 | OUTPATIENT HOSPITAL |
| 23 | HOSPITAL EMERGENCY ROOM |
| 24 | AMBULATORY SURGICAL CENTER |
| 25 | BIRTHING CENTER |
| 26 | MILITARY TREATMENT FACILITY |

| *Code* | *Value* |
|---|---|
| 31 | SKILLED NURSING FACILITY |
| 32 | NURSING FACILITY |
| 33 | CUSTODIAL CARE FACILITY |
| 34 | HOSPICE |
| 41 | AMBULANCE – LAND |
| 42 | AMBULANCE - AIR OR WATER |
| 49 | INDEPENDENT CLINIC |
| 50 | FEDERALLY QUALIFIED HEALTH CENTER |
| 51 | INPATIENT PSYCHIATRIC FACILITY |
| 52 | PSYCHIATRIC FACILITY PARTIAL HOSPITALIZATION |
| 53 | COMUNITY MENTAL HEALTH CENTER |
| 54 | INTERMEDIATE CARE FACILITY/MENTALLY RETARDED |
| 55 | RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY |
| 56 | PSYCHIATRIC RESIDENTIAL TREATMENT CENTER |
| 57 | NON-RES SUBST ABS TRTMNT FCLTY |
| 60 | MASS IMMUNIZATION |
| 61 | COMPREHENSIVE INPATIENT REHABILITATION FACILITY |
| 62 | COMPREHENSIVE OUTPATIENT REHALILITATION FACILITY |
| 65 | END STAGE RENAL DISEASE TREATMENT FACILITY |
| 71 | STATE OR LOCAL PUBLIC HEALTH CLINIC |
| 72 | RURAL HEALTH CLINIC |
| 81 | INDEPENDENT LABORATORY |
| 99 | OTHER UNLISTED FACILITY |

**Edit Applications:**

- Must be a valid entry.
- 00071 Place Of Service Code Invalid

**MEDS III Transaction Segment: Professional**

| **Data Element Name:** | **SERVICE START DATE** |
|---|---|
| Submission Status: | Required for COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75 |
| Encounter Record Position(s): | 292-299;390-397;488-495;586-593;684-691;782-789;880-887;978-985;1076-1083;1174-1181 |
| Format - Length: | Date - CCYYMMDD |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1022/3013 |

**Definition**: The date the service was received or initiated.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Professional | CMS-1500 | #24A "From" |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Code | Page No. |
|---|---|---|---|---|---|---|---|
| Professional | 837P | 2400 | DTP | 02<br><br>03 | 1250<br><br>1251 | D8 & RD8 | 436 |

**Codes and Values**:

- Must be a valid date format CCYYMMDD

| Valid Century (CC) | Valid Year (YY) |
|---|---|
| 20 | >=04 |

| Valid Month Code (MM) | Valid Day Code (DD) |
|---|---|
| 01, 03, 05, 07, 08, 10, 12 | Greater than 00 and less than 32 |
| 04, 06, 09, 11 | Greater than 00 and less than 31 |
| 02 | Greater than 00 and less than 29 (less than 30 on a leap year) |

**Edit Applications:**

- 00018 Date Of Service/Fill Date Invalid
- 00020 Service/Fill Date Later Than Receipt Date
- 01006 Thru Service Prior to From Service Date
- 001292 Date of Service Two Years Prior to Date Received

**MEDS III Transaction Segment: Professional**

| **Data Element Name:** | **SERVICE END DATE** |
|---|---|
| Submission Status: | Required for COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75 |
| Encounter Record Position(s): | 300-307;398-405;496-503;594-601;692-699;790-797;888-895;986-993;1084-1091;1182-1189 |
| Format - Length: | Date - CCYYMMDD |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1023/3015 |

**Definition**: The date on which the service ended.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Professional | CMS-1500 | #24A "To" |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Code | Page No. |
|---|---|---|---|---|---|---|---|
| Professional | 837P | 2400 | DTP | 02<br>03 | 1250<br>1251 | D8 & RD8 | 436 |

**Codes and Values**:

- Must be a valid date format CCYYMMDD

| Valid Century (CC) | Valid Year (YY) |
|---|---|
| 20 | >=04 |

| Valid Month Code (MM) | Valid Day Code (DD) |
|---|---|
| 01, 03, 05, 07, 08, 10, 12 | Greater than 00 and less than 32 |
| 04, 06, 09, 11 | Greater than 00 and less than 31 |
| 02 | Greater than 00 and less than 29 (less than 30 on a leap year) |

**Edit Applications:**

- 00705 Duplicate Claim in History
- 01004 Thru Service Date Invalid
- 01006 Thru Service Prior to From Service Date

**MEDS III Transaction Segment: Professional**

| **Data Element Name:** | **CPT/HCPCS PROCEDURE CODES [UP TO 10]** |
|---|---|
| Submission Status: | Required for COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75 |
| Encounter Record Position(s): | 308-312;406-410;504-508;602-606;700-704;798-802;896-900;994-998;1092-1096;1190-1194 |
| Format - Length: | Character - 5 |
| Effective Date: | 1/1/2009 |
| Version Number - Date: | 2.8 - January 2009 |
| MEDS III DE# / DW#: | 2042/5055 |

**Definition**: The CPT/HCPCS procedure code that describes the service(s) rendered during Professional encounters. Fields for reporting of up to ten procedures or services are available. If more than ten procedures were performed during the encounter, submit a second encounter record with the additional procedures listed and using a different Encounter Control Number and identical information on all other elements that were included in the first record (with the exception of Total Amount Paid).

Injections and immunizations administered or DME provided during the encounter should be recorded using the appropriate procedure codes. Diagnostic tests performed during the encounter should be reported. Diagnostic testing performed on subsequent days should be reported as separate encounters.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Professional | CMS-1500 | #24D |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Code | Page No. |
|---|---|---|---|---|---|---|---|
| Professional | 837P | 2400 | SV1 | 01-1<br>01-2 | 235<br>234 | HC | 401 |

**Codes and Values**:

- Left-justified.
- Must be a CPT/HCPCS Code.

**Edit Applications:**

- Must be a valid entry.
- 00070 Procedure Code Invalid
- 00170 Procedure Code Not On File
- 00710 Procedure Code Exceeds Service Limits

**MEDS III Transaction Segment: Professional**

| **Data Element Name:** | **PROCEDURE MODIFIER CODE 1 [UP TO 10]** |
|---|---|
| Submission Status: | Required for COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75 |
| Encounter Record Position(s): | 313-314;411-412;509-510;607-608;705-706;803-804;901-902;999-1000;1097-1098;1195-1196 |
| Format - Length: | Character - 2 |
| Effective Date: | 1/1/2009 |
| Version Number - Date: | 2.8 - January 2009 |
| MEDS III DE# / DW#: | 3227_1 |

**Definition**: Procedure Modifier Codes are used in conjunction with the CPT procedure code to uniquely describe the service(s) rendered by a provider during an encounter. Fields for reporting a single modifier on each of the up to ten procedures or services are available.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Professional | CMS-1500 | #44 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Composite | Element ID | Page No. |
|---|---|---|---|---|---|---|---|
| Professional | 837P | 2400 | SV1 | 01 | 3 | 1339 | 401 |

**Codes and Values**:

- Space-fill if not applicable.
- Entered exactly as shown in the American Medical Association's Current Procedural Terminology - 4th Edition (CPT-4).
- Not applicable for inpatient encounters

**Edit Applications:**

- 00927 Modifier Invalid For Procedure Code

**MEDS III Transaction Segment: Professional**

| **Data Element Name:** | **PROCEDURE MODIFIER CODE 2** |
|---|---|
| Submission Status: | Required for COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75 |
| Encounter Record Position(s): | 315-316;413-414;511-512;609-610;707-708;805-806;903-904;1001-1002;1099-1100;1197-1198 |
| Format - Length: | Character - 2 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | 3227_1 |

**Definition**: Procedure Modifier Codes are used in conjunction with the CPT procedure code to uniquely describe the service(s) rendered by a provider during an encounter. Fields for reporting a single modifier on each of the up to ten procedures or services are available.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Professional | CMS-1500 | #44 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Composite | Element ID | Page No. |
|---|---|---|---|---|---|---|---|
| Professional | 837P | 2400 | SV1 | 01 | 4 | 1339 | 402 |

**Codes and Values**:

- Space-fill if not applicable.
- Entered exactly as shown in the American Medical Association's Current Procedural Terminology - 4th Edition (CPT-4).
- Not applicable for inpatient encounters

**Edit Applications:**

- 00927 Modifier Invalid For Procedure Code

**MEDS III Transaction Segment: Professional**

**Data Element Name: PROCEDURE MODIFIER CODE 3**

Submission Status: Required for COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75

Encounter Record Position(s): 317-318;415-416;513-514;611-612;709-710;807-808;905-906;1003-1004;1101-1102;1199-1200

Format - Length: Character - 2

Effective Date: 4/1/2012

Version Number - Date: 3.2 – April 2012

MEDS III DE# / DW#: 3227_1

**Definition**: Procedure Modifier Codes are used in conjunction with the CPT procedure code to uniquely describe the service(s) rendered by a provider during an encounter. Fields for reporting a single modifier on each of the up to ten procedures or services are available.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Professional | CMS-1500 | #44 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Composite | Element ID | Page No. |
|---|---|---|---|---|---|---|---|
| Professional | 837P | 2400 | SV1 | 01 | 5 | 1339 | 402 |

**Codes and Values**:

- Space-fill if not applicable.
- Entered exactly as shown in the American Medical Association's Current Procedural Terminology - 4th Edition (CPT-4).
- Not applicable for inpatient encounters

**Edit Applications:**

- 00927 Modifier Invalid For Procedure Code

**MEDS III Transaction Segment: Professional**

| **Data Element Name:** | **PROCEDURE MODIFIER CODE 4** |
|---|---|
| Submission Status: | Required for COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75 |
| Encounter Record Position(s): | 319-320;417-418;515-516;613-614;711-712;809-810;907-908;1005-1006;1103-1104;1201-1202 |
| Format - Length: | Character - 2 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | 3227_1 |

**Definition**: Procedure Modifier Codes are used in conjunction with the CPT procedure code to uniquely describe the service(s) rendered by a provider during an encounter. Fields for reporting a single modifier on each of the up to ten procedures or services are available.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Professional | CMS-1500 | #44 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Composite | Element ID | Page No. |
|---|---|---|---|---|---|---|---|
| Professional | 837P | 2400 | SV1 | 01 | 5 | 1339 | 402 |

**Codes and Values**:

- Space-fill if not applicable.
- Entered exactly as shown in the American Medical Association's Current Procedural Terminology - 4th Edition (CPT-4).
- Not applicable for inpatient encounters

**Edit Applications:**

- 00927 Modifier Invalid For Procedure Code

**MEDS III Transaction Segment: Professional**

**Data Element Name: NUMBER OF UNITS/VISITS [UP TO 10]**

Submission Status: Required for COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75

Encounter Record Position(s): 321-331;419-429;517-527;615-625;713-723;811-821;909-919;1007-1017;1105-1115;1203-1213

Format - Length: Numeric - 11

Effective Date: 3/1/2005

Version Number - Date: 2.6 - July 2008

MEDS III DE# / DW#: 1092/3029

**Definition**: A whole number indicating the number of times a procedure or service was provided during the encounter; or the number of units, visits, or days a procedure or service was rendered during an episode of care defined by Service Start and End Dates.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Professional | CMS-1500 | #24G |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Elem-ent ID | Code | Page No. |
|---|---|---|---|---|---|---|---|
| Professional | 837P | 2400 | SV1 | 03<br>04 | 355<br>380 | UN | 403 |

**Codes and Values**:

- Right-justified and zero filled. ( i.e. '1' would be reported as '00000000001' )
- Must be a non-zero number when an associated procedure has been recorded.

**Edit Applications:**

- Must be a valid entry.
- 00094 Number of Units Not Greater Than Zero
- 00180 units Greater Than Maximum
- 00710 Procedure Code Exceeds Service Limits

**MEDS III Transaction Segment: Professional**

**Data Element Name: NDC (FORMULARY) CODE [UP TO 10]**

| | |
|---|---|
| Submission Status: | Required for COS 01 |
| Encounter Record Position(s): | 332-342;430-440;528-538;626-636;724-734;822-832;920-930;1018-1028;1116-1126;1214-1224 |
| Format - Length: | Character - 11 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | 1856/E1856 |

**Definition**: National Drug Code (NDC) is an 11-digit national drug identification number assigned by the Federal Drug Administration used to identify OTC medications. The NDC uniquely identifies a drug and includes information on the manufacturer, product code, and package size.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Professional | CMS-1500 | #44 |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Page No. |
|---|---|---|---|---|---|---|
| Institutional | 837P | 2410 | CTP | 04 | 380 | 426 |

**Codes and Values**:

- Right-justified and zero filled.
- Valid values for this data element are defined and maintained by First DataBank.

**Edit Applications:**

- 00544 NDC Code Non-Numeric
- 00561 Drug Code Not On file
- 01610 Missing or Invalid Alternate Product Code
- 02066 Drug Code Missing

**MEDS III Transaction Segment: Professional**

**Data Element Name: NDC (FORMULARY) UNITS [UP TO 10]**

| | |
|---|---|
| Submission Status: | Required for COS 01 |
| Encounter Record Position(s): | 343-353;441-451;539-549;637-647;735-745;833-843;931-941;1029-1039;1127-1137;1225-1235 |
| Format - Length: | Numeric - 11 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |
| MEDS III DE# / DW#: | 4217/3251 |

**Definition**: The dispensing quantity based upon the unit of measure as defined by the National Drug Code.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Professional | CMS-1500 | #24G |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Page No. |
|---|---|---|---|---|---|---|
| Institutional | 837P | 2410 | CTP | 04 | 380 | 426 |

**Codes and Values**:

- Must be entered if a National Drug Code has been entered
- Right-justified and zero filled with 3 implied decimal points
- Must be a positive numeric value
- Fractions must be reported to the nearest 1000th (.001)

**Edit Applications:**

- Must be a valid entry
- 00528 Missing Or Invalid Quantity Dispensed

Examples:
2.755 units = 00000002755
2.5 units = 00000002500
25 units = 00000025000
250 units = 00000250000

**MEDS III Transaction Segment: Professional**

**Data Element Name: CHARGED AMOUNT [UP TO 10]**

Submission Status: Required for COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75

Encounter Record Position(s): 354-364;452-462;550-560;648-658;746-756;844-854;942-952;1040-1050;1138-1148;1236-1246

Format - Length: Numeric - 11

Effective Date: 4/1/2012

Version Number - Date: 3.2 – April 2012

MEDS III DE# / DW#: 3199/3199

**Definition**: The total amount charged for each listed service.

**Mapping**:

- **Paper Form**:

| Encounter Type | Form | Element |
|---|---|---|
| Professional | CMS-1500 | #24F |

- **Electronic**:

| Encounter Type | EDI Format | X12 Mapping Loop | X12 Mapping Segment | Seg. Ele. (Ref) | Element ID | Page No. |
|---|---|---|---|---|---|---|
| Institutional | 837P | 2400 | SV1 | 02 | 782 | 402 |

**Codes and Values**:

- Right-justified and zero filled
- This amount is defined with two implied decimal places (e.g., $1,000.00 is reported as 100000)

**Edit Applications:**

- Must be a valid format
- Must be entered as a positive number
- 00036 M/I Usual and Customary

| | |
|---|---|
| **MEDS III Transaction Segment:** | **Professional** |
| **Data Element Name:** | **MEDICARE PAID AMOUNT** |
| Submission Status: | Required for COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75 |
| Encounter Record Position(s): | 365-375;463-473;561-571;659-669;757-767;855-865;953-963;1051-1061;1149-1159;1247-1257 |
| Format - Length: | Numeric - 11 |
| Effective Date: | 2/18/2010 |
| Version Number - Date: | 2.9 – April 2010 |
| MEDS III DE# / DW#: | 1085/L3033_2 |

**Definition**: The amount Medicare paid for each listed service line that is received by dual eligible Medicaid/Medicare enrollees or beneficiaries. A service line is identified through either HCPCS/CPT procedure codes or revenue codes. This is the Medicare Paid Amount on the service line. It is required if member is enrolled in Medicare.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Right-justified and zero filled.
- The amount is defined with two implied decimal places
- Must be entered as a positive number.

**Edit Applications:**

- Must be a valid entry.

**MEDS III Transaction Segment: Professional**

| **Data Element Name:** | **PAID AMOUNT [UP TO 10]** |
|---|---|
| Submission Status: | Required for COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75 |
| Encounter Record Position(s): | 376-386;474-484;572-582;670-680;768-778;866-876;964-974;1062-1072;1160-1170;1258-1268 |
| Format - Length: | Numeric - 11 |
| Effective Date: | 3/1/2005 |
| Version Number - Date: | 2.6 - July 2008 |
| MEDS III DE# / DW#: | 1028/3157 |

**Definition**: The amount Medicaid paid by insurer for each listed service.

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

- Right-justified and zero filled.
- This amount is defined with two implied decimal places and must be entered as a positive number.
- On the service line level the paid amount by Claim/Encounter Indicator should be as follows:

| **Claim/Encounter Indicator** | **Total Paid Amount** |
|---|---|
| "E" – Encounter | Proxy Cost Amount |
| "C" – Within Plan Claim | Actual Cost Amount |
| "A" – Administrative Denial | Zero Dollars |

**Edit Applications:**

- Must be a valid entry.

***Important Note:***

***Plans should use internal proxy fee schedules when determining the proxy cost amount***

**MEDS III Transaction Segment: Professional**

**Data Element Name: PROFESSIONAL CLAIM/ENCOUNTER INDICATOR [UP TO 10]**

Submission Status: Required for COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75
Encounter Record Position(s): 387;485;583;681;779;877;975;1073;1171; 1269
Format - Length: Character - 1
Effective Date: 3/1/2005
Version Number - Date: 2.6 - July 2008
MEDS III DE# / DW#: 1983/E1983

**Definition**: Indicates whether the professional service provided was a capitated service within the health organization's contract ("E"); a within plan claim ("C") or an administratively denied service ("A").

Administratively denied encounters are those encounters which reflect services performed normally paid for, but were denied due to failure of at least one requirement of the agreement between provider and plan. For example, a plan requires encounters be submitted within 60 days of the service date. A well-child encounter submitted 63 days after date of service would be administratively denied. (Claim received too late).

**Mapping**:

- New York State Specific Data Element

**Codes and Values**:

| *Code* | *Value* |
|---|---|
| E | Capitated Encounter, or service not paid directly by the health organization. |
| C | Within Plan Claim |
| A | Administrative Denial |

**Edit Applications:**

- Must be a valid entry.
- 00437 Claim Encounter Ind Invalid

**MEDS III Transaction Segment: Professional**

| **Data Element Name:** | **FILLER** |
|---|---|
| Submission Status: | Required |
| Encounter Record Position(s): | 1270-3000 |
| Format - Length: | Character - 1731 |
| Effective Date: | 4/1/2012 |
| Version Number - Date: | 3.2 – April 2012 |

**Definition**: Space-fill positions 1270 to 3000.

**Mapping**:

- New York State Specific data element

**Codes and Values:**

- Left-justified and space-filled

**Edit Applications:**

- Tier One Edit – Record is not 3000 bytes.

## APPENDIX A – Provider Profession Codes

This list is available for download on the MEDS Home Page on the HCS under the heading MEDS III.

| ***Code*** | ***Value*** |
|---|---|
| 009 | Medical Physicist-Diagnostic Radiological |
| 010 | Licensed Practical Nurse |
| 011 | Medical Physicist-Medical Health |
| 012 | Medical Physicist-Medical Nuclear |
| 013 | Medical Physicist-Therapeutic Radiological |
| 020 | Pharmacist |
| 021 | Pharmacist, limited license (3 year) |
| 022 | Registerd Professional Nurse |
| 023 | Registered Physician Assistant |
| 024 | Registered Specialist Assistant |
| 025 | Acupuncture |
| 027 | Massage Therapist |
| 028 | Midwife |
| 030 | Nurse Practitioner, Adult Health |
| 031 | Nurse Practitioner, College Health |
| 032 | Nurse Practitioner, Community Health |
| 033 | Nurse Practitioner, Family Health |
| 034 | Nurse Practitioner, Gerentology |
| 035 | Nurse Practitioner, Neonatology |
| 036 | Nurse Practitioner, Obstetrics & Gynecology |
| 037 | Nurse Practitioner, Oncology |
| 038 | Nurse Practitioner, Pediatrics |
| 039 | Nurse Practitioner, Perinatology |
| 040 | Nurse Practitioner, Psychiatry |
| 041 | Nurse Practitioner, School Health |
| 042 | Nurse Practitioner, Women's Health |
| 043 | Nurse Practitioner, Acute Care |
| 044 | Nurse Practitioner, Palliative Care |
| 045 | Nurse Practitioner, Holistic medicine |
| 048 | Dietition/Nutritionist, Certified |
| 049 | Dental Assistant |
| 050 | Dentist |
| 051 | Dental Hygienist |
| 052 | Respiratory Therapist |
| 053 | Respiratory Therapy Technician |
| 055 | Ophthalmic Dispenser |
| 056 | Optometrist |
| 057 | Audiologist |
| 058 | Speech-Language Pathologist |
| 059 | Dentist, limited license (3 year) |

| *Code* | *Value* |
|---|---|
| 060 | Medicine |
| 061 | Medicine, limited license (3 year) |
| 062 | Physical Therapist |
| 063 | Occupational Therapist |
| 064 | Occupational Therapy Assistant |
| 065 | Podiatrist |
| 066 | Physical Therapy Assistant |
| 067 | Athletic Trainer |
| 068 | Psychologist |
| 069 | Dental Hygiene with Limited License |
| 070 | Chiropractor |
| 072 | Licensed Master Social Worker (no privileges) |
| 073 | Licensed Clinical Social Worker (R/P psychotherapy priv.) |
| 080 | Social Worker (obsolete split into 072, 073 eff. 9/1/2004) |
| 081 | Dental Parenteral Conscious Sedation (eff. 1/1/01) |
| 082 | Dental General Anesthesia (eff. 1/1/01) |
| 083 | Dental Enteral Conscious Sedation (eff. 1/1/01) |
| 084 | Dental Hygiene Anesthesia |
| 088 | Dental, Parenteral Conscious Sedation (prior to 1/1/01) |
| 089 | Dental Anesthesia (prior to 1/1/01) |

**APPENDIX B – Provider Specialty Codes**

These provider specialty codes for MEDS III reporting are available for download on the MEDS Home Page on the HCS under the heading MEDS III.

| Code | Provider Specialty/Service Description |
|---|---|
| 007 | ALCOHOLISM/SUBSTANCE ABUSE INPATIENT |
| 010 | ALLERGY AND IMMUNOLOGY |
| 011 | GENERAL HOSPITAL (ARTICLE 28) |
| 017 | OMH PSYCH CTR/OASAS ASA INPATIENT |
| 018 | PRIVATE PSYCH & ASA INPATIENT |
| 020 | ANESTHESIOLOGY |
| 030 | COLON AND RECTAL SURGERY |
| 040 | DERMATOLOGY |
| 041 | DERMATOPATHOLOGY |
| 050 | FAMILY PRACTICE |
| 055 | ADOLESCENT MEDICINE: FAMILY MEDICINE |
| 056 | ADOLESCENT MEDICINE: PEDIATRICS |
| 057 | BEHAVIORAL PEDIATRICS |
| 058 | INTERNAL MEDICINE AND PEDIATRICS |
| 059 | PEDIATRIC RHEUMATOLOGY |
| 060 | INTERNAL MEDICINE |
| 061 | PEDIATRIC INFECTIOUS DISEASE |
| 062 | CARDIOVASCULAR DISEASE |
| 063 | ENDOCRINOLOGY AND METABOLISM |
| 064 | GASTROENTEROLOGY |
| 065 | HEMATOLOGY - INTERNAL MED |
| 066 | INFECTIOUS DISEASES |
| 067 | NEPHROLOGY |
| 068 | PULMONARY DISEASES |
| 069 | RHEUMATOLOGY |
| 070 | NEUROLOGICAL SURGERY |
| 071 | SPINAL CORD INJURY MEDICINE |
| 072 | PEDIATRIC NEUROSURGERY |
| 073 | PEDIATRIC DERMATOLOGY |
| 074 | MEDICAL TOXICOLOGY |
| 075 | UNDERSEA & HYPERBARIC MEDICINE |
| 076 | PEDIATRIC REHABILITATION |
| 080 | NUCLEAR MEDICINE |
| 081 | MEDICAL NUCLEAR PHYSICS |
| 083 | NEUROMUSCULAR MEDICINE |
| 084 | NEURORADIOLOGY |
| 085 | NEUROTOLOGY |
| 089 | OBSTETRICS AND GYNECOLOGY |
| 092 | MATERNAL AND FETAL MEDICINE |
| 093 | REPRODUCTIVE ENDOCRINOLOGY |
| 095 | CERTIFIED DIABETES EDUCATOR |

| Code | Provider Specialty/Service Description |
|---|---|
| 100 | OPTHALMOLOGY |
| 101 | PEDIATRIC OPHTHALMOLOGY |
| 102 | CERTIFIED ASTHMA EDUCATOR |
| 110 | ORTHOPEDIC SURGERY |
| 111 | HAND SURGERY - ORTHOPEDIC SURGERY |
| 112 | HAND SURGERY - PLASTIC SURGERY |
| 113 | HAND SURGERY - SURGERY |
| 114 | PLASTIC SURGERY WITH THE HEAD & NECK |
| 120 | OTOLARYNGOLOGY |
| 121 | PEDIATRIC OTOLARYNGOLOGY |
| 127 | CLIA REGISTRATION/COMPLIANCE/ACCREDITATION |
| 128 | CLIA WAIVER |
| 129 | CLIA PHYSICIAN PERFORMED MICROSCOPY PROCEDURE |
| 130 | CLIA WAIVER/REGISTRATION |
| 131 | BLOOD BANKING |
| 135 | CLINICAL PATHOLOGY |
| 136 | FORENSIC PATHOLOGY |
| 137 | HEMATOLOGY - PSC PATH |
| 138 | CHEMICAL PATHOLOGY |
| 139 | MEDICAL MICROBIOLOGY |
| 140 | PATHOLOGY WITH MOLECULAR GENETIC SPEC |
| 141 | NEUROPATHOLOGY |
| 142 | ANATOMIC PATHOLOGY |
| 143 | DERMATOPATHOLOGY - PSC PATH |
| 144 | TRANSPLANT HEPATOLOGY |
| 145 | PEDIATRIC TRANSPLANT HEPATOLOGY |
| 146 | ANATOMIC AND CLINICAL PATHOLOGY |
| 147 | PEDIATRIC PATHOLOGY |
| 148 | RADIOISOTOPIC PATHOLOGY |
| 149 | PEDIATRIC EMERGENCY MEDICINE |
| 150 | PEDIATRICS |
| 151 | PEDIATRIC CARDIOLOGY |
| 152 | PEDIATRIC HEMATOLOGY - ONCOLOGY |
| 153 | PEDIATRIC SURGERY |
| 154 | PEDIATRIC NEPHROLOGY |
| 155 | PEDIATRIC NEONATAL - PERINATAL MEDICINE |
| 156 | PEDIATRIC ENDOCRINOLOGY |
| 157 | PEDIATRIC PULMONOLOGY |
| 158 | PREFERRED PHYSICIANS AND CHILDREN PROG |
| 159 | MEDICAID OBSTETRICAL & MATERNAL SVC PROG |
| 160 | PHYSICAL MEDICINE & REHABILITATION |
| 161 | PEDIATRIC CRITICAL CARE |
| 162 | OSTEOPATHIC MANIPULATIVE MEDICINE |
| 163 | PEDIATRIC GASTROENTOLOGY |
| 164 | CRITICAL CARE MED - ANESTHESIOLOGIST |

| Code | Provider Specialty/Service Description |
|---|---|
| 165 | CRITICAL CARE MEDICINE - INTERNAL |
| 166 | CRITICAL CARE MEDICINE - OBSTETRICS |
| 167 | CRITICAL CARE MEDICINE - SURGERY |
| 169 | MEDICAID OBSTERICAL & MATERNAL SERVICES PRGM (MOMS): HEALTH SUPPORTIVE SERVICES |
| 170 | PLASTIC SURGERY |
| 171 | CLINICAL MOLECULAR GENETICS |
| 180 | CLINICAL BIOCHEMICAL GENETICS |
| 181 | AEROSPACE |
| 182 | GENERAL PREVENTIVE MEDICINE |
| 183 | OCCUPATIONAL MEDICINE |
| 184 | PUBLIC HEALTH - PREVENTIVE MEDICINE |
| 185 | AEROSPACE MEDICINE |
| 186 | T.B. DIRECTLY OBSERVED THERAPY/PHYSICIAN |
| 187 | MEDICAL GENETICS |
| 188 | CLINICAL GENETICS |
| 189 | MOLECULAR GENETIC PATHOLOGY |
| 190 | PAIN MANAGEMENT-PSYCHIATRY & NEUROLOGY |
| 191 | CHILD PSYCHIATRY |
| 192 | PSYCHIATRY |
| 193 | CHILD NEUROLOGY |
| 194 | NEUROLOGY |
| 195 | PSYCHIATRY & NEUROLOGY |
| 196 | CLOZAPINE CASE MANAGER - PSYCH |
| 197 | GERIATRIC PSYCHIATRY |
| 198 | ADDICTION PSYCHIATRY |
| 199 | NERODEVELOPMENTAL DISABILITIES |
| 200 | RADIOLOGY |
| 201 | DIAGNOSTIC RADIOLOGY |
| 202 | DIAGNOSTIC ROENTGENOLOGY |
| 205 | THERAPEUTIC RADIOLOGY |
| 206 | RADIOLOGICAL PHYSICS |
| 207 | THERAPEUTIC RADIOLOGICAL PHYSICS |
| 208 | DIAGNOSTIC RADIOLOGICAL PHYSICS |
| 210 | GENERAL SURGERY |
| 211 | HOSPITALIST |
| 220 | THORACIC SURGERY |
| 230 | UROLOGY |
| 231 | PEDIATRIC UROLOGY |
| 240 | VASCULAR NEUROLOGY |
| 241 | ONCOLOGY |
| 242 | GYNECOLOGIC ONCOLOGY |
| 243 | VASCULAR MEDICINE |
| 244 | RADIOLOGIST ONCOLOGY |
| 245 | PEDIATRIC RADIOLOGY |

| Code | Provider Specialty/Service Description |
|---|---|
| 246 | VASCULAR&INTERVENTIONAL RADIOLOGY |
| 247 | MANAGED CARE - PHYSICIAN ENHANCED FEE |
| 248 | MANAGED CARE - DENTAL ENHANCED FEE |
| 249 | HIV PRIMARY CARE SERVICES |
| 250 | EMERGENCY MEDICINE |
| 252 | PRIMARY CARE INITIATIVE IN UNDERSERVED AREAS |
| 253 | SPECIALSTS PRIMARY CARE INIT - UNDERSRVD AREA |
| 254 | SPECIALISTS IN PHYSICIANS CASE MGMT PROGRAM |
| 270 | CHILD HEALTH ASSURANCE PROGRAM |
| 280 | CHIROPRACTIC |
| 281 | CLINICAL SOCIAL WORKER |
| 282 | CERTIFIED DRUG & ALCOHOL COUNSELOR |
| 283 | COUNSELOR |
| 290 | ACUPUNCTURIST |
| 300 | PHYSICAL THERAPY |
| 301 | OCCUPATIONAL THERAPY |
| 302 | SPEECH THERAPY |
| 303 | AIDS/HIV SERVICES |
| 304 | MEDICAL REHAB |
| 305 | PEDIATRIC SPECIALTY - ALL EXCEPT PRIMARY CARE |
| 306 | SCHOOL SUPPORTIVE HEALTH SERVICES PROGRAM |
| 307 | DURABLE MEDICAL EQUIPMENT |
| 308 | HIV PRIMARY CARE SERVICES - CLINIC SPECIALTY |
| 309 | MEDICALLY SUPERVISED SUBSTANCE ABUSE |
| 310 | OMH ADULT CLINIC (STATE OPR) |
| 311 | OMH CHILD CLINIC(STATE OPR) |
| 312 | OMH CONTINUING DAY TRTMT (STATE OPR) |
| 313 | OMH PARTIAL HOSPITALIZATION (STATE OPR) |
| 314 | OMH INTEN PSYCH REHAB TRTMT (STATE OPR) |
| 315 | OMH ADULT CLINIC |
| 316 | OMH CHILD CLINIC |
| 317 | OMH CONTINUING DAY TREATMENT |
| 318 | OMH PARTIAL HOSPITALIZATION |
| 319 | OMH INTENSIVE PSYCH REHAB TREATMENT |
| 320 | CLOZAPINE CASE MANAGER - CLINIC |
| 321 | COMPREHENSIVE SPECIALTY CLINIC SERVICES |
| 322 | OMH COMPREHENSIVE OUTPATIENT PROGRAM (COPS) CLINIC |
| 323 | OMH COMP OUTPAT PROG (COPS) CONTINUING DAY TRTMT |
| 324 | PRE-SCHOOL SUPPORTIVE HEALTH CARE |
| 325 | EARLY INTERVENTION |
| 326 | OMH/CR ADULT (VOLUNTARY) |
| 327 | OMH/CR CHILDREN (VOLUNTARY) |
| 328 | OMH FAMILY BASED TREATMENT |
| 329 | OMH/CR ADULT (STATE OPR) |
| 330 | OMH/CR CHILDREN (STATE OPR) |

| Code | Provider Specialty/Service Description |
|---|---|
| 331 | OMH TEACHING FAMILY HOME |
| 332 | OMR/DD CR (STATE OPR) |
| 350 | PPCP ASSOCIATED DENTAL CLINIC - ORAL SURGERY |
| 351 | PPCP ASSOCIATED DENTAL CLINIC - GENERAL DENTISTRY |
| 352 | PPCP ASSOCIATED COPS |
| 353 | PPCP ASSOCIATED OMH CLINICS |
| 354 | PPCP ASSOCIATED PSYCHIATRY, GENERAL |
| 355 | AIDS DAY HEALTH CARE SERVICES |
| 356 | HOME & COMMUNITY BASED SERVICE (HCBS) WAIVER |
| 357 | OUTPATIENT CHEMICAL DEPENDENCE WITHDRAWL |
| 358 | TBI SERVICES |
| 359 | RISPERDAL CONSTA ADMINISTRATION |
| 365 | MH RESIDENTIAL (NON-INPATIENT) |
| 371 | CASE MANAGEMENT |
| 375 | MH OUTPATIENT (NON-RESIDENTIAL) |
| 376 | MENTAL HEALTH PRACTITIONER |
| 400 | MICROBIOLOGY |
| 401 | FQ OUT-OF-STATE (NON-CMMA) |
| 402 | FQ PRIMARY |
| 403 | FQ SECONDARY |
| 404 | FQ AUTHORIZED |
| 410 | BACTERIOLOGY |
| 411 | BACTERIOLOGY - GENERAL |
| 412 | BACTERIOLOGY - LIMITED |
| 413 | BACTERIOLOGY - AEROBES ONLY |
| 414 | BACTERIOLOGY - NEISSERIA GONORRHOEAE SCREENG |
| 415 | BACTEROLOGY - GC SMEARS ONLY |
| 416 | BACTERIOLOGY-RESTRICTED (DENTAL) |
| 419 | MYCOBACTERIOLOGY - SMEARS AND CULTURE |
| 420 | MYCOBACTERIOLOGY - GENERAL |
| 421 | MYCOBACTERIOLOGY - LIMITED |
| 422 | MYCOBACTERIOLOGY - SMEARS ONLY |
| 423 | DIAGNOSTIC IMMUNOLOGY - COMPREHENSIVE |
| 424 | DIAGNOSTIC IMMUNOLOGY - OTHER |
| 427 | DIAGNOSTIC IMMUNOLOGY - GENERAL/LIMITED |
| 429 | DIAGNOSTIC IMMUNOLOGY - SPECIAL |
| 430 | HUMAN IMMUNODEFICIENCY VIRUS - RESTRICTED A |
| 431 | HUMAN IMMUNODEFICIENCY VIRUS - RESTRICTED B |
| 432 | HUMAN IMMUNODEFICIENCY VIRUS - COMPREHENSIVE |
| 433 | SEROLOGY - ROUTINE |
| 434 | SEROLOGY - LIMITED |
| 435 | CELLULAR IMMUNOLOGY - LIMITED I |
| 436 | CELLULAR IMMUNOLOGY - LIMITED II |
| 437 | SEROLGY - OTHER |
| 438 | CELLULAR IMMUNOLOGY - GENERAL |

| Code | Provider Specialty/Service Description |
|---|---|
| 439 | CELLULAR IMMUNOLOGY - LIMITED III |
| 440 | VIROLOGY - GENERAL I OR GENERAL II |
| 441 | VIROLOGY - LIMITED |
| 442 | VIROLOGY - RESTRICTED |
| 450 | MYCOLOGY - GENERAL |
| 451 | MYCOLOGY - LIMITED(YEAST ONLY) |
| 460 | PARASITOLOGY |
| 461 | PARASITOLOGY - STOOL |
| 462 | PARASITOLOGY - OTHER |
| 463 | PARASITOLOGY - BLOOD |
| 470 | URINE PREGNANCY TESTING |
| 480 | HEMATOLOGY |
| 481 | HEMATOLOGY - COMPREHENSIVE |
| 482 | HEMATOLOGY - GENERAL |
| 483 | HEMATOLOGY - COAGULATION ONLY |
| 484 | HEMATOLOGY - LIMITED |
| 485 | HEMATOLOGY - OTHER |
| 486 | CYTOHEMATOLOGY - LIMITED/DIAGNOSTIC |
| 490 | IMMUNOHEMATOLOGY |
| 491 | BLOOD SERVICES - DIAGNOSTIC IMMUNOHEMATOLOGY |
| 492 | IMMUNOHEMATOLOGY SPC 492 |
| 493 | IMMUNOHEMATOLOGY SPC 493 |
| 510 | CLINICAL CHEMISTRY - GENERAL |
| 511 | CLINICAL CHEMISTRY - LIMITED |
| 512 | TOXICOLOGY - ERYTHROCYTE PROTOPORPHYRIN-HEMAT |
| 513 | TOXICOLOGY - ERYTHROCYTE PROTOPORHYRIN-EXTRCT |
| 514 | TOXICOLOGY - DRUG ANALYSIS-QUAL (OR FORENSIC) |
| 515 | TOXICOLOGY - BLOOD LEAD |
| 516 | ENDOCRINOLOGY |
| 517 | CHEMLIMIT |
| 518 | QUALITATIVE TOXICOLOGY - REHABILITATION PROGS |
| 519 | CHEM RESERV |
| 520 | CHEM ALL |
| 521 | BLOOD PH AND GASES |
| 522 | CHEM IMD |
| 523 | THERAPEUTIC SUBSTANCE MONITORING/QUAN TOXICOL |
| 524 | URINALYSIS |
| 530 | PATHOLOGY SPC 530 |
| 531 | HISTOPATHOLOGY - GENERAL/ORAL/DERMATOPATHALGY |
| 532 | PATHOLOGY SPC 532 |
| 533 | PATHOLOGY SPC 533 |
| 540 | CYTOPATHOLOGY |
| 550 | ONCOFETAL ANTIGEN - GENERAL |
| 551 | ONCOFETAL ANTIGEN - LIMITED |
| 552 | ONCOFETAL ANTIGEN - GENERAL, SERA ONLY |

| Code | Provider Specialty/Service Description |
|---|---|
| 553 | ONCOFETAL ANTIGEN - GENL, AMNIOTIC FLUID ONLY |
| 560 | GENETIC TESTING |
| 561 | BLOOD TRANSFUSION COLLECTION |
| 562 | BLOOD TRANSFUSION |
| 570 | MISCELLANEOUS |
| 571 | CYTOGENETICS - GENERAL |
| 572 | CYTOGENETICS - LIMITED |
| 573 | CYTOGENETICS - HEMATOLOGICAL DISORDERS |
| 574 | MISCELLANEOUS HIS |
| 575 | MISCELLANEOUS LIMITED HIS |
| 576 | MISCELLANEOUS MISCELLANEOUS |
| 579 | NURSE: MEDICALLY FRAGILE CHILDREN |
| 580 | HISTOCOMPATIBILITY - LIMITED |
| 585 | MISCELLANEOUS CLINIC CHEM |
| 590 | MISCELLANEOUS SPECIALTY TEST |
| 599 | LABORATORY |
| 600 | SPORTS MEDICINE - EMERGENCY |
| 601 | SPORTS MEDICINE - FAMILY MEDICINE |
| 602 | SPORTS MEDICINE - INTERNAL |
| 603 | SPORTS MEDICINE - PEDIATRICS |
| 604 | SPORTS MEDICINE - ORTHOPEDIC |
| 615 | PERSONAL EMERGENCY RESPONSE SYSTEM |
| 616 | MENTAL HEALTH INPATIENT |
| 620 | GERIATRICS - FAMILY MEDICINE |
| 621 | GERIATRICS - INTERNAL |
| 630 | PAIN MANAGEMENT |
| 640 | AUDIOLOGIST |
| 650 | GENERAL VASCULARY SURGERY |
| 651 | CARDIO-THORACIC |
| 652 | INTERVENTION CARDIOLOGY |
| 653 | CLINICAL CARDIAC ELECTROPHYSIOLOGY |
| 655 | AIDS SKILLED NURSING FACILITY |
| 656 | HEAD INJURY/TBI INJURY SNF |
| 657 | BEHAVIORAL HEALTH INTERVENTION SKILLED NURSING FACILITY (NEURO) |
| 658 | PEDIATRIC SKILLED NURSING FACILITY |
| 659 | VENT SKILLED NURSING FACILITY |
| 660 | INSTITUTIONAL LTC |
| 661 | SOCIAL AND ENVIRONMENTAL SUPPORTS |
| 662 | SOCIAL DAY CARE |
| 663 | NURSING HOME CARE SHORT TERM REHAB |
| 664 | ADULT DAY HEALTH CARE |
| 665 | NON INSTITUTIONAL LTC |
| 666 | ASSISTED LIVING PROGRAM |
| 667 | HOME DELIVERED MEALS/CONGREGATE MEALS |
| 668 | HOME CARE - HOME HEALTH AIDE |

| Code | Provider Specialty/Service Description |
|---|---|
| 669 | HOSPICE CARE |
| 670 | AMBULANCE |
| 671 | OTHER TRANSPORTATION (NON-EMERGENT) |
| 672 | PARALEVEL1 PARAPROFESSIONAL SERVICES: LEVEL 1 HMMAKER/HOUSKP |
| 673 | PARALEVEL2 PARAPROFESSIONAL SERVICES: LEVEL 2 PERSONAL CARE |
| 674 | RESPIRATORY THERAPY |
| 675 | CONSUMER DIRECTED PERSONAL CARE: LEVEL 1 |
| 676 | CONSUMER DIRECTED PERSONAL CARE: LEVEL 2 |
| 680 | NURSING |
| 711 | PRESCRIPTION FOOTWEAR |
| 714 | LOW VISION SPECIALIST |
| 715 | OPTICIAN/CONTACT LENS PRIVILGE |
| 716 | OPTOMETRIST/DIAGNOSTIC PHARMEUTICALS |
| 730 | INBORN METABOLIC DISEASE CENTER |
| 738 | PORTABLE X-RAY COMPANIES |
| 739 | INDEPENDENT PHYSIOLOGICAL LABS |
| 740 | REGIONAL PERINATAL TRANSPORTATION PROV |
| 741 | TRANSPLANT SURGERY |
| 749 | ASA GENERAL OUTPATIENT |
| 750 | METHADONE MAINTENANCE (PHYSICIAN) |
| 751 | METHADONE MAINTENANCE PREFERRED PROV |
| 754 | ASA MEDICALLY MONITORED WITHDRAWAL |
| 760 | PHARMACY |
| 762 | HOME CARE SERVICES AGENCY LIMITED LICENSE |
| 775 | ALL SPECIALITIES |
| 776 | GENERAL PRACTICE ONLY - NO SPEC |
| 777 | ALL PHYSICIAN |
| 778 | PODIATRIST |
| 779 | NURSE PRAC |
| 780 | CLINICAL PSYCHLG |
| 781 | CERT SOCIAL WKRS |
| 782 | NURSE MIDWIVES |
| 790 | RESPITE |
| 791 | S/HMO (ELDERPLAN) |
| 798 | LONG TERM HOME HEALTH |
| 799 | NO SPECIALTY REQUIRED |
| 800 | GENERAL DENTIST |
| 801 | ORTHODONTURE |
| 802 | ENDODONTIST |
| 803 | ORAL PATHOLOGIST |
| 804 | PEDODONTIST |
| 805 | PROSTHODONTIST |
| 806 | PERIODONTIST |
| 807 | PUBLIC HEALTH |
| 808 | ORAL SURGEON |

| Code | Provider Specialty/Service Description |
|---|---|
| 809 | DENTAL ANESTHESIOLOGIST |
| 810 | PARENTERAL CONSCIOUS SEDATION |
| 811 | MAXILLOFACIAL SURGERY |
| 815 | DENTIST - FAMILY |
| 816 | ASSERTIVE COMMUNITY TREATMENT |
| 817 | ASSISTIVE TECHNOLOGY |
| 818 | COMMUNITY INTEGRATION COUNSELING |
| 819 | COMMUNITY TRANSITIONAL SERVICE PROVIDER |
| 820 | ENVIRONMENTAL MODIFICATIONS SERVICES |
| 821 | FREESTANDING BIRTH CENTER |
| 822 | INDEPENDENT LIVING SKILLS TRAINING PROVIDER |
| 823 | URGENT CARE |
| 824 | MOBILE MENTAL HEALTH TREATMENT PROVIDER |
| 825 | MOVING ASSISTANCE PROVIDER |
| 826 | PALLIATIVE CARE PROVIDER |
| 827 | PEER DELIVERED SERVICES |
| 828 | PEER MENTORING PROVIDER |
| 829 | PERSONALIZED RECOVERY ORIENTED SERVICES |
| 830 | POSITIVE BEHAVIORAL INTERVENTIONS AND SUPPORTS |
| 831 | SOCIAL DAY CARE TRANSPORTATION |
| 832 | STRUCTURED DAY PROGRAM |
| 833 | TELEHEALTH |
| 834 | HOME AND COMMUNITY SUPPORT SERVICES |
| 835 | HCBS PROVIDER TRAVEL |
| 836 | HCBS PSYCHOSOCIAL REHAB |
| 837 | HCBS PEER SUPPORT |
| 838 | OMH OTHER LICENSED PRACTITIONERS |
| 839 | HCBS COMMUNITY PSYCHIATRIC SUPPORTS AND TREATMENT |
| 851 | OTHER VISION CARE |
| 852 | PCCM ENHANCEMENT |
| 853 | PCCM QUALITY ENHANCEMENT |
| 854 | HABILITATION SUPPORT SERVICES |
| 855 | FAMILY SUPPORT AND TRAINING |
| 856 | SHORT-TERM CRISIS RESPITE |
| 857 | INTENSIVE CRISIS RESPITE |
| 858 | PRE-VOCATIONAL SERVICES |
| 859 | TRANSITIONAL EMPLOYMENT |
| 860 | INTENSIVE SUPPORTIVE EMPLOYMENT |
| 861 | ONGOING SUPPORTED EMPLOYMENT |
| 862 | EDUCATION SUPPORT SERVICES |
| 899 | HOSPITAL INPATIENT |
| 900 | HMO CO-PAYMENT |
| 901 | EMERGENCY ROOM |

| Code | Provider Specialty/Service Description |
|---|---|
| 902 | ENDOCRINE |
| 903 | DIABETES |
| 904 | OBSTETRICS |
| 905 | GYNECOLOGY |
| 906 | FAMILY PLANNING |
| 907 | ABORTION |
| 908 | CHILD HEALTH ASSURANCE PROGRAM (CHAP) |
| 909 | NUTRITION |
| 910 | ORAL SURGERY - CLINIC SPECIALTY |
| 911 | GENERAL DENTISTRY - CLINIC SPECIALTY |
| 912 | ORTHODONTICS |
| 913 | HEMODIALYSIS |
| 914 | GENERAL MEDICINE - CLINIC SPECIALTY |
| 915 | ALLERGY |
| 916 | ARTHRITIS |
| 917 | RHEUMATOLOGY - CLINIC SPECIALTY |
| 918 | PODIATRIST CENTER |
| 919 | EYE/VISION CENTER |
| 920 | PHYSICAL THERAPY - CLINIC SPECIALTY |
| 921 | SPEECH THERAPY- CLINIC SPECIALTY |
| 922 | METHADONE MAINTENANCE TREATMENT PROGRAM |
| 923 | OCCUPATIONAL THERAPY- CLINIC SPECIALTY |
| 924 | REHABILITATION MEDICINE- CLINIC SPECIALTY |
| 925 | HYPERTENSION - CLINIC SPECIALTY |
| 926 | HEMATOLOGY- CLINIC SPECIALTY |
| 927 | CARDIOLOGY |
| 928 | CARDIOVASCULAR- CLINIC SPECIALTY |
| 929 | PULMONARY-CLINIC SPECIALTY |
| 930 | GASTROENTEROLOGY - CLINIC SPECIALTY |
| 931 | NEUROLOGY- CLINIC SPECIALTY |
| 932 | NEUROSURGERY- CLINIC SPECIALTY |
| 933 | CANCER DETECTION |
| 934 | ONCOLOGY - THERAPY (RADIATION OR CHEMO) |
| 935 | EAR, NOSE & THROAT- CLINIC SPECIALTY |
| 936 | PEDIATRIC GENERAL MEDICINE- CLINIC SPECIALTY |
| 937 | PEDIATRIC ALLERGY- CLINIC SPECIALTY |
| 938 | PEDIATRIC NEUROLOGY- CLINIC SPECIALTY |
| 939 | PEDIATRIC HEMATOLOGY- CLINIC SPECIALTY |
| 940 | PEDIATRIC CARDIAC - CLINIC SPECIALTY |
| 941 | PEDIATRIC RENAL- CLINIC SPECIALTY |
| 942 | PEDIATRIC PULMONARY- CLINIC SPECIALTY |
| 943 | PEDIATRIC ORTHOPEDIC- CLINIC SPECIALTY |
| 944 | PEDIATRIC ENDOCRINE - CLINIC SPECIALTY |
| 945 | PSYCHIATRY - INDIVIDUAL |
| 946 | PSYCHIATRY - GROUP |

| Code | Provider Specialty/Service Description |
|---|---|
| 947 | PSYCHIATRY - HALF DAY CARE |
| 948 | PSYCHIATRY - FULL DAY CARE |
| 949 | ALCOHOLISM TREATMENT PROGRAM |
| 950 | ORTHOPEDIC- CLINIC SPECIALTY |
| 951 | SURGICAL, MINOR |
| 952 | SURGICAL, GENERAL |
| 953 | UROLOGY - CLINIC SPECIALTY |
| 954 | NEPHROLOGY - CLINIC SPECIALTY |
| 955 | GENITO-URINARY- CLINIC SPECIALTY |
| 956 | DERMATOLOGY - CLINIC SPECIALTY |
| 957 | CONTRACT CARRIER |
| 958 | OPTHALMOLOGY - CLINIC SPECIALTY |
| 959 | OUTPAT CHEM DEPENDENCY PROG FOR YOUTH |
| 960 | PEDIATRIC DERMATOLOGY - CLINIC SPECIALTY |
| 961 | PEDIATRIC DIABETES- CLINIC SPECIALTY |
| 962 | PEDIATRIC SURGERY - CLINIC SPECIALTY |
| 963 | CHILD PSYCHIATRY - CLINIC SPECIALTY |
| 964 | PSYCHIATRY-GENERAL- CLINIC SPECIALTY |
| 965 | TUBERCULOSIS- CLINIC SPECIALTY |
| 966 | INFECTIOUS DISEASES - CLINIC SPECIALTY |
| 967 | SPEECH & HEARING- CLINIC SPECIALTY |
| 968 | AMPUTEE CENTER |
| 969 | HOSP DME/ORTHOTIC/PROSTH APPLNC VENDOR |
| 970 | NURSING HOME HOSPITAL DAYCARE (NO CLAIM) |
| 971 | MH CLINIC TREATMENT (STATE OPR) |
| 972 | MH DAY TREATMENT (STATE OPR) |
| 973 | MH CONTINUING TREATMENT (STATE OPR) |
| 974 | MENTAL HEALTH CLINIC TREATMENT |
| 975 | MENTAL HEALTH DAY TREATMENT |
| 976 | MENTAL HEALTH CONTINUING TREATMENT |
| 977 | MR/DD CLINIC TREATMENT (STATE OPR) |
| 978 | PREFERRED PRIMARY CARE CLINIC |
| 979 | MR/DD CLINIC TREATMENT |
| 980 | T.B. DIRECTLY OBSERVED THERAPY/CLINIC |
| 981 | DIAG AND RESEARCH CLINIC MR (STATE OPR) |
| 982 | APNEA CENTER |
| 983 | SPECIALTY CLINIC - MENTAL RETARDATION |
| 984 | ALCOHOLISM CLINIC TREATMENT (STATE OPR) |
| 985 | ALCOHOLISM DAY REHAB (STATE OPR) |
| 986 | ALCOHOLISM CLINIC TREATMENT |
| 987 | ALCOHOLISM DAY REHABILIATION |
| 988 | COMPREHENSIVE ALCOHOLISM CARE |
| 989 | MEDICALLY SUPERVISED WITHDRAWAL-OUTPATIENT |
| 990 | COMP PHYSICAL EXAM (SCHOOL HEALTH PROJ) |
| 991 | ROUTINE VISIT (SCHOOL HEALTH PROJECT) |

| Code | Provider Specialty/Service Description |
|---|---|
| 992 | OMH COMPREHENSIVE PSYCHIATRIC EMERGENCY PROG |
| 993 | HOSP-BASED/FREESTANDING AMBULAT SURGERY |
| 994 | BLOOD PRODUCTS (ORDERED AMBULATORY) |
| 995 | GENETIC COUNSELING (ORDERED AMBULATORY) |
| 996 | HEARING SERVICES (ORDERED AMBULATORY) |
| 997 | OPERATING ROOM (ORDERED AMBULATORY) |
| 998 | RADIOLOGY (ORDERED AMBULATORY) |
| 999 | OTHER |

## APPENDIX C - Codes and Values for Tooth Number or Letter

| *Code* | *Value* |
|---|---|
| 01 | PERMANENT THIRD MOLAR-UPPER RIGHT |
| 02 | PERMANENT SECOND MOLAR-UPPER RIGHT |
| 03 | PERMANENT FIRST MOLAR-UPPER RIGHT |
| 04 | PERMANENT SECOND PREMOLAR-UPPER RIGHT |
| 05 | PERMANENT FIRST PREMOLAR-UPPER RIGHT |
| 06 | PERMANENT CANINE-UPPER RIGHT |
| 07 | PERMANENT LATERAL INCISOR-UPPER RIGHT |
| 08 | PERMANENT CENTRAL INCISOR-UPPER RIGHT |
| 09 | PERMANENT CENTRAL INCISOR-UPPER LEFT |
| 10 | PERMANENT LATERAL INCISOR-UPPER LEFT |
| 11 | PERMANENT CANINE-UPPER LEFT |
| 12 | PERMANENT FIRST PREMOLAR-UPPER LEFT |
| 13 | PERMANENT SECOND PREMOLAR-UPPER LEFT |
| 14 | PERMANENT FIRST MOLAR-UPPER LEFT |
| 15 | PERMANENT SECOND MOLAR-UPPER LEFT |
| 16 | PERMANENT THIRD MOLAR-UPPER LEFT |
| 17 | PERMANENT THIRD MOLAR-LOWER LEFT |
| 18 | PERMANENT SECOND MOLAR-LOWER LEFT |
| 19 | PERMANENT FIRST MOLAR-LOWER LEFT |
| 20 | PERMANENT SECOND PREMOLAR-LOWER LEFT |
| 21 | PERMANENT FIRST PREMOLAR-LOWER LEFT |
| 22 | PERMANENT CANINE-LOWER LEFT |
| 23 | PERMANENT LATERAL INCISOR-LOWER LEFT |
| 24 | PERMANENT CENTRAL INCISOR-LOWER LEFT |
| 25 | PERMANENT CENTRAL INCISOR-LOWER RIGHT |
| 26 | PERMANENT LATERAL INCISOR-LOWER RIGHT |
| 27 | PERMANENT CANINE-LOWER RIGHT |
| 28 | PERMANENT FIRST PREMOLAR-LOWER RIGHT |
| 29 | PERMANENT SECOND PREMOLAR-LOWER RIGHT |
| 30 | PERMANENT FIRST MOLAR-LOWER RIGHT |
| 31 | PERMANENT SECOND MOLAR-LOWER RIGHT |
| 32 | PERMANENT THIRD MOLAR-LOWER RIGHT |
| 51 | SUPERNUMARY 01 |
| 52 | SUPERNUMARY 02 |
| 53 | SUPERNUMARY 03 |
| 54 | SUPERNUMARY 04 |
| 55 | SUPERNUMARY 05 |
| 56 | SUPERNUMARY 06 |
| 57 | SUPERNUMARY 07 |
| 58 | SUPERNUMARY 08 |
| 59 | SUPERNUMARY 09 |
| 60 | SUPERNUMARY 10 |
| 61 | SUPERNUMARY 11 |
| 62 | SUPERNUMARY 12 |
| 63 | SUPERNUMARY 13 |

| *Code* | *Value* |
|---|---|
| 64 | SUPERNUMARY 14 |
| 65 | SUPERNUMARY 15 |
| 66 | SUPERNUMARY 16 |
| 67 | SUPERNUMARY 17 |
| 68 | SUPERNUMARY 18 |
| 69 | SUPERNUMARY 19 |
| 70 | SUPERNUMARY 20 |
| 71 | SUPERNUMARY 21 |
| 72 | SUPERNUMARY 22 |
| 73 | SUPERNUMARY 23 |
| 74 | SUPERNUMARY 24 |
| 75 | SUPERNUMARY 25 |
| 76 | SUPERNUMARY 26 |
| 77 | SUPERNUMARY 27 |
| 78 | SUPERNUMARY 28 |
| 79 | SUPERNUMARY 29 |
| 80 | SUPERNUMARY 30 |
| 81 | SUPERNUMARY 31 |
| 82 | SUPERNUMARY 32 |
| A | PRIMARY SECOND MOLAR-UPPER RIGHT |
| AL | LOWER ARCH |
| AS | TOOTH CODES AS |
| AU | UPPER ARCH UPPER ARCH |
| B | PRIMARY FIRST MOLAR-UPPER RIGHT |
| BS | TOOTH CODES BS |
| C | PRIMARY CANINE-UPPER RIGHT |
| CS | TOOTH CODES CS |
| D | PRIMARY LATERAL INCISOR-UPPER RIGHT |
| DE | ALL DECIDUOUS |
| DS | TOOTH CODES DS |
| E | PRIMARY CENTRAL INCISOR-UPPER RIGHT |
| ES | TOOTH CODES ES |
| F | PRIMARY CENTRAL INCISOR-UPPER LRFT |
| FS | TOOTH CODES FS |
| G | PRIMARY LATERAL INCISOR-UPPER LEFT |
| GS | TOOTH CODES GS |
| H | PRIMARY CANINE-UPPER LEFT |
| HS | TOOTH CODES HS |
| I | PRIMARY FIRST MOLAR-UPPER LEFT |
| IS | TOOTH CODES IS |
| J | PRIMARY SECOND MOLAR-UPPER LEFT |
| JS | TOOTH CODES JS |
| K | PRIMARY SECOND MOLAR-LOWER LEFT |
| KS | TOOTH CODES KS |
| L | PRIMARY FIRST MOLAR-LOWER LEFT |
| LL | LOWER LEFT QUADRANT |

| *Code* | *Value* |
|---|---|
| LR | LOWER RIGHT QUADRANT |
| LS | TOOTH CODES LS |
| M | PRIMARY CANINE-LOWER LEFT |
| MS | TOOTH CODES MS |
| N | PRIMARY LATERAL INCISOR-LOWER LEFT |
| NS | TOOTH CODES NS |
| O | PRIMARY CENTRAL INCISOR-LOWER LEFT |
| OS | TOOTH CODES OS |
| P | PRIMARY CENTRAL INCISOR-LOWER LEFT |
| PE | ALL PERMANENT |
| PS | TOOTH CODES PS |
| Q | PRIMARY LATERAL INCISOR-LOWER LEFT |
| QS | TOOTH CODES QS |
| R | PRIMARY CANINE-LOWER RIGHT |
| RS | TOOTH CODES RS |
| S | PRIMARY FIRST MOLAR-LOWER RIGHT |
| SS | TOOTH CODES SS |
| T | PRIMARY SECOND MOLAR-LOWER RIGHT |
| TS | TOOTH CODES TS |
| UL | UPPER LEFT QUADRANT |
| UR | UPPER RIGHT QUADRANT |

# Medicaid Encounter Data System III (MEDS III) Supplemental Manual On Applicable Edits

I. MEDS III Categories of Service, Applicable Encounter Type Indicators and Form Type/EDI
II. Tier One Edits
III. Edit Logic
IV. Edit Severity Matrix
V. Response Report Reconciliation

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## I. MEDS III Categories of Service, Applicable Encounter Type Indicators (ETI) and Form Type/EDI

| *COS Code* | *COS Description* | *ETI* | *ETI Description* | *Form Type/EDI* |
|---|---|---|---|---|
| 01 | Physician Services | P | Professional | CMS-1500 / 837P |
| 03 | Podiatry | P | Professional | CMS-1500 / 837P |
| 04 | Psychology | P | Professional | CMS-1500 / 837P |
| 05 | Eye Care / Vision | P | Professional | CMS-1500 / 837P |
| 06 | Rehabilitation Therapy | I | Institutional | UB-92 / 837I |
| 07 | Nursing | P | Professional | CMS-1500 / 837P |
| 11 | Inpatient | I | Institutional | UB-92 / 837I |
| 12 | Institutional LTC | I | Institutional | UB-92 / 837I |
| 13 | Dental | T | Dental | ADA / 837D |
| 14 | Pharmacy | D | Pharmacy/DME | NCPDP |
| 15 | Home Health Care/Non-Institutional Long Term Care | I | Institutional | UB-92 / 837I |
| 16 | Laboratories | P | Professional | CMS-1500 / 837P |
| 19 | Transportation | P | Professional | CMS-1500 / 837P |
| 22 | DME and Hearing Aids | P | Professional | CMS-1500 / 837P |
| 28 | Intermediate Care Facilities | I | Institutional | UB-92 / 837I |
| 41 | NPs/Midwives | P | Professional | CMS-1500 / 837P |
| 73 | Hospice | I | Institutional | UB-92 / 837I |
| 75 | Clinical Social Worker | P | Professional | CMS-1500 / 837P |
| 85 | Freestanding Clinic | I | Institutional | UB-92 / 837I |
| 87 | Hospital OP/ER Room | I | Institutional | UB-92 / 837I |

**Additional Copies:**
Additional copies of this manual may be obtained via download from the MEDS Home Page on the HCS.

**CSC Contact Information**:
CSC Provider Relations Staff at: MEDSSupport@csc.com
http://www.emedny.org/ProviderManuals/ManagedCare/index.html

**II. Tier One Edits**

After submitting a file of encounter data to CSC via the eMedNY eXchange or FTP options, plans will receive notification that the file was received and processed. When an encounter file does not pass through the front end processing it is due to failing a 'Tier One' edit. When this occurs the entire file is rejected for one of the following 'Tier One' edits.

| Tier One Error | Message Returned |
|---|---|
| Record is not 3000 bytes | 'Incomplete " ", Header Record' – will give the size and record that is not 3000 bytes |
| Required records missing (H1, D1, and a T1) | Required " " record missing' – will include the record type missing |
| Required records not in sequence (H1, D1, and a T1) | 'Record " " is of unknown type or invalid sequence' – will include the record type in error |
| Test/Prod indicator is incorrect – must be PROD | 'Specified mode " " does not match' 'Test/Prod Indicator' |
| The carriage return (CR) is too short/long or misaligned | 'Misaligned ASCII " ", "CR" in record " " column " " ' |
| | 'Unexpected ASCII " ", "CR" in record " " column " " ' |
| Newline/linefeed (NL) in record | 'Unexpected ASCII " ", "NL" in record " " column " " ' |
| Non-printable characters in file | 'Non-ASCII character' |
| End of file not in the correct place | 'Premature end-of-file' |
| No records are found | 'FILE CONTAINS NO CLAIM RECORDS' |
| H1 record is found when unexpected | 'UNEXPECTED H1 RECORD RECEIVED' 'AT RECORD #:' |
| H1 record is not found when expected (after user record) | 'EXPECTED H1 CONTROL RECORD NOT RECEIVED' 'AT RECORD #:' |
| D1 record is found, and it is expected, and the encounter type is other than I, D, T, or P | 'INVALID D1 RECORD RECEIVED' |
| | 'AT RECORD #:' |
| D1 record is found when unexpected | 'UNEXPECTED D1 RECORD RECEIVED' 'AT RECORD #:' |
| D1 record is not found when expected | 'EXPECTED D1 CONTROL RECORD NOT RECEIVED' 'AT RECORD #:' |
| T1 record is found when unexpected | 'UNEXPECTED T1 RECORD RECEIVED' 'AT RECORD #:' |
| Record is other than H1, D1, or T1 | 'RECEIVED RECORD NOT H1/D1/T1"AT RECORD #:' |
| Provider Check Digit | The Provider Identification is Invalid |
| Provider Zip Code | The Provider Service Location is Invalid/Non-Numeric |

If the encounter transmission does not fail for any of the above listed 'Tier One' edits, plans will receive a message that the file was passed on for further processing. What this means is that the encounter file will now be processed in the CSC Claims System and a MEDS III Response File will be generated and sent back to the plan.

**III. Edit Logic**

| Edit Number | Edit Description | Edit Logic |
|---|---|---|
| 00018 | DATE OF SERVICE/ FILL DATE INVALID | If Service Date is not a valid date (CCYYMMDD), the edit is failed. |
| 00020 | SERVICE/ FILL DATE LATER THAN RECEIPT DATE | If the Service Start Date or Service End Date is greater than the CSC processing date, the edit is failed. |
| 00021 | PATIENT STATUS CODE INVALID | If Patient Status or Disposition Code is not equal to: 01-09, 20, 30, 40-43, 50-51, 61-66, 70 the edit is failed. |
| 00036 | M/I USUAL AND CUSTOMARY | The Charged Amount is Missing or Invalid |
| 00039 | PRIMARY DIAGNOSIS CODE FAILED | If the Principal/Primary Diagnosis Code for institutional encounters is blank, the edit is failed. |
| 00062 | PROVIDER ID NUMBER INVALID | **For Dental and Professional Encounters** – If the Provider Identification Number is spaces, the edit is failed. |
| 00070 | PROCEDURE CODE INVALID | **For Dental and Professional Encounters** – For each service line reported, if the Procedure Code is blank, the edit is failed. |
| | | **For Institutional-Outpatient Encounters** - For each service line reported, if the HCPCS Code and Revenue Code are blank, the edit is failed. |
| 00071 | PLACE OF SERVICE CODE INVALID | If the Place of Service/Place of Treatment Code is not equal to: 03-08, 11-15, 20-26, 31-34, 41-42,49-57, 60-62, 65, 71-72, 81, 99 the edit is failed. |
| 00074 | RECIPIENT ID NUMBER INVALID | If the CIN is not a valid CIN (CCNNNNNC), the edit is failed. (C = Character N = Number) |
| 00076 | M/I PROVIDER ID | Provider ID No. is non-numeric or the eighth position of the provider identification number is not a valid check digit. |
| 00078 | REFERRING PROVIDER ID NUMBER INVALID | If the Provider Id does not match a Provider Id on the eMedNY Provider Reference File, the edit is failed. |
| 00094 | NUMBER OF UNITS NOT GREATER THAN ZERO | If the Quantity or Units Submitted is equal to zero, the edit is failed. |
| 00103 | ADJ/ VOID FIELDS INCOMPLETE | If the Transaction Status Code equals 7 or 8 and the Previous Transaction Control Number equals spaces or zeros, the edit is failed. |
| 00132 | PROVIDER ID NOF | Provider ID No. not on file |
| 00140 | RECIPIENT ID NOT ON FILE | If the CIN is not on the WMS (Client Demographic Table), the edit is failed. |
| 00146 | PRIMARY DIAGNOSIS NOT ON FILE | If Diagnosis Code is not on the eMedNY Reference Diagnosis Code Table, the edit is failed (i.e., must be a valid diagnosis code as reported in the coding manual.) |
| 00162 | CLIENT NOT ELIG ON SVC DT | Client not eligible on service date. |

| Edit Number | Edit Description | Edit Logic |
|---|---|---|
| 00170 | PROCEDURE CODE NOT ON FILE | If the Procedure Code is not on the eMedNY Reference Procedure Code Table, the edit is failed (i.e., must be a valid CPT/HCPCS code as reported in the coding manual.). |
| 00175 | PROVIDER ID NOT ON FILE | If the Provider Id does not match a Provider Id on the eMedNY Provider Reference File, the edit is failed. |
| 00180 | UNITS GREATER THAN MAXIMUM | If the Procedure Units is greater than allowed amount on the eMedNY Procedure Reference File, the edit is failed. |
| 00204 | PROC NOT AVAILABLE ON DOS | The Procedure Code that was submitted is not valid for the Date of Service indicated. |
| 00240 | OVER TWO YEAR OLD CLAIM HELD FOR FUTURE ADJUDICATION | Over two year old claim held for future adjudication. |
| 00262 | MEDICARE PAID, NO MEDICARE ON FILE | If a Medicare paid amount is reported and the recipient is not shown to have Medicare insurance on file with eMedNY, the edit is failed. |
| 00263 | SERVICING PROVIDER LICENSE NUM | Servicing provider ID or license No. and profession code are required. |
| 00400 | ENCOUNTER CONTROL NUMBER MISSING | If the Encounter Control Number is blank, the edit is failed. |
| 00401 | BENEFICIARY ID MISSING | Beneficiary ID missing. |
| 00402 | DX CODE AND PROC CODE MISSING | Missing/incomplete/invalid diagnosis or condition. |
| 00404 | PROVIDER SPECIALTY MISSING | If the Provider Specialty Code is blank or equal to zero, the edit is failed. |
| 00405 | PRINCIPAL PROCEDURE CODE MISSING | If Procedure Code is blank or equal to zero, the edit is failed. |
| 00406 | DIAGNOSIS CODE MISSING | **For Practitioner Encounters** - If the first Diagnosis Code is blank, the edit is failed.<br>**For Institutional Encounters** - If the Primary Diagnosis Code is blank, the edit is failed. |
| 00408 | CATEGORY OF SERVICE (COS) MISSING | If the Category of Service is not equal to: 01, 03-07, 11-16, 19, 22, 28, 41, 73, 75, 85, 87 the edit is failed. |
| 00409 | INPATIENT MMIS PROVIDER ID IS NOT A HOSPITAL | If the Provider Type Code is not equal to: 012, 016, 028, 038 for referring Provider Id, the edit is failed. (The Provider Type Code is assigned by eMedNY according to the MMIS ID.) |
| 00410 | DRG CODE MISSING | For inpatient encounters, if the APR-DRG Code is blank, the edit is failed |
| 00411 | DRG CODE AND DX CODE MISSING | Missing/incomplete/invalid diagnosis or condition. |
| 00412 | DIAGNOSIS CODE NOT ON FILE | If the Diagnosis Code is not on the eMedNY Diagnosis Code Reference Table, the edit is failed. |
| 00413 | PROVIDER SPECIALTY NOT ON FILE | If the Provider Specialty Code is not on the eMedNY Provider Specialty Reference Table, the edit is failed. |

| Edit Number | Edit Description | Edit Logic |
|---|---|---|
| 00414 | SVC/ADMIT DATE PRIOR TO 1/1/96 | Service/Admittance date prior to 1/1/1996. |
| 00415 | COS NOT ALLWD TO SUB BLOCK ENC | Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. |
| 00416 | LICENSE NUMBER IS MISSING | If the Provider License Number is blank or equal to all zeros, the edit is failed. |
| 00422 | PRENATAL PROC CODE NOT ALLOW | Prenatal procedure code not allowed. |
| 00423 | MMIS PLAN ID MISSING | If the MMIS Plan Id is blank, the edit is failed. |
| 00424 | MMIS PLAN ID NOT ON FILE | If the MMIS Plan Id does not match a provider Id on the eMedNY Provider Reference File, the edit is failed. |
| 00425 | MMIS PLAN ID NOT HMO PROVIDER | If the Provider Type Code associated with the MMIS Plan Id is not 022, the edit is failed. (The Provider Type Code is assigned by eMedNY according to the MMIS ID.) |
| 00431 | NEONATE BIRTH WEIGHT CODE INVALID | **For Inpatient Encounters** - If the Recipient (CIN) Date of Birth and the Admit Date on the claim are equal and the Neonate Value Code is not equal to '54', the edit is failed. |
| 00432 | ATTEND PROV ID NOT ON FILE | If the Attending Provider Id does not match a Provider ID on the eMedNY Provider Reference File, the edit is failed. |
| 00433 | OPER PROV ID NOT ON FILE | If the Surgeon Provider Id does not match a Provider Id on the eMedNY Provider Reference File, the edit is failed. |
| 00434 | BIRTH WEIGHT NOT REASONABLE | If the Neonate Value Code equals '54', the Birth Weight must be between '0000099' and '0008000', else the edit is failed. |
| 00435 | SOURCE OF ADMISSION CODE INVALID | **For Inpatient Encounters** - If Source of Admission Code is not a valid value: '1-9', 'A-C', the edit is failed. For all other institutional encounters, if the Source of Admission Code does not equal spaces, the edit is failed. |
| 00436 | TYPE OF BILL DIGIT 3 INVALID | If the Type of Bill Code is greater than spaces and the third digit of the Type of Bill Code is not a valid value; '0-9', 'A' the edit is failed. |
| 00437 | CLAIM/ENCOUNTER IND INVALID | If the Claim/Encounter Indicator does not equal; 'A', 'C', or 'E', the edit is failed. |
| 00525 | PRESCRIBING LICENSE NUMBER MISSING | If the Prescribing License Number is blank or equal to zero, the edit is failed. |
| 00526 | M/I PRESCRIPTION NUMBER | Prescription Number Missing or Invalid |
| 00528 | MISSING OR INVALID QUANTITY DISPENSED | If the Quantity Dispensed is blank or equal to zero, the edit is failed. |
| 00530 | NEW/REFILL CODE INVALID | Missing or Invalid New or Refill Number |
| 00531 | AUTHORIZED REFILL INVALID | If the number of authorized refill is not valid or numeric. |

| Edit Number | Edit Description | Edit Logic |
|---|---|---|
| 00534 | DATE ORDERED INVALID | If the Date Ordered is not a valid date (CCYYMMDD), the edit is failed. |
| 00540 | NUMBER OF DAYS SUPPLY INVALID | If the Days Supply is blank or equal to zero, the edit is failed. |
| 00544 | NDC CODE NON-NUMERIC | If the NDC Code is non-numeric or blank, the edit is failed. |
| 00548 | FILL DATE PRECEDES ORDER DATE | If the Fill Date is less than the Ordered Date, the edit is failed. |
| 00561 | DRUG CODE NOT ON FILE | If the NDC Code is not on the eMedNY Reference Drug Table, the edit is failed. |
| 00600 | ADMISSION DATE INVALID | If the Admission Date is not a valid date (CCYYMMDD), the edit is failed. |
| 00603 | ADMISSION TYPE CODE INVALID | If the Admission Type Code is not: 1-5, the edit is failed. |
| 00604 | ADMITTING DIAGNOSIS CODE MISSING | If Admit Diagnosis Code is blank, the edit is failed. |
| 00613 | PRINCIPAL PROCEDURE DATE INVALID | Principal Procedure Date for Institutional Claim is Invalid |
| 00625 | DISCHARGE DATE ILLOGICAL | If the Discharge Date is not a valid date (CCYYMMDD), the edit is failed. |
| 00627 | DISCHARGE STATUS INVALID | Discharge status invalid. |
| 00652 | DISCHARGE DATE PRIOR TO ADMISSION DATE | If Discharge Date is valid, but less than Admission Date, the edit is failed. |
| 00653 | STATEMENT FROM DATE PRIOR TO ADMISSION DATE | Statement from date prior to admission date. |
| 00655 | DISCHARGE DATE DIFFERENT THAN STATEMENT THRU DATE | If the Discharge Date is different than the Statement Thru Date, the edit is failed. |
| 00664 | ATTENDING PHYSICIAN LICENSE NUMBER MISSING | If Attending Physician License Number is blank or equal to zero, the edit is failed. |
| 00689 | RECIPIENT NOT ENROLLED IN PLAN ON DATE OF SERVICE | If recipient is not enrolled on Managed Care Master File in your Plan on date of service, the edit is failed. |
| 00693 | RECIPIENT NEVER ENROLLED IN MANAGED CARE | If the Recipient (CIN) is not on the Managed Care Master File, the edit is failed. |
| 00694 | RECIPIENT NOT ENROLLED IN MANAGED CARE ON DATE OF SERVICE | If the Recipient (CIN) is not on the Managed Care Master file on the date of service, the edit is failed. |
| 00696 | RECIPIENT ENROLLED IN ANOTHER MANAGED CARE PLAN ON DATE OF SERVICE | If the Recipient (CIN) is on the Managed Care Master file on the date of service, but enrolled in another MC Plan, the edit is failed. |
| 00705 | DUPLICATE CLAIM IN HISTORY | **Encounters (Professional - Non-dental, Non-DME)**<br>**COS 01, 03, 04, 05, 06, 07, 16, 19, 21, 41, 75**<br><br>This edit will fail when the following fields are equal between the Claim and History Records:<br><br>· Claim Type Code |

| Edit Number | Edit Description | Edit Logic |
|---|---|---|
| | | · Client Identification Number (CIN)<br>· Billing Provider Number<br>· Rendering Provider Number<br>· Procedure Code<br>· Service Dates<br>· Diagnosis Code (Primary)<br>· Provider Specialty Code |
| | | **<u>Encounters (Dental)</u> – COS 13**<br><br>This edit will fail when the following fields are equal between the Claim and History Records:<br>· Claim Type Code<br>· Client Identification Number (CIN)<br>· Procedure Code<br>· Service Dates<br>· Billing Provider Number<br>· Rendering Provider Number<br>· Oral Cavity Designation Code<br>· Tooth Code<br>· Tooth Surface Code |
| | | **<u>Encounters (DME)</u> - COS 22 (DME and Hearing Aids)**<br><br>This edit will fail when the following fields are equal between the Claim and History Records:<br>· Claim Type Code<br>· Client Identification Number (CIN)<br>· Billing Provider Number<br>· Rendering Provider Number<br>· Procedure Code<br>· Service Dates |
| | | **<u>Encounters (Inpatient)</u> – COS 11**<br><br>This edit will fail when the following fields are equal between the Claim and History Records:<br>· Claim Type Code<br>· Client Identification Number (CIN)<br>· Billing Provider Number<br>· Referring Provider Number<br>· Admission Date |

| Edit Number | Edit Description | Edit Logic |
|---|---|---|
| | | **<u>Encounters (Nursing Home, Child Care, ICF/DD, and Managed Care)</u> - COS 12, 28, 73**<br><br>This edit will fail when the following fields are equal between the Claim and History Records:<br>· Claim Type Code<br>· Client Identification Number (CIN)<br>· Billing Provider Number<br>· Referring Provider Number<br>· Procedure Code<br>· Specialty Code<br>· Diagnosis Code (Principal)<br>· Service Begin Date |
| | | **<u>Encounters (Clinic and Home Health)</u> - COS 15, 80, 85, 87**<br><br>This edit will fail when the following fields are equal between the Claim and History Records:<br>· Claim Type Code<br>· Client Identification Number (CIN)<br>· Billing Provider Number<br>· Referring Provider Number<br>· Service Begin Date<br>· Service End Date<br>· Procedure Code<br>· Revenue Code |
| | | **<u>Encounters (Pharmacy)</u> – COS 14**<br><br>This edit will fail when the following fields are equal between the Claim and History Records:<br>· Claim Type Code<br>· Client Identification Number (CIN)<br>· Billing Provider Number<br>· **Prescribing Physician Provider Number<br>· National Drug Code (NDC)<br>· Service Date (1022)<br>**If the In-process pharmacy encounter Prescribing Physician Provider Number is an out of network NPI (Prescribing Provider Number is blank), then the Prescribing Physician Provider Number is ignored during History comparisons otherwise, Prescribing Physician Provider Number is matched between In-process and History pharmacy encounters. |

| Edit Number | Edit Description | Edit Logic |
|---|---|---|
| 00710 | PROCEDURE CODE EXCEEDS SERVICE LIMITS | If the procedure code reported has exceeded the established service limit, the edit is failed. |
| 00725 | HISTORY RECORD NOT FOUND ADJUSTMENT/VOID | If the Previous Transaction Control Number (TCN) is not valid, the edit is failed. |
| 00736 | DIAG CD BLANK - FULL ICD-9-CM | Diagnosis code blank, full ICD-9 CM code required. |
| 00737 | ICD-9-CM DIAG CODE ON PHYS CLM | The Diagnosis Code entered on the claim is not a valid Diagnosis code. Medicaid requires the 4th and 5th digit sub-classification when available. |
| 00897 | PRESCRIBER ID NOT ON FILE | If the Prescriber Id does not match a Provider Id on the eMedNY Provider Reference File, the edit is failed. |
| 00901 | CLAIM TYPE UNKNOWN | If the Claim/Encounter does not equal a valid claim type (i.e., correct ETI/MEDS III COS combination), the edit is failed.<br><br>The Encounter Type Indicator (ETI) must be equal to "I", "T", "D" or "P", and in the correct MEDS III Category of Service. Correct submission standards are detailed in the MEDS III Data Element Dictionary in Section II. Encounter Type Assignment by Category of Service. |
| 00903 | PROVIDER ID OR LICENSE NUMBER MISSING | **For Institutional or Pharmacy Encounters** - If the Provider Id and Provider License Number are blank, the edit is failed. |
| 00927 | MODIFIER INVALID FOR PROCEDURE CODE | If procedure modifier not allowable for procedure code, the edit is failed |
| 00931 | REQUIRED TOOTH FOR PROCEDURE INVALID | If the Procedure Code indicates a tooth number is required and Tooth Number or Letter not equal to a value in Appendix C of the MEDS III Data Element Dictionary, the edit is failed. |
| 01004 | THRU SERVICE DATE INVALID | If the Thru Service Date is not a valid date (CCYYMMDD), the edit is failed. |
| 01006 | THRU SERVICE PRIOR TO FROM SERVICE DATE | If the Thru Service Date is prior to From Service Date, the edit is failed. |
| 01042 | UNITS NOT CONSISTENT W/ SVC DT | Submitted units not consistent with dates of service. |
| 01044 | SVC DTS CANNOT SPAN MONTHS | Dates of service cannot span across months. |
| 01046 | SUBMTD UNITS NOT EVENLY DIVISB | Submitted units not evenly divisible. |
| 01073 | PROC CD FOR BLOCK BILL INVALID | Procedure code for block bill invalid. |
| 01292 | DATE OF SERVICE TWO YEARS PRIOR TO DATE RECEIVED | If the Date of Service/Begin Date is greater than 734 days (2 years) from the CSC processing date, the edit is failed. |
| 01608 | ERROR OVERFLOW | If the encounter record has more than 23 edits (combination of soft or hard), the edit is failed. This will fail the entire encounter. |

| Edit Number | Edit Description | Edit Logic |
|---|---|---|
| 01610 | MISSING OR INVALID ALTERNATE PRODUCT CODE | If the Product Code is entered and the first 11 digits are not alphanumeric, the edit is failed. |
| 01705 | REVENUE CODE NOT ON FILE | If the Revenue Code is not found on the eMedNY Revenue Code Table, the edit is failed (i.e., must be a valid Revenue Code as reported in the coding manual.) |
| 01714 | REVENUE CODE MISSING | Missing/incomplete/invalid diagnosis or condition. |
| 01718 | TYPE OF BILL INVALID | If the Type of Bill is not equal to: 11-18, 21-28, 32-34, 41-48, 51-58, 61-68, 71-76, 79, 81-86, 89 the edit is failed. |
| 01724 | LINE DOS OUTSIDE FROM/THROUGH DATES | If the Line Service Begin Date is less than the Header Service Begin Date, the edit is failed.<br><br>If the Line Service Begin Date is greater than the Header Service End Date, the edit is failed.<br><br>If the Line Service End Date is greater than the Header Service End Date, the edit is failed.<br><br>If the Line Service End Date is less than the Header Service Begin Date, the edit is failed. |
| 01737 | VALUE AMOUNT INVALID FOR SUBMITTED VALUE CODE | If the Neonate Value Amount is blank or equal to zero and a Neonate Value Code is present, the edit is failed. |
| 02002 | PRESCRIPTION SERIAL NUMBER MISSING | If Prescription Serial Number for Pharmacy Claim is blank |
| 02022 | MISSING REFERRING NPI | If Referring NPI is blank, and the Referring Group MMIS ID or License Number field is not equal to spaces, this edit is failed. |
| 02023 | MISSING ATTENDING NPI | If Attending NPI is blank, and the Attending MMIS ID or License Number field is not equal to spaces, this edit is failed. |
| 02024 | MISSING OPERATING NPI | If Operating NPI is blank, and the Operating MMIS ID or License Number field is not equal to spaces, this edit is failed. |
| 02025 | MISSING RENDERING NPI | If Rendering NPI is blank, and the Rendering MMIS ID or License Number field is not equal to spaces, this edit is failed. |
| 02029 | MISSING PRESCRIBING NPI | If Prescribing NPI is blank, and the Prescribing MMIS ID or License Number field is not equal to spaces this edit is failed. |
| 02030 | INVALID BILLING NPI | Billing national provider identifier is invalid. |
| 02031 | INVALID GROUP NPI | This edit is failed when the NPI of a group provider was invalid according to a "check digit" routine. |
| 02032 | INVALID REFERRING NPI | If Referring NPI check digit is invalid, this edit is failed. |
| 02033 | INVALID ATTENDING NPI | If Attending NPI check digit is invalid, this edit is failed. |

| Edit Number | Edit Description | Edit Logic |
|---|---|---|
| 02034 | INVALID OPERATING NPI | If Operating NPI check digit is invalid, this edit is failed. |
| 02035 | INVALID RENDERING NPI | If Rendering NPI check digit is invalid, this edit is failed. |
| 02036 | INVALID SUPERVISING NPI | Invalid supervising NPI. |
| 02037 | INVALID OTHER NPI | Invalid other NPI. |
| 02038 | INVALID ASSISTANT SURGEON NPI | Invalid assistant surgeon NPI. |
| 02039 | INVALID PRESCRIBING NPI | If Prescribing NPI check digit is invalid, this edit is failed. |
| 02066 | DRUG CODE MISSING | If the drug code is missing or invalid, this edit is failed. |
| 02070 | INVALID ORDERING NPI | Invali ordering NPI. |
| 02079 | PRESENT ON ADMISSION CODE MISSING OR INVALID | If the either the Principal or Other Diagnoses is greater than spaces and POA Code equals spaces or invalid, the edit is failed. |
| 02116 | MISSING PRESCRIPTION ORIGIN CODE | If the Prescription Origin Code is Not Reported |
| 02117 | INVALID PRESCRIPTION ORIGIN CODE | If the reported Prescription Origin Code is not a valid value |
| 02171 | NDC OCCURS MORE THAN ONCE | If the NDC Occurs More Than Once in a Compound for Pharmacy Claim, the edit is failed. |
| 02174 | ICD VERSION CODE NOT VALID | If the reported ICD Version Code is a Not Valid Value, the edit is failed. |
| 02193 | CONTROLLED SUBSTANCE LIMIT EXCEEDED | If the Prescription Origin Code is 2<br><br>AND<br><br>Drug Enforcement Agency (DEA) code on the Reference Drug Table is 2, 3 or 5<br><br>OR<br><br>DEA code is 4 and the Therapeutic Class Code (State Formulary) is in Claims System list 1963<br><br>AND<br><br>Drugs Day Supply Count (submitted) is greater than the maximum allowed quantity limit specified in Claims System Parameter 0038 |
| 02210 | IDC-9 PROCEDURE CODE DATE AFTER SERVICE DATE | If the reported ICD-9 Procedure Date is After The Service Date, the edit is failed. |
| 02211 | ICD-9 PROCEDURE WITHOUT ICD-9 DATE | If the Reported Procedure is Sent Without a Service Date, the edit is failed. |

**IV. Edit Severity Matrix**

This section details current edit severity programming within the CSC Encounter/Claim System Processing. The edits correspond to the logic indicated in Section III, and not all edits apply to all Encounter Type/Category of Service/Claim type record submissions.

Up to 24 edits may be assigned to an encounter record before the entire record is rejected.

Each edit is assigned a severity level as follows:

| Code | Edit Severity | File Processing Implication |
|---|---|---|
| F | Fatal Record Error | There is a fatal error in the encounter record. The claim system has stopped reading the encounter record, and the entire record is rejected. |
| H | Hard Edit (Deny) | There is a vital error in the encounter record.<br><br>If the error is at the header level, the entire record will reject, and should be resubmitted as an original encounter.<br><br>If the error is on the service line, the affected service line will reject (with an edit code and service line indicated in the response report. Please refer to Section V of this manual for more detail).<br><br>Subsequent service lines, if correctly submitted, will be accepted for further processing. |
| S | Soft Edit (Accept) | Edit indicates that the data provided is inaccurate. However, the record is accepted for further processing. The inaccurate information should be corrected and resubmitted as an adjustment. |
| N | Non-Edit | Edit does not apply to the ETI/Clinic Type/MEDS COS combination. |

## III. Edit Severity Matrix

| | ETI: | I=Institutional | | | | | | | | D | T | P=Professional | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Claim Type: | Clinic | | | IP | Nursing Home | | HH | ICF | Rx | Dental | Practitioner | | | | | | Eye | Lab | Trans | DME |
| Edit Code | COS: | 06 | 85 | 87 | 11 | 12 | 73 | 15 | 28 | 14 | 13 | 01 | 03 | 04 | 07 | 41 | 75 | 05 | 16 | 19 | 22 |
| 00018 | DATE OF SERVICE/FILL DATE INVALID | F | | | F | F | | F | F | F | F | F | | | | | | F | F | F | F |
| 00020 | SERVICE/FILL DATE LATER THAN RECEIPT DATE | H | | | H | H | | H | H | H | H | H | | | | | | H | H | H | H |
| 00021 | PATIENT STATUS CODE INVALID | N | | | H | H | | N | H | N | N | N | | | | | | N | N | N | N |
| 00036 | M/I USUAL AND CUSTOMARY | S | | | S | S | | S | S | S | S | S | | | | | | S | S | S | S |
| 00039 | PRIMARY DIAGNOSIS CODE BLANK | H | | | H | S | | S | S | N | N | N | | | | | | N | N | N | N |
| 00062 | PROVIDER ID NUMBER INVALID | N | | | N | N | | N | N | N | N | N | | | | | | N | N | H | N |
| 00070 | PROCEDURE CODE INVALID | H | | | N | H | | H | H | N | H | H | | | | | | H | H | H | H |
| 00071 | PLACE OF SERVICE CODE INVALID | N | | | N | N | | N | N | N | H | H | | | | | | H | H | S | H |
| 00074 | RECIPIENT ID NUMBER INVALID | F | | | F | F | | F | F | F | F | F | | | | | | F | F | F | F |
| 00076 | M/I PROVIDER ID | N | | | N | N | | N | N | N | N | N | | | | | | N | N | N | N |

Legend: F=Fatal; H=Hard Edit (Deny); S=Soft Edit (Accept); N=Non-Edit (Ignore)

| | ETI: | I=Institutional | | | | | | | | D | T | P=Professional | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Claim Type: | Clinic | | | IP | Nursing Home | | HH | ICF | Rx | Dental | Practitioner | | | | | | Eye | Lab | Trans | DME |
| Edit Code | COS: | 06 | 85 | 87 | 11 | 12 | 73 | 15 | 28 | 14 | 13 | 01 | 03 | 04 | 07 | 41 | 75 | 05 | 16 | 19 | 22 |
| 00078 | REFERRING PROVIDER ID NUMBER INVALID | H | | | H | H | | H | H | N | N | N | | | | | | N | N | N | N |
| 00094 | NUMBER OF UNITS NOT GREATER THAN ZERO | H | | | N | H | | H | H | N | H | H | | | | | | H | H | H | H |
| 00103 | ADJUSTMENT / VOID FIELDS INCOMPLETE | H | | | H | H | | H | H | H | H | H | | | | | | H | H | H | H |
| 00132 | PROVIDER ID NOF | N | | | N | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 00140 | RECIPIENT ID NOT ON FILE | H | | | H | H | | H | H | H | H | H | | | | | | H | H | H | H |
| 00146 | PRIMARY DIAGNOSIS NOT ON FILE | H | | | H | S | | S | S | N | N | N | | | | | | N | N | N | N |
| 00162 | CLIENT NOT ELIG ON SVC DT | N | | | N | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 00170 | PROCEDURE CODE NOT ON FILE | H | | | H | H | | H | H | N | H | H | | | | | | H | H | H | H |
| 00175 | PROVIDER ID NOT ON FILE | N | | | N | N | | N | N | N | H | H | | | | | | H | H | H | H |
| 00180 | UNITS GREATER THAN MAXIMUM | S | | | N | N | | S | N | N | S | S | | | | | | S | N | N | S |
| 00204 | PROC NOT AVAILABLE ON DOS | N | | | N | N | | N | N | N | N | N | | | | | | N | N | N | N |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Claim Type: | Clinic | | | IP | Nursing Home | | HH | ICF | Rx | Dental | Practitioner | | | | | | Eye | Lab | Trans | DME |
| Edit Code | COS: | 06 | 85 | 87 | 11 | 12 | 73 | 15 | 28 | 14 | 13 | 01 | 03 | 04 | 07 | 41 | 75 | 05 | 16 | 19 | 22 |
| 00240 | OVER TWO YEAR OLD CLAIM HELD FOR FUTURE ADJUDICATION | N | | | N | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 00262 | MEDICARE PAID, NO MEDICARE ON FILE | S | | | S | S | | S | S | S | S | S | | | | | | S | S | S | S |
| 00263 | SERVICING PROVIDER LICENSE NUM | N | | | N | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 00400 | ENCOUNTER CONTROL NUMBER MISSING | S | | | S | S | | S | S | S | S | S | | | | | | S | S | S | S |
| 00401 | BENEFICIARY ID MISSING | N | | | N | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 00402 | DX CODE AND PROC CODE MISSING | N | | | N | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 00404 | PROVIDER SPECIALTY MISSING | H | | | N | H | | H | H | N | H | H | | | | | | H | H | H | H |
| 00405 | PRINCIPAL PROCEDURE CODE MISSING | N | | | S | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 00406 | DIAGNOSIS CODE MISSING | H | | | H | H | | H | H | N | N | H | | | | | | H | S | S | S |

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| | ETI: | I=Institutional | | | | | | | | D | T | P=Professional | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Claim Type: | Clinic | | | IP | Nursing Home | | HH | ICF | Rx | Dental | Practitioner | | | | | | Eye | Lab | Trans | DME |
| Edit Code | COS: | 06 | 85 | 87 | 11 | 12 | 73 | 15 | 28 | 14 | 13 | 01 | 03 | 04 | 07 | 41 | 75 | 05 | 16 | 19 | 22 |
| 00408 | CATEGORY OF SERVICE (COS) MISSING | F | | | F | F | | F | F | F | F | F | | | | | | F | F | F | F |
| 00409 | INPATIENT MMIS PROVIDER ID IS NOT A HOSPITAL | N | | | H | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 00410 | DRG CODE MISSING | N | | | H | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 00411 | DRG CODE AND DX CODE MISSING | N | | | N | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 00412 | DIAGNOSIS CODE NOT ON FILE | H | | | H | H | | H | H | N | N | H | | | | | | H | S | S | S |
| 00413 | PROVIDER SPECIALTY NOT ON FILE | H | | | N | H | | H | H | N | H | H | | | | | | H | H | H | H |
| 00414 | SVC/ADMIT DATE PRIOR TO 1/1/96 | N | | | N | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 00415 | COS NOT ALLWD TO SUB BLOCK ENC | N | | | N | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 00416 | LICENSE NUMBER IS MISSING | N | | | N | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 00422 | PRENATAL PROC CODE NOT ALLOW | N | | | N | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 00423 | MMIS PLAN ID MISSING | F | | | F | F | | F | F | F | F | F | | | | | | F | F | F | F |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Claim Type: | Clinic | | | IP | Nursing Home | | HH | ICF | Rx | Dental | Practitioner | | | | | | Eye | Lab | Trans | DME |
| Edit Code | COS: | 06 | 85 | 87 | 11 | 12 | 73 | 15 | 28 | 14 | 13 | 01 | 03 | 04 | 07 | 41 | 75 | 05 | 16 | 19 | 22 |
| 00424 | MMIS PLAN ID NOT ON FILE | F | | | F | F | | F | F | F | F | F | | | | | | F | F | F | F |
| 00425 | MMIS PLAN ID NOT HMO PROVIDER | H | | | H | H | | H | H | H | H | H | | | | | | H | H | H | H |
| 00431 | NEONATE BIRTH WEIGHT CODE INVALID | N | | | H | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 00432 | ATTEND PROV ID NOT ON FILE | H | | | H | H | | H | H | N | N | N | | | | | | N | N | N | N |
| 00433 | OPER PROV ID NOT ON FILE | N | | | H | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 00434 | BIRTH WEIGHT NOT REASONABLE | N | | | H | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 00435 | SOURCE OF ADMISSION CD INVALID | N | | | H | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 00436 | TYPE OF BILL DIGIT 3 INVALID | H | | | H | H | | H | H | N | N | N | | | | | | N | N | N | N |
| 00437 | CLAIM/ENCOUNTER IND INVALID | H | | | H | H | | H | H | H | H | H | | | | | | H | H | H | H |
| 00525 | PRESCRIBING LIC NO. MISSING | N | | | N | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 00526 | M/I PRESCRIPTION # | N | | | N | N | | N | N | S | N | N | | | | | | N | N | N | N |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Claim Type: | Clinic | | | IP | Nursing Home | | HH | ICF | Rx | Dental | Practitioner | | | | | | Eye | Lab | Trans | DME |
| Edit Code | COS: | 06 | 85 | 87 | 11 | 12 | 73 | 15 | 28 | 14 | 13 | 01 | 03 | 04 | 07 | 41 | 75 | 05 | 16 | 19 | 22 |
| 00528 | M/I QUANTITY DISPENSED | S | | | N | N | | N | N | H | N | S | | | | | | N | N | N | N |
| 00530 | NEW/REFILL CODE INVALID | N | | | N | N | | N | N | S | N | N | | | | | | N | N | N | N |
| 00531 | AUTHORIZED REFILL INVALID | N | | | N | N | | N | N | S | N | N | | | | | | N | N | N | N |
| 00534 | DATE ORDERED INVALID | N | | | N | N | | N | N | H | N | N | | | | | | N | N | N | N |
| 00540 | NO. OF DAYS SUPPLY INVALID | N | | | N | N | | N | N | H | N | N | | | | | | N | N | N | N |
| 00544 | NDC CODE NON-NUMERIC | N | | | N | N | | N | N | H | N | N | | | | | | N | N | N | N |
| 00548 | FILL DATE PRIOR ORDER DATE | N | | | N | N | | N | N | H | N | N | | | | | | N | N | N | N |
| 00561 | DRUG CODE NOT ON FILE | H | | | N | N | | N | N | H | N | H | | | | | | N | N | N | S |
| 00600 | ADMISSION DATE INVALID | N | | | H | H | | N | H | N | N | N | | | | | | N | N | N | N |
| 00603 | ADMIT TYPE CODE INVALID | N | | | H | S | | N | S | N | N | N | | | | | | N | N | N | N |
| 00604 | ADMITTING DIAGNOSIS CODE MISSING | N | | | S | N | | N | N | N | N | N | | | | | | N | N | N | N |

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| | ETI: | I=Institutional | | | | | | | | D | T | P=Professional | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Claim Type: | Clinic | | | IP | Nursing Home | | HH | ICF | Rx | Dental | Practitioner | | | | | | Eye | Lab | Trans | DME |
| Edit Code | COS: | 06 | 85 | 87 | 11 | 12 | 73 | 15 | 28 | 14 | 13 | 01 | 03 | 04 | 07 | 41 | 75 | 05 | 16 | 19 | 22 |
| 00613 | PRINCIPAL PROC DATE INVALID | N | | | S | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 00625 | DISCHARGE DATE ILLOGICAL | N | | | H | H | | N | H | N | N | N | | | | | | N | N | N | N |
| 00627 | DISCHARGE STATUS INVALID | N | | | N | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 00652 | DISCHARGE DATE PRIOR TO ADMIT DATE | N | | | H | H | | N | H | N | N | N | | | | | | N | N | N | N |
| 00653 | STATEMENT FROM DATE PRIOR TO A | N | | | N | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 00655 | D/C DATE DIFF THAN THRU DATE | N | | | H | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 00664 | ATTENDING PHYSICIAN LIC NO. MISSING | N | | | N | N | | N | S | N | N | N | | | | | | N | N | N | N |
| 00689 | RECIPIENT NOT ENROLLED IN PLAN ON DATE OF SERVICE | H | | | H | H | | H | H | H | H | H | | | | | | H | H | H | H |
| 00693 | RECIPIENT NEVER ENROLLED IN MNGD CARE | H | | | H | H | | H | H | H | H | H | | | | | | H | H | H | H |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Claim Type: | Clinic | | | IP | Nursing Home | | HH | ICF | Rx | Dental | Practitioner | | | | | | Eye | Lab | Trans | DME |
| Edit Code | COS: | 06 | 85 | 87 | 11 | 12 | 73 | 15 | 28 | 14 | 13 | 01 | 03 | 04 | 07 | 41 | 75 | 05 | 16 | 19 | 22 |
| 00694 | RECIPIENT NOT ENROLLED IN MNGD CARE ON DATE OF SRVCE | H | | | H | H | | H | H | H | H | H | | | | | | H | H | H | H |
| 00696 | RECIPIENT ENROLLED IN ANOTHER MNGD CARE PLAN ON DATE OF SRVCE | H | | | H | H | | H | H | H | H | S | | | | | | S | S | S | S |
| 00705 | DUPLICATE CLAIM IN HISTORY | H | | | H | H | | H | H | H | H | H | | | | | | H | H | H | H |
| 00710 | PROCEDURE EXCEEDS SERVICE LIMITS | S | | | N | N | | N | N | S | S | S | | | | | | S | S | S | S |
| 00725 | HISTRY RECORD NOT FOUND ADJUSTMENT/VOID | H | | | H | H | | H | H | H | H | H | | | | | | H | H | H | H |
| 00736 | DIAG CD BLANK - FULL ICD-9-CM | N | | | N | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 00737 | ICD-9-CM DIAG CODE ON PHYS CLM | N | | | N | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 00897 | PRESCRIBER ID NOT ON FILE | N | | | N | N | | N | N | S | N | N | | | | | | N | N | N | N |
| 00901 | CLAIM TYPE UNKNOWN | F | | | F | F | | F | F | F | F | F | | | | | | F | F | F | F |

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| | ETI: | I=Institutional | | | | | | | | D | T | P=Professional | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Claim Type: | Clinic | | | IP | Nursing Home | | HH | ICF | Rx | Dental | Practitioner | | | | | | Eye | Lab | Trans | DME |
| Edit Code | COS: | 06 | 85 | 87 | 11 | 12 | 73 | 15 | 28 | 14 | 13 | 01 | 03 | 04 | 07 | 41 | 75 | 05 | 16 | 19 | 22 |
| 00903 | PROVIDER ID NUMBER MISSING | H | | | H | H | | H | H | H | N | N | | | | | | N | N | N | N |
| 00927 | MODIFIER INVALID FOR PROCEDURE CODE | S | | | N | N | | S | N | N | S | S | | | | | | S | S | S | S |
| 00931 | REQUIRED TOOTH FOR PROCEDURE INVALID | N | | | N | N | | N | N | N | S | N | | | | | | N | N | N | N |
| 01004 | THRU SERVICE DATE INVALID | H | | | N | H | | H | H | N | H | H | | | | | | H | H | H | H |
| 01006 | THRU SERVICE PRIOR TO FROM SERVICE DATE | H | | | N | H | | H | H | N | H | H | | | | | | H | H | H | H |
| 01042 | UNITS NOT CONSISTENT W/ SVC DT | N | | | N | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 01044 | SVC DTS CANNOT SPAN MONTHS | N | | | N | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 01046 | SUBMTD UNITS NOT EVENLY DIVISB | N | | | N | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 01073 | PROC CD FOR BLOCK BILL INVALID | N | | | N | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 01292 | DATE OF SERVICE TWO YEARS PRIOR TO DATE RECEIVED | H | | | H | H | | H | H | N | H | H | | | | | | H | H | H | H |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Claim Type: | Clinic | | | IP | Nursing Home | | HH | ICF | Rx | Dental | Practitioner | | | | | | Eye | Lab | Trans | DME |
| Edit Code | COS: | 06 | 85 | 87 | 11 | 12 | 73 | 15 | 28 | 14 | 13 | 01 | 03 | 04 | 07 | 41 | 75 | 05 | 16 | 19 | 22 |
| 01608 | ERROR OVERFLOW | H | | | H | H | | H | H | H | H | H | | | | | | H | H | H | H |
| 01610 | MISSING OR INVALID ALTERNATE PRODUCT CODE | N | | | N | N | | N | N | S | N | N | | | | | | N | N | N | N |
| 01705 | REVENUE CODE NOT ON FILE | H | | | H | H | | H | H | N | N | N | | | | | | N | N | N | N |
| 01714 | REVENUE CODE MISSING | N | | | N | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 01718 | TYPE OF BILL IS INVALID | H | | | H | H | | H | H | N | N | N | | | | | | N | N | N | N |
| 01724 | LINE DOS OUTSIDE FROM/THROUGH DATES | H | | | N | N | | H | H | N | N | N | | | | | | N | N | N | N |
| 01737 | VALUE AMOUNT INVALID FOR SUBMITTED VALUE CODE | N | | | H | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 02002 | RX SERIAL NO MISSING | N | | | N | N | | N | N | S | N | N | | | | | | N | N | N | N |
| 02022 | MISSING REFERRING NPI | S | | | S | S | | S | S | S | N | N | | | | | | N | N | N | N |
| 02023 | MISSING ATTENDING NPI | S | | | S | S | | S | S | N | N | N | | | | | | N | N | N | N |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Claim Type: | Clinic | | | IP | Nursing Home | | HH | ICF | Rx | Dental | Practitioner | | | | | | Eye | Lab | Trans | DME |
| Edit Code | COS: | 06 | 85 | 87 | 11 | 12 | 73 | 15 | 28 | 14 | 13 | 01 | 03 | 04 | 07 | 41 | 75 | 05 | 16 | 19 | 22 |
| 02024 | MISSING OPERATING NPI | N | | | S | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 02025 | MISSING RENDERING NPI | N | | | N | N | | N | N | N | S | S | | | | | | S | S | S | S |
| 02029 | MISSING PRESCRIBING NPI | N | | | N | N | | N | N | S | N | N | | | | | | N | N | N | N |
| 02030 | INVALID BILLING NPI | H | | | H | H | | H | H | H | H | H | | | | | | H | H | H | H |
| 02031 | INVALID GROUP NPI | N | | | N | N | | N | N | N | H | N | | | | | | N | N | N | N |
| 02032 | INVALID REFERRING NPI | S | | | S | S | | S | S | S | N | N | | | | | | N | N | N | N |
| 02033 | INVALID ATTENDING NPI | H | | | H | H | | H | H | N | N | N | | | | | | N | N | N | N |
| 02034 | INVALID OPERATING NPI | N | | | S | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 02035 | INVALID RENDERING NPI | N | | | N | N | | N | N | N | S | S | | | | | | S | S | S | S |
| 02036 | INVALID SUPERVISING NPI | N | | | N | N | | N | N | N | N | H | | | | | | H | N | H | H |
| 02037 | INVALID OTHER NPI | N | | | N | N | | N | N | N | H | H | | | | | | H | H | H | H |
| 02038 | INVALID ASSISTANT SURGEON NPI | N | | | N | N | | N | N | N | H | N | | | | | | N | N | N | N |
| 02039 | INVALID PRESCRIBING NPI | N | | | N | N | | N | N | S | N | N | | | | | | N | N | N | N |

Legend: F=Fatal; H=Hard Edit (Deny); S=Soft Edit (Accept); N=Non-Edit (Ignore)

| | ETI: | I=Institutional | | | | | | | | D | T | P=Professional | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Claim Type: | Clinic | | | IP | Nursing Home | | HH | ICF | Rx | Dental | Practitioner | | | | | | Eye | Lab | Trans | DME |
| Edit Code | COS: | 06 | 85 | 87 | 11 | 12 | 73 | 15 | 28 | 14 | 13 | 01 | 03 | 04 | 07 | 41 | 75 | 05 | 16 | 19 | 22 |
| 02066 | DRUG CODE MISSING | H | | | N | N | | N | N | N | N | H | | | | | | N | N | N | S |
| 02070 | INVALID ORDERING NPI | N | | | N | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 02079 | POA CODE MISSION OR INVALID | N | | | H | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 02116 | MISSING RX ORIGIN CODE | N | | | N | N | | N | N | S | N | N | | | | | | N | N | N | N |
| 02117 | INVALID RX ORIGIN CODE | N | | | N | N | | N | N | S | N | N | | | | | | N | N | N | N |
| 02171 | NDC OCCURS MORE THAN ONCE | N | | | N | N | | N | N | S | N | N | | | | | | N | N | N | N |
| 02174 | ICD VERSION CODE INVALID | S | | | S | S | | S | S | S | N | S | | | | | | S | S | S | S |
| 02193 | CONTROLLED SUBSTANCE LIMIT EXCEEDED | N | | | N | N | | N | N | S | N | N | | | | | | N | N | N | N |
| 02210 | ICD-9 PROC DATE AFTER SERVICE DATE | N | | | S | N | | N | N | N | N | N | | | | | | N | N | N | N |
| 02211 | ICD-9 PROC WITHOUT DATE | N | | | S | N | | N | N | N | N | N | | | | | | N | N | N | N |

Legend: F=Fatal; H=Hard Edit (Deny); S=Soft Edit (Accept); N=Non-Edit (Ignore)

## V. Response File Reconciliation

Plans will receive a transmission file confirming the acceptance or rejection of each encounter file submitted. Files will stay within the plan's eMedNY Exchange mailbox for a period of twenty-eight (28) days. Responses returned via FTP will remain in the plan's FTP directory for twenty-eight (28) days or until downloaded. Plans will also receive a response file for all encounter files submitted during the processing cycle. When submitting to the Provider Test Environment (PTE) the processing cycle happens daily and the plan will receive a response file the following day after a test file is processed. When submitting to the Production System the processing cycle pulls encounter files in daily and processes them in a weekly cycle. Therefore, you will receive your response file 7 days after processing.

The response file provides valuable feedback to the plan on the quality of the encounter data submitted. The plan will receive information on whether the record was accepted or rejected as well as up to 24 edits.

| Data Element | Width | Record Positions |
|---|---|---|
| Encounter Control Number | 11 | 1-11 |
| Claim Line Number | 04 | 12-15 |
| Edit Status Code | 01 | 16 |
| Claim Edit Code | 05 | 17-21 |
| COS Code ("EN" precedes code) | 04 | 22-25 |
| TCN | 16 | 26-41 |
| Plan ID | 08 | 42-49 |
| TSN | 03 | 50-52 |
| Filler | 28 | 53-80 |

Plans should use information provided in the feedback report [Encounter Control Number (ECN), Claim Line Number, Edit Status Code, Claim Edit Number, Category of Service (COS Code), and Transaction Control Number (TCN)] to match the status of each line of the encounter record.

Since the Response File reports errors on the service line level, plans should be aware of four general rules about feedback reports:

**Rule # 1:**

If the encounter record passes through without hitting any edits, the plan will receive one record line back with an edit status code of 'P' at line number '0000'. The plan should store the associated TCN and the Accepted status in their data system. Any changes to these records should be handled as an adjustment.

Example:

Plan ID '12345678' with a TSN of 'ABC' submits a professional service encounter with an ECN of '00000000001' and a COS of '01'. The encounter passes all edits. The feedback report will produce the following response:

000000000010000P EN010522000001549520123456 78ABC

Using the feedback report layout allows the plan to match the result back to the reported encounter.

ECN = '00000000001'
Line Number = '0000'
Edit Status Code = 'P' [Paid/Accepted]
COS = 'EN01'
TCN = '0522000001549520'
Plan ID = '12345678'
TSN = 'ABC'

Plan ID '12345678' should tag encounter '00000000001' as an accepted encounter with a TCN of '0522000001549520' within their system. If the encounter needs to be adjusted in the future, the plan has stored the transaction control number (TCN) to identify the record.

**Rule # 2:**

If the encounter record rejects at the header level (line = '0000' and edit status code = '2' ) the entire encounter record is rejected. Plans should correct all errors identified and resubmit the encounter as an original.

Example:

Plan '12345678' with a TSN of 'ABC' submits a professional services encounter with an ECN of '00000000002', a COS of '01', five different valid procedure codes, but did not submit the MMIS Provider Id. Everything else in the encounter record is correct. The feedback report will produce the following response.

00000000002000020017 5EN0105220000015495 4012345678ABC

Using the feedback report layout allows the plan to match the result back to the reported encounter.

ECN = '00000000002'
Line Number = '0000'
Edit Status Code = '2' [Deny/Rejected]
Claim Edit Code = '00175' [Servicing Provider Id Not on File]
COS = 'EN01'
TCN = '0522000001549540'
plan ID = '12345678'
TSN = 'ABC'

Anything that fails at the Header level (line number= '00') will cause the entire encounter to reject. In this case the plan would not store the associated TCN because it will not be used after errors are corrected and the encounter is re-submitted as an original.

**Rule # 3:**

If the encounter record includes both accepted and rejected service lines (line number(s) = '01' – '10' and edit status codes of '2' and '3') the encounter has been partially accepted. The plan should store the associated TCN and the accepted and rejected

status of each service line. All corrections to the encounter would be handled as an adjustment to the original encounter.
Example:

Plan ‘12345678’ with a TSN of ‘ABC’ submits a professional services encounter with an ECN of ‘00000000003’, a COS of ‘01’. Within this encounter there are two service lines. One line reports a valid procedure code ‘99214’, and the second line does not ‘9TY32’. Everything else within the encounter record is correct. The feedback report will produce the following response.

00000000003000220017 0EN01052200000154956012345678ABC

Using the feedback report layout allows the plan to match each result back to the reported encounter. The response file identifies when a record is accepted and when a record has errors. If the plan has submitted a multiple service line encounter and receives responses to only some service lines, the plan should assume the other service lines are accepted. In the example above, the plan will not receive a response line to the first procedure code of ‘99214’ because it was accepted. However, for line ‘0002’ the plan should receive the response line shown above, which is interpreted as follows:

| | |
|---|---|
| ECN | = ‘00000000003’ |
| Line Number | = ‘0002’ |
| Edit Status Code | = ‘2’ [Deny/Rejected] |
| Claim Edit Code | = ‘00170’ [Procedure Code Not on File] |
| COS | = ‘EN01’ |
| TCN | = ‘0522000001549560’ |
| Plan ID | = ‘12345678’ |
| TSN | = ‘ABC’ |

This record has been partially accepted in the claims system. Line ‘01’ with the valid procedure code of ‘99214’ was accepted. Line ‘02’ with the invalid procedure code of ‘9TY32’ was rejected. Plan ‘12345678’ should incorporate the TCN ‘0522000001549560’ and the status code for each claim line into their data system. Line ‘02’ should be corrected, and the entire encounter should be re-submitted as an adjustment.

**Rule # 4:**

For every adjusted encounter the plan will receive two response lines returned. The eMedNY claims system creates a 'void' line in the claim system that removes the original encounter. It then creates a new replacement/adjustment line. The first TCN, which represents the 'void' line, should always end in '1'. Plans should disregard this TCN. The second TCN, which represents the 'replacement/adjustment' line, will always end in '2'. Plans should store this TCN with the new encounter record.

Example:

Plan ‘12345678’ with a TSN of ‘ABC’ decides to correct the professional services encounter (ECN ‘00000000003’) that was partially accepted in Example 3. In order to correct the record, the plan changes the second procedure code from ‘9TY32’ to ‘99215’ and submits the adjusted record following the rules identified in the MEDS III Data Element Dictionary. The adjusted encounter is determined to be correct and is accepted for processing. The feedback report produces the following response.

0000000000030000P EN0105220000015495911234567 8ABC
0000000000030000P EN0105220000015495921234567 8ABC

The first response line indicates the removal of the original encounter was accepted.

ECN = '00000000003'
Line Number = '0000'
Edit Status Code = 'P' [Paid/Accepted]
COS = 'EN01'
TCN = '0522000001549591'
Plan ID = '12345678'
TSN = 'ABC'

The second response line indicates the 'adjusted' encounter was accepted.

ECN = '00000000003'
Line Number = '0000'
Edit Status Code = 'P' [Paid/Accepted]
COS = 'EN01'
TCN = '0522000001549592'
Plan ID = '12345678'
TSN = 'ABC'

**MEDS-L**

The Division of Health Plan Contracting & Oversight has created an email listserv group called MEDS-L. The purpose of the listserv is to provide a forum to interactively discuss issues related to encounter data reporting under the new MEDS III system.

The listserv is closed, restricted to health plans and associated parties that are involved with the submission of Medicaid encounter data.

If you wish to be added to the MEDS-L listserv please contact the MEDS Unit at omcmeds@health.ny.gov

# APPENDIX E – Transaction Layout with Record Positions

The MEDS III transaction file will be a fixed width file of 3,000 characters. Filler should be added at the end of each record type so that the file width equals 3,000.

| MEDS Data Element Name | Length | Start | End |
|---|---|---|---|
| **Header Record** | | | |
| Record Type | 2 | 1 | 2 |
| Provider Transmission Supplier Number (TSN) | 4 | 3 | 6 |
| Input Serial Number | 6 | 7 | 12 |
| TSN Certification Date | 9 | 13 | 21 |
| Vendor Software Number | 5 | 22 | 26 |
| Vendor Software Update Level | 2 | 27 | 28 |
| Test / Prod Indicator | 4 | 29 | 32 |
| Plan Identification Number | 8 | 33 | 40 |
| Submitter Name | 21 | 41 | 61 |
| Submitter Address 1 | 18 | 62 | 79 |
| Submitter Address 2 | 18 | 80 | 97 |
| Submitter Address City | 15 | 98 | 112 |
| Submitter Address State | 2 | 113 | 114 |
| Submitter Zip | 9 | 115 | 123 |
| Submitter Fax Number | 11 | 124 | 134 |
| Submitter Phone Number | 11 | 135 | 145 |
| MEDS Version Number | 3 | 146 | 148 |
| **Common Detail Segment** | | | |
| Record Type | 2 | 1 | 2 |
| Encounter Type Indicator | 1 | 3 | 3 |
| Encounter Control Number | 11 | 4 | 14 |
| Previous Transaction Control Number | 16 | 15 | 30 |
| Transaction Status Code | 1 | 31 | 31 |
| Client Identification Number | 8 | 32 | 39 |
| Beneficiary Identification Number | 25 | 40 | 64 |
| Provider Profession Code | 3 | 65 | 67 |
| Provider License Number | 8 | 68 | 75 |
| Provider Identification Number | 10 | 76 | 85 |
| Provider Service Location | 9 | 86 | 94 |
| Category of Service (COS) Code | 2 | 95 | 96 |
| Total Charged Amount | 11 | 97 | 107 |
| Total Paid Amount | 11 | 108 | 118 |
| Medicare Total Paid Amount | 11 | 119 | 129 |
| Other Insurance Total Paid Amount | 11 | 130 | 140 |
| Other Payer Name | 35 | 141 | 175 |
| Other Insurance Type Code | 2 | 176 | 177 |
| Medicare Total Deductible Paid | 11 | 178 | 188 |
| Medicare Total Co-Insurance Paid | 11 | 189 | 199 |
| Medicare Total Copay Paid | 11 | 200 | 210 |
| Other Insurance Total Deductible Paid | 11 | 211 | 221 |
| Other Insurance Total Co-Insurance Paid | 11 | 222 | 232 |
| Other Insurance Total Copay Paid | 11 | 233 | 243 |
| FILLER | 14 | 244 | 257 |

| MEDS Data Element Name | Length | Start | End |
|---|---|---|---|
| **Institutional Segment** | | | |
| Provider Specialty Code | 3 | 258 | 260 |
| Hospital Inpatient Claim/Encounter Indicator | 1 | 261 | 261 |
| NYS DRG Code | 4 | 262 | 265 |
| Type of Bill Digits 1 & 2 Code | 2 | 266 | 267 |
| Type of Bill Digit 3 Code | 1 | 268 | 268 |
| Statement Covers Period From | 8 | 269 | 276 |
| Statement Covers Period Thru | 8 | 277 | 284 |
| Type of Admission | 1 | 285 | 285 |
| Source of Admission | 1 | 286 | 286 |
| Patient Status or Disposition Code | 2 | 287 | 288 |
| Medical Record Number | 20 | 289 | 308 |
| Neonate Birth Weight Value Code [1] | 2 | 309 | 310 |
| Neonate Birth Weight in Grams [1] | 7 | 311 | 317 |
| Neonate Birth Weight Value Code [2] | 2 | 318 | 319 |
| Neonate Birth Weight in Grams [2] | 7 | 320 | 326 |
| Service Date [1] | 8 | 327 | 334 |
| Revenue Code [1] | 4 | 335 | 338 |
| CPT/HCPCS Code [1] | 5 | 339 | 343 |
| Procedure Modifier Code 1 [1] | 2 | 344 | 345 |
| Procedure Modifier Code 2 [1] | 2 | 346 | 347 |
| Procedure Modifier Code 3 [1] | 2 | 348 | 349 |
| Procedure Modifier Code 4 [1] | 2 | 350 | 351 |
| Quantity or Units Submitted [1] | 11 | 352 | 362 |
| NDC (Formulary) Code [1] | 11 | 363 | 373 |
| NDC (Formulary) Units [1] | 12 | 374 | 385 |
| Charged Amount [1] | 11 | 386 | 396 |
| Medicare Paid Amount [1] | 11 | 397 | 407 |
| Paid Amount [1] | 11 | 408 | 418 |
| Non-Inpatient Claim/Encounter Indicator [1] | 1 | 419 | 419 |
| Service Date [2] | 8 | 420 | 427 |
| Revenue Code [2] | 4 | 428 | 431 |
| CPT/HCPCS Code [2] | 5 | 432 | 436 |
| Procedure Modifier Code 1 [2] | 2 | 437 | 438 |
| Procedure Modifier Code 2 [2] | 2 | 439 | 440 |
| Procedure Modifier Code 3 [2] | 2 | 441 | 442 |
| Procedure Modifier Code 4 [2] | 2 | 443 | 444 |
| Quantity or Units Submitted [2] | 11 | 445 | 455 |
| NDC (Formulary) Code [2] | 11 | 456 | 466 |
| NDC (Formulary) Units [2] | 12 | 467 | 478 |
| Charged Amount [2] | 11 | 479 | 489 |
| Medicare Paid Amount [2] | 11 | 490 | 500 |
| Paid Amount [2] | 11 | 501 | 511 |
| Non-Inpatient Claim/Encounter Indicator [2] | 1 | 512 | 512 |
| Service Date [3] | 8 | 513 | 520 |
| Revenue Code [3] | 4 | 521 | 524 |
| CPT/HCPCS Code [3] | 5 | 525 | 529 |
| Procedure Modifier Code 1 [3] | 2 | 530 | 531 |
| Procedure Modifier Code 2 [3] | 2 | 532 | 533 |
| Procedure Modifier Code 3 [3] | 2 | 534 | 535 |

| MEDS Data Element Name | Length | Start | End |
|---|---|---|---|
| Procedure Modifier Code 4 [3] | 2 | 536 | 537 |
| Quantity or Units Submitted [3] | 11 | 538 | 548 |
| NDC (Formulary) Code [3] | 11 | 549 | 559 |
| NDC (Formulary) Units [3] | 12 | 560 | 571 |
| Charged Amount [3] | 11 | 572 | 582 |
| Medicare Paid Amount [3] | 11 | 583 | 593 |
| Paid Amount [3] | 11 | 594 | 604 |
| Non-Inpatient Claim/Encounter Indicator [3] | 1 | 605 | 605 |
| Service Date [4] | 8 | 606 | 613 |
| Revenue Code [4] | 4 | 614 | 617 |
| CPT/HCPCS Code [4] | 5 | 618 | 622 |
| Procedure Modifier Code 1 [4] | 2 | 623 | 624 |
| Procedure Modifier Code 2 [4] | 2 | 625 | 626 |
| Procedure Modifier Code 3 [4] | 2 | 627 | 628 |
| Procedure Modifier Code 4 [4] | 2 | 629 | 630 |
| Quantity or Units Submitted [4] | 11 | 631 | 641 |
| NDC (Formulary) Code [4] | 11 | 642 | 652 |
| NDC (Formulary) Units [4] | 12 | 653 | 664 |
| Charged Amount [4] | 11 | 665 | 675 |
| Medicare Paid Amount [4] | 11 | 676 | 686 |
| Paid Amount [4] | 11 | 687 | 697 |
| Non-Inpatient Claim/Encounter Indicator [4] | 1 | 698 | 698 |
| Service Date [5] | 8 | 699 | 706 |
| Revenue Code [5] | 4 | 707 | 710 |
| CPT/HCPCS Code [5] | 5 | 711 | 715 |
| Procedure Modifier Code 1 [5] | 2 | 716 | 717 |
| Procedure Modifier Code 2 [5] | 2 | 718 | 719 |
| Procedure Modifier Code 3 [5] | 2 | 720 | 721 |
| Procedure Modifier Code 4 [5] | 2 | 722 | 723 |
| Quantity or Units Submitted [5] | 11 | 724 | 734 |
| NDC (Formulary) Code [5] | 11 | 735 | 745 |
| NDC (Formulary) Units [5] | 12 | 746 | 757 |
| Charged Amount [5] | 11 | 758 | 768 |
| Medicare Paid Amount [5] | 11 | 769 | 779 |
| Paid Amount [5] | 11 | 780 | 790 |
| Non-Inpatient Claim/Encounter Indicator [5] | 1 | 791 | 791 |
| Service Date [6] | 8 | 792 | 799 |
| Revenue Code [6] | 4 | 800 | 803 |
| CPT/HCPCS Code [6] | 5 | 804 | 808 |
| Procedure Modifier Code 1 [6] | 2 | 809 | 810 |
| Procedure Modifier Code 2 [6] | 2 | 811 | 812 |
| Procedure Modifier Code 3 [6] | 2 | 813 | 814 |
| Procedure Modifier Code 4 [6] | 2 | 815 | 816 |
| Quantity or Units Submitted [6] | 11 | 817 | 827 |
| NDC (Formulary) Code [6] | 11 | 828 | 838 |
| NDC (Formulary) Units [6] | 12 | 839 | 850 |
| Charged Amount [6] | 11 | 851 | 861 |
| Medicare Paid Amount [6] | 11 | 862 | 872 |
| Paid Amount [6] | 11 | 873 | 883 |
| Non-Inpatient Claim/Encounter Indicator [6] | 1 | 884 | 884 |

| MEDS Data Element Name | Length | Start | End |
|---|---|---|---|
| Service Date [7] | 8 | 885 | 892 |
| Revenue Code [7] | 4 | 893 | 896 |
| CPT/HCPCS Code [7] | 5 | 897 | 901 |
| Procedure Modifier Code 1 [7] | 2 | 902 | 903 |
| Procedure Modifier Code 2 [7] | 2 | 904 | 905 |
| Procedure Modifier Code 3 [7] | 2 | 906 | 907 |
| Procedure Modifier Code 4 [7] | 2 | 908 | 909 |
| Quantity or Units Submitted [7] | 11 | 910 | 920 |
| NDC (Formulary) Code [7] | 11 | 921 | 931 |
| NDC (Formulary) Units [7] | 12 | 932 | 943 |
| Charged Amount [7] | 11 | 944 | 954 |
| Medicare Paid Amount [7] | 11 | 955 | 965 |
| Paid Amount [7] | 11 | 966 | 976 |
| Non-Inpatient Claim/Encounter Indicator [7] | 1 | 977 | 977 |
| Service Date [8] | 8 | 978 | 985 |
| Revenue Code [8] | 4 | 986 | 989 |
| CPT/HCPCS Code [8] | 5 | 990 | 994 |
| Procedure Modifier Code 1 [8] | 2 | 995 | 996 |
| Procedure Modifier Code 2 [8] | 2 | 997 | 998 |
| Procedure Modifier Code 3 [8] | 2 | 999 | 1000 |
| Procedure Modifier Code 4 [8] | 2 | 1001 | 1002 |
| Quantity or Units Submitted [8] | 11 | 1003 | 1013 |
| NDC (Formulary) Code [8] | 11 | 1014 | 1024 |
| NDC (Formulary) Units [8] | 12 | 1025 | 1036 |
| Charged Amount [8] | 11 | 1037 | 1047 |
| Medicare Paid Amount [8] | 11 | 1048 | 1058 |
| Paid Amount [8] | 11 | 1059 | 1069 |
| Non-Inpatient Claim/Encounter Indicator [8] | 1 | 1070 | 1070 |
| Service Date [9] | 8 | 1071 | 1078 |
| Revenue Code [9] | 4 | 1079 | 1082 |
| CPT/HCPCS Code [9] | 5 | 1083 | 1087 |
| Procedure Modifier Code 1 [9] | 2 | 1088 | 1089 |
| Procedure Modifier Code 2 [9] | 2 | 1090 | 1091 |
| Procedure Modifier Code 3 [9] | 2 | 1092 | 1093 |
| Procedure Modifier Code 4 [9] | 2 | 1094 | 1095 |
| Quantity or Units Submitted [9] | 11 | 1096 | 1106 |
| NDC (Formulary) Code [9] | 11 | 1107 | 1117 |
| NDC (Formulary) Units [9] | 12 | 1118 | 1129 |
| Charged Amount [9] | 11 | 1130 | 1140 |
| Medicare Paid Amount [9] | 11 | 1141 | 1151 |
| Paid Amount [9] | 11 | 1152 | 1162 |
| Non-Inpatient Claim/Encounter Indicator [9] | 1 | 1163 | 1163 |
| Service Date [10] | 8 | 1164 | 1171 |
| Revenue Code [10] | 4 | 1172 | 1175 |
| CPT/HCPCS Code [10] | 5 | 1176 | 1180 |
| Procedure Modifier Code 1 [10] | 2 | 1181 | 1182 |
| Procedure Modifier Code 2 [10] | 2 | 1183 | 1184 |
| Procedure Modifier Code 3 [10] | 2 | 1185 | 1186 |
| Procedure Modifier Code 4 [10] | 2 | 1187 | 1188 |
| Quantity or Units Submitted [10] | 11 | 1189 | 1199 |

| MEDS Data Element Name | Length | Start | End |
|---|---|---|---|
| NDC (Formulary) Code [10] | 11 | 1200 | 1210 |
| NDC (Formulary) Units [10] | 12 | 1211 | 1222 |
| Charged Amount [10] | 11 | 1223 | 1233 |
| Medicare Paid Amount [10] | 11 | 1234 | 1244 |
| Paid Amount [10] | 11 | 1245 | 1255 |
| Non-Inpatient Claim/Encounter Indicator [10] | 1 | 1256 | 1256 |
| ICD Version Code | 1 | 1257 | 1257 |
| Principal/Primary Diagnosis Code | 7 | 1258 | 1264 |
| Other Diagnosis Codes [1] | 7 | 1265 | 1271 |
| Other Diagnosis Codes [2] | 7 | 1272 | 1278 |
| Other Diagnosis Codes [3] | 7 | 1279 | 1285 |
| Other Diagnosis Codes [4] | 7 | 1286 | 1292 |
| Other Diagnosis Codes [5] | 7 | 1293 | 1299 |
| Other Diagnosis Codes [6] | 7 | 1300 | 1306 |
| Other Diagnosis Codes [7] | 7 | 1307 | 1313 |
| Other Diagnosis Codes [8] | 7 | 1314 | 1320 |
| Other Diagnosis Codes [9] | 7 | 1321 | 1327 |
| Other Diagnosis Codes [10] | 7 | 1328 | 1334 |
| Other Diagnosis Codes [11] | 7 | 1335 | 1341 |
| Other Diagnosis Codes [12] | 7 | 1342 | 1348 |
| Other Diagnosis Codes [13] | 7 | 1349 | 1355 |
| Other Diagnosis Codes [14] | 7 | 1356 | 1362 |
| Other Diagnosis Codes [15] | 7 | 1363 | 1369 |
| Other Diagnosis Codes [16] | 7 | 1370 | 1376 |
| Other Diagnosis Codes [17] | 7 | 1377 | 1383 |
| Other Diagnosis Codes [18] | 7 | 1384 | 1390 |
| Other Diagnosis Codes [19] | 7 | 1391 | 1397 |
| Other Diagnosis Codes [20] | 7 | 1398 | 1404 |
| Other Diagnosis Codes [21] | 7 | 1405 | 1411 |
| Other Diagnosis Codes [22] | 7 | 1412 | 1418 |
| Other Diagnosis Codes [23] | 7 | 1419 | 1425 |
| Other Diagnosis Codes [24] | 7 | 1426 | 1432 |
| Admit Diagnosis | 7 | 1433 | 1439 |
| External Diagnosis Code (E Code) | 7 | 1440 | 1446 |
| Present on Admission Code [1] | 1 | 1447 | 1447 |
| Present on Admission Code [2] | 1 | 1448 | 1448 |
| Present on Admission Code [3] | 1 | 1449 | 1449 |
| Present on Admission Code [4] | 1 | 1450 | 1450 |
| Present on Admission Code [5] | 1 | 1451 | 1451 |
| Present on Admission Code [6] | 1 | 1452 | 1452 |
| Present on Admission Code [7] | 1 | 1453 | 1453 |
| Present on Admission Code [8] | 1 | 1454 | 1454 |
| Present on Admission Code [9] | 1 | 1455 | 1455 |
| Present on Admission Code [10] | 1 | 1456 | 1456 |
| Present on Admission Code [11] | 1 | 1457 | 1457 |
| Present on Admission Code [12] | 1 | 1458 | 1458 |
| Present on Admission Code [13] | 1 | 1459 | 1459 |
| Present on Admission Code [14] | 1 | 1460 | 1460 |
| Present on Admission Code [15] | 1 | 1461 | 1461 |
| Present on Admission Code [16] | 1 | 1462 | 1462 |

| MEDS Data Element Name | Length | Start | End |
|---|---|---|---|
| Present on Admission Code [17] | 1 | 1463 | 1463 |
| Present on Admission Code [18] | 1 | 1464 | 1464 |
| Present on Admission Code [19] | 1 | 1465 | 1465 |
| Present on Admission Code [20] | 1 | 1466 | 1466 |
| Present on Admission Code [21] | 1 | 1467 | 1467 |
| Present on Admission Code [22] | 1 | 1468 | 1468 |
| Present on Admission Code [23] | 1 | 1469 | 1469 |
| Present on Admission Code [24] | 1 | 1470 | 1470 |
| Present on Admission Code [25] | 1 | 1471 | 1471 |
| Principal Procedure Code | 7 | 1472 | 1478 |
| Procedure Date [1] | 8 | 1479 | 1486 |
| Other Procedure Codes [1] | 7 | 1487 | 1493 |
| Procedure Date [2] | 8 | 1494 | 1501 |
| Other Procedure Codes [2] | 7 | 1502 | 1508 |
| Procedure Date [3] | 8 | 1509 | 1516 |
| Other Procedure Codes [3] | 7 | 1517 | 1523 |
| Procedure Date [4] | 8 | 1524 | 1531 |
| Other Procedure Codes [4] | 7 | 1532 | 1538 |
| Procedure Date [5] | 8 | 1539 | 1546 |
| Other Procedure Codes [5] | 7 | 1547 | 1553 |
| Procedure Date [6] | 8 | 1554 | 1561 |
| Other Procedure Codes [6] | 7 | 1562 | 1568 |
| Procedure Date [7] | 8 | 1569 | 1576 |
| Other Procedure Codes [7] | 7 | 1577 | 1583 |
| Procedure Date [8] | 8 | 1584 | 1591 |
| Other Procedure Codes [8] | 7 | 1592 | 1598 |
| Procedure Date [9] | 8 | 1599 | 1606 |
| Other Procedure Codes [9] | 7 | 1607 | 1613 |
| Procedure Date [10] | 8 | 1614 | 1621 |
| Other Procedure Codes [10] | 7 | 1622 | 1628 |
| Procedure Date [11] | 8 | 1629 | 1636 |
| Other Procedure Codes [11] | 7 | 1637 | 1643 |
| Procedure Date [12] | 8 | 1644 | 1651 |
| Other Procedure Codes [12] | 7 | 1652 | 1658 |
| Procedure Date [13] | 8 | 1659 | 1666 |
| Other Procedure Codes [13] | 7 | 1667 | 1673 |
| Procedure Date [14] | 8 | 1674 | 1681 |
| Other Procedure Codes [14] | 7 | 1682 | 1688 |
| Procedure Date [15] | 8 | 1689 | 1696 |
| Other Procedure Codes [15] | 7 | 1697 | 1703 |
| Procedure Date [16] | 8 | 1704 | 1711 |
| Other Procedure Codes [16] | 7 | 1712 | 1718 |
| Procedure Date [17] | 8 | 1719 | 1726 |
| Other Procedure Codes [17] | 7 | 1727 | 1733 |
| Procedure Date [18] | 8 | 1734 | 1741 |
| Other Procedure Codes [18] | 7 | 1742 | 1748 |
| Procedure Date [19] | 8 | 1749 | 1756 |
| Other Procedure Codes [19] | 7 | 1757 | 1763 |
| Procedure Date [20] | 8 | 1764 | 1771 |
| Other Procedure Codes [20] | 7 | 1772 | 1778 |

| MEDS Data Element Name | Length | Start | End |
|---|---|---|---|
| Procedure Date [21] | 8 | 1779 | 1786 |
| Other Procedure Codes [21] | 7 | 1787 | 1793 |
| Procedure Date [22] | 8 | 1794 | 1801 |
| Other Procedure Codes [22] | 7 | 1802 | 1808 |
| Procedure Date [23] | 8 | 1809 | 1816 |
| Other Procedure Codes [23] | 7 | 1817 | 1823 |
| Procedure Date [24] | 8 | 1824 | 1831 |
| Other Procedure Codes [24] | 7 | 1832 | 1838 |
| Procedure Date [25] | 8 | 1839 | 1846 |
| Attending Provider Profession Code | 3 | 1847 | 1849 |
| Attending Provider License Number | 8 | 1850 | 1857 |
| Attending Provider ID | 10 | 1858 | 1867 |
| Surgeon Profession Code | 3 | 1868 | 1870 |
| Surgeon License Number | 8 | 1871 | 1878 |
| Surgeon Provider ID | 10 | 1879 | 1888 |
| Admission Date | 8 | 1889 | 1896 |
| Discharge Date | 8 | 1897 | 1904 |
| FILLER | 1096 | 1905 | 3000 |
| **Pharmacy Segment** | | | |
| Prescription Origin Code | 1 | 258 | 258 |
| Prescription Number | 12 | 259 | 270 |
| Prescribing Provider Profession Code | 3 | 271 | 273 |
| Prescribing Provider License Code | 8 | 274 | 281 |
| Prescribing Provider ID | 10 | 282 | 291 |
| Prescription Ordered Date | 8 | 292 | 299 |
| Date Filled | 8 | 300 | 307 |
| Drug Days Supply Count | 3 | 308 | 310 |
| National Drug Code (NDC) or Product Code [1] | 11 | 311 | 321 |
| Quantity Dispensed [1] | 12 | 322 | 333 |
| Amount Charged [1] | 11 | 334 | 344 |
| Amount Paid [1] | 11 | 345 | 355 |
| Pharmacy Claim/Encounter Indicator [1] | 1 | 356 | 356 |
| National Drug Code (NDC) or Product Code [2] | 11 | 357 | 367 |
| Quantity Dispensed [2] | 12 | 368 | 379 |
| Amount Charged [2] | 11 | 380 | 390 |
| Amount Paid [2] | 11 | 391 | 401 |
| Pharmacy Claim/Encounter Indicator [2] | 1 | 402 | 402 |
| National Drug Code (NDC) or Product Code [3] | 11 | 403 | 413 |
| Quantity Dispensed [3] | 12 | 414 | 425 |
| Amount Charged [3] | 11 | 426 | 436 |
| Amount Paid [3] | 11 | 437 | 447 |
| Pharmacy Claim/Encounter Indicator [3] | 1 | 448 | 448 |
| National Drug Code (NDC) or Product Code [4] | 11 | 449 | 459 |
| Quantity Dispensed [4] | 12 | 460 | 471 |
| Amount Charged [4] | 11 | 472 | 482 |
| Amount Paid [4] | 11 | 483 | 493 |
| Pharmacy Claim/Encounter Indicator [4] | 1 | 494 | 494 |
| National Drug Code (NDC) or Product Code [5] | 11 | 495 | 505 |
| Quantity Dispensed [5] | 12 | 506 | 517 |
| Amount Charged [5] | 11 | 518 | 528 |

| MEDS Data Element Name | Length | Start | End |
|---|---|---|---|
| Amount Paid [5] | 11 | 529 | 539 |
| Pharmacy Claim/Encounter Indicator [5] | 1 | 540 | 540 |
| National Drug Code (NDC) or Product Code [6] | 11 | 541 | 551 |
| Quantity Dispensed [6] | 12 | 552 | 563 |
| Amount Charged [6] | 11 | 564 | 574 |
| Amount Paid [6] | 11 | 575 | 585 |
| Pharmacy Claim/Encounter Indicator [6] | 1 | 586 | 586 |
| National Drug Code (NDC) or Product Code [7] | 11 | 587 | 597 |
| Quantity Dispensed [7] | 12 | 598 | 609 |
| Amount Charged [7] | 11 | 610 | 620 |
| Amount Paid [7] | 11 | 621 | 631 |
| Pharmacy Claim/Encounter Indicator [7] | 1 | 632 | 632 |
| National Drug Code (NDC) or Product Code [8] | 11 | 633 | 643 |
| Quantity Dispensed [8] | 12 | 644 | 655 |
| Amount Charged [8] | 11 | 656 | 666 |
| Amount Paid [8] | 11 | 667 | 677 |
| Pharmacy Claim/Encounter Indicator [8] | 1 | 678 | 678 |
| National Drug Code (NDC) or Product Code [9] | 11 | 679 | 689 |
| Quantity Dispensed [9] | 12 | 690 | 701 |
| Amount Charged [9] | 11 | 702 | 712 |
| Amount Paid [9] | 11 | 713 | 723 |
| Pharmacy Claim/Encounter Indicator [9] | 1 | 724 | 724 |
| National Drug Code (NDC) or Product Code [10] | 11 | 725 | 735 |
| Quantity Dispensed [10] | 12 | 736 | 747 |
| Amount Charged [10] | 11 | 748 | 758 |
| Amount Paid [10] | 11 | 759 | 769 |
| Pharmacy Claim/Encounter Indicator [10] | 1 | 770 | 770 |
| National Drug Code (NDC) or Product Code [11] | 11 | 771 | 781 |
| Quantity Dispensed [11] | 12 | 782 | 793 |
| Amount Charged [11] | 11 | 794 | 804 |
| Amount Paid [11] | 11 | 805 | 815 |
| Pharmacy Claim/Encounter Indicator [11] | 1 | 816 | 816 |
| National Drug Code (NDC) or Product Code [12] | 11 | 817 | 827 |
| Quantity Dispensed [12] | 12 | 828 | 839 |
| Amount Charged [12] | 11 | 840 | 850 |
| Amount Paid [12] | 11 | 851 | 861 |
| Pharmacy Claim/Encounter Indicator [12] | 1 | 862 | 862 |
| National Drug Code (NDC) or Product Code [13] | 11 | 863 | 873 |
| Quantity Dispensed [13] | 12 | 874 | 885 |
| Amount Charged [13] | 11 | 886 | 896 |
| Amount Paid [13] | 11 | 897 | 907 |
| Pharmacy Claim/Encounter Indicator [13] | 1 | 908 | 908 |
| National Drug Code (NDC) or Product Code [14] | 11 | 909 | 919 |
| Quantity Dispensed [14] | 12 | 920 | 931 |
| Amount Charged [14] | 11 | 932 | 942 |
| Amount Paid [14] | 11 | 943 | 953 |
| Pharmacy Claim/Encounter Indicator [14] | 1 | 954 | 954 |
| National Drug Code (NDC) or Product Code [15] | 11 | 955 | 965 |
| Quantity Dispensed [15] | 12 | 966 | 977 |
| Amount Charged [15] | 11 | 978 | 988 |

| MEDS Data Element Name | Length | Start | End |
|---|---|---|---|
| Amount Paid [15] | 11 | 989 | 999 |
| Pharmacy Claim/Encounter Indicator [15] | 1 | 1000 | 1000 |
| National Drug Code (NDC) or Product Code [16] | 11 | 1001 | 1011 |
| Quantity Dispensed [16] | 12 | 1012 | 1023 |
| Amount Charged [16] | 11 | 1024 | 1034 |
| Amount Paid [16] | 11 | 1035 | 1045 |
| Pharmacy Claim/Encounter Indicator [16] | 1 | 1046 | 1046 |
| National Drug Code (NDC) or Product Code [17] | 11 | 1047 | 1057 |
| Quantity Dispensed [17] | 12 | 1058 | 1069 |
| Amount Charged [17] | 11 | 1070 | 1080 |
| Amount Paid [17] | 11 | 1081 | 1091 |
| Pharmacy Claim/Encounter Indicator [17] | 1 | 1092 | 1092 |
| National Drug Code (NDC) or Product Code [18] | 11 | 1093 | 1103 |
| Quantity Dispensed [18] | 12 | 1104 | 1115 |
| Amount Charged [18] | 11 | 1116 | 1126 |
| Amount Paid [18] | 11 | 1127 | 1137 |
| Pharmacy Claim/Encounter Indicator | 1 | 1138 | 1138 |
| National Drug Code (NDC) or Product Code [19] | 11 | 1139 | 1149 |
| Quantity Dispensed [19] | 12 | 1150 | 1161 |
| Amount Charged [19] | 11 | 1162 | 1172 |
| Amount Paid [19] | 11 | 1173 | 1183 |
| Pharmacy Claim/Encounter Indicator | 1 | 1184 | 1184 |
| National Drug Code (NDC) or Product Code [20] | 11 | 1185 | 1195 |
| Quantity Dispensed [20] | 12 | 1196 | 1207 |
| Amount Charged [20] | 11 | 1208 | 1218 |
| Amount Paid [20] | 11 | 1219 | 1229 |
| Pharmacy Claim/Encounter Indicator [20] | 1 | 1230 | 1230 |
| National Drug Code (NDC) or Product Code [21] | 11 | 1231 | 1241 |
| Quantity Dispensed [21] | 12 | 1242 | 1253 |
| Amount Charged [21] | 11 | 1254 | 1264 |
| Amount Paid [21] | 11 | 1265 | 1275 |
| Pharmacy Claim/Encounter Indicator [21] | 1 | 1276 | 1276 |
| National Drug Code (NDC) or Product Code [22] | 11 | 1277 | 1287 |
| Quantity Dispensed [22] | 12 | 1288 | 1299 |
| Amount Charged [22] | 11 | 1300 | 1310 |
| Amount Paid [22] | 11 | 1311 | 1321 |
| Pharmacy Claim/Encounter Indicator [22] | 1 | 1322 | 1322 |
| National Drug Code (NDC) or Product Code [23] | 11 | 1323 | 1333 |
| Quantity Dispensed [23] | 12 | 1334 | 1345 |
| Amount Charged [23] | 11 | 1346 | 1356 |
| Amount Paid [23] | 11 | 1357 | 1367 |
| Pharmacy Claim/Encounter Indicator [23] | 1 | 1368 | 1368 |
| National Drug Code (NDC) or Product Code [24] | 11 | 1369 | 1379 |
| Quantity Dispensed [24] | 12 | 1380 | 1391 |
| Amount Charged [24] | 11 | 1392 | 1402 |
| Amount Paid [24] | 11 | 1403 | 1413 |
| Pharmacy Claim/Encounter Indicator [24] | 1 | 1414 | 1414 |
| National Drug Code (NDC) or Product Code [25] | 11 | 1415 | 1425 |
| Quantity Dispensed [25] | 12 | 1426 | 1437 |
| Amount Charged [25] | 11 | 1438 | 1448 |

| MEDS Data Element Name | Length | Start | End |
|---|---|---|---|
| Amount Paid [25] | 11 | 1449 | 1459 |
| Pharmacy Claim/Encounter Indicator | 1 | 1460 | 1460 |
| Refill Indicator | 2 | 1461 | 1462 |
| Number of Refills Authorized | 2 | 1463 | 1464 |
| Dispensed As Written | 1 | 1465 | 1465 |
| ICD Version Code | 1 | 1466 | 1466 |
| Diagnosis Code | 7 | 1467 | 1473 |
| Prescription Serial Number | 12 | 1474 | 1485 |
| Submission Clarification Code | 2 | 1486 | 1487 |
| Dispensing Fee | 11 | 1488 | 1498 |
| Mail Order Pharmacy Indicator | 1 | 1499 | 1499 |
| FILLER | 1501 | 1500 | 3000 |
| **Dental Segment** | | | |
| Provider Specialty Code | 3 | 258 | 260 |
| Service Start Date [1] | 8 | 261 | 268 |
| Service End Date [1] | 8 | 269 | 276 |
| Place of Service/Place of Treatment [1] | 2 | 277 | 278 |
| Procedure Code [1] | 5 | 279 | 283 |
| Procedure Modifier Code 1 [1] | 2 | 284 | 285 |
| Procedure Modifier Code 2 [1] | 2 | 286 | 287 |
| Procedure Modifier Code 3 [1] | 2 | 288 | 289 |
| Procedure Modifier Code 4 [1] | 2 | 290 | 291 |
| Tooth Number or Letter [1] | 2 | 292 | 293 |
| Dental Number of Units/Visits [1] | 11 | 294 | 304 |
| Charged Amount [1] | 11 | 305 | 315 |
| Medicare Paid Amount [1] | 11 | 316 | 326 |
| Paid Amount [1] | 11 | 327 | 337 |
| Dental Claim/Encounter Indicator [1] | 1 | 338 | 338 |
| Service Start Date [2] | 8 | 339 | 346 |
| Service End Date [2] | 8 | 347 | 354 |
| Place of Service/Place of Treatment [2] | 2 | 355 | 356 |
| Procedure Code [2] | 5 | 357 | 361 |
| Procedure Modifier Code 1 [2] | 2 | 362 | 363 |
| Procedure Modifier Code 2 [2] | 2 | 364 | 365 |
| Procedure Modifier Code 3 [2] | 2 | 366 | 367 |
| Procedure Modifier Code 4 [2] | 2 | 368 | 369 |
| Tooth Number or Letter [2] | 2 | 370 | 371 |
| Dental Number of Units/Visits [2] | 11 | 372 | 382 |
| Charged Amount [2] | 11 | 383 | 393 |
| Medicare Paid Amount [2] | 11 | 394 | 404 |
| Paid Amount [2] | 11 | 405 | 415 |
| Dental Claim/Encounter Indicator [2] | 1 | 416 | 416 |
| Service Start Date [3] | 8 | 417 | 424 |
| Service End Date [3] | 8 | 425 | 432 |
| Place of Service/Place of Treatment [3] | 2 | 433 | 434 |
| Procedure Code [3] | 5 | 435 | 439 |
| Procedure Modifier Code 1 [3] | 2 | 440 | 441 |
| Procedure Modifier Code 2 [3] | 2 | 442 | 443 |
| Procedure Modifier Code 3 [3] | 2 | 444 | 445 |
| Procedure Modifier Code 4 [3] | 2 | 446 | 447 |

| MEDS Data Element Name | Length | Start | End |
|---|---|---|---|
| Tooth Number or Letter [3] | 2 | 448 | 449 |
| Dental Number of Units/Visits [3] | 11 | 450 | 460 |
| Charged Amount [3] | 11 | 461 | 471 |
| Medicare Paid Amount [3] | 11 | 472 | 482 |
| Paid Amount [3] | 11 | 483 | 493 |
| Dental Claim/Encounter Indicator [3] | 1 | 494 | 494 |
| Service Start Date [4] | 8 | 495 | 502 |
| Service End Date [4] | 8 | 503 | 510 |
| Place of Service/Place of Treatment [4] | 2 | 511 | 512 |
| Procedure Code [4] | 5 | 513 | 517 |
| Procedure Modifier Code 1 [4] | 2 | 518 | 519 |
| Procedure Modifier Code 2 [4] | 2 | 520 | 521 |
| Procedure Modifier Code 3 [4] | 2 | 522 | 523 |
| Procedure Modifier Code 4 [4] | 2 | 524 | 525 |
| Tooth Number or Letter [4] | 2 | 526 | 527 |
| Dental Number of Units/Visits [4] | 11 | 528 | 538 |
| Charged Amount [4] | 11 | 539 | 549 |
| Medicare Paid Amount [4] | 11 | 550 | 560 |
| Paid Amount [4] | 11 | 561 | 571 |
| Dental Claim/Encounter Indicator [4] | 1 | 572 | 572 |
| Service Start Date [5] | 8 | 573 | 580 |
| Service End Date [5] | 8 | 581 | 588 |
| Place of Service/Place of Treatment [5] | 2 | 589 | 590 |
| Procedure Code [5] | 5 | 591 | 595 |
| Procedure Modifier Code 1 [5] | 2 | 596 | 597 |
| Procedure Modifier Code 2 [5] | 2 | 598 | 599 |
| Procedure Modifier Code 3 [5] | 2 | 600 | 601 |
| Procedure Modifier Code 4 [5] | 2 | 602 | 603 |
| Tooth Number or Letter [5] | 2 | 604 | 605 |
| Dental Number of Units/Visits [5] | 11 | 606 | 616 |
| Charged Amount [5] | 11 | 617 | 627 |
| Medicare Paid Amount [5] | 11 | 628 | 638 |
| Paid Amount [5] | 11 | 639 | 649 |
| Dental Claim/Encounter Indicator [5] | 1 | 650 | 650 |
| Service Start Date [6] | 8 | 651 | 658 |
| Service End Date [6] | 8 | 659 | 666 |
| Place of Service/Place of Treatment [6] | 2 | 667 | 668 |
| Procedure Code [6] | 5 | 669 | 673 |
| Procedure Modifier Code 1 [6] | 2 | 674 | 675 |
| Procedure Modifier Code 2 [6] | 2 | 676 | 677 |
| Procedure Modifier Code 3 [6] | 2 | 678 | 679 |
| Procedure Modifier Code 4 [6] | 2 | 680 | 681 |
| Tooth Number or Letter [6] | 2 | 682 | 683 |
| Dental Number of Units/Visits [6] | 11 | 684 | 694 |
| Charged Amount [6] | 11 | 695 | 705 |
| Medicare Paid Amount [6] | 11 | 706 | 716 |
| Paid Amount [6] | 11 | 717 | 727 |
| Dental Claim/Encounter Indicator [6] | 1 | 728 | 728 |
| Service Start Date [7] | 8 | 729 | 736 |
| Service End Date [7] | 8 | 737 | 744 |

| MEDS Data Element Name | Length | Start | End |
|---|---|---|---|
| Place of Service/Place of Treatment [7] | 2 | 745 | 746 |
| Procedure Code [7] | 5 | 747 | 751 |
| Procedure Modifier Code 1 [7] | 2 | 752 | 753 |
| Procedure Modifier Code 2 [7] | 2 | 754 | 755 |
| Procedure Modifier Code 3 [7] | 2 | 756 | 757 |
| Procedure Modifier Code 4 [7] | 2 | 758 | 759 |
| Tooth Number or Letter [7] | 2 | 760 | 761 |
| Dental Number of Units/Visits [7] | 11 | 762 | 772 |
| Charged Amount [7] | 11 | 773 | 783 |
| Medicare Paid Amount [7] | 11 | 784 | 794 |
| Paid Amount [7] | 11 | 795 | 805 |
| Dental Claim/Encounter Indicator [7] | 1 | 806 | 806 |
| Service Start Date [8] | 8 | 807 | 814 |
| Service End Date [8] | 8 | 815 | 822 |
| Place of Service/Place of Treatment [8] | 2 | 823 | 824 |
| Procedure Code [8] | 5 | 825 | 829 |
| Procedure Modifier Code 1 [8] | 2 | 830 | 831 |
| Procedure Modifier Code 2 [8] | 2 | 832 | 833 |
| Procedure Modifier Code 3 [8] | 2 | 834 | 835 |
| Procedure Modifier Code 4 [8] | 2 | 836 | 837 |
| Tooth Number or Letter [8] | 2 | 838 | 839 |
| Dental Number of Units/Visits [8] | 11 | 840 | 850 |
| Charged Amount [8] | 11 | 851 | 861 |
| Medicare Paid Amount [8] | 11 | 862 | 872 |
| Paid Amount [8] | 11 | 873 | 883 |
| Dental Claim/Encounter Indicator [8] | 1 | 884 | 884 |
| Service Start Date [9] | 8 | 885 | 892 |
| Service End Date [9] | 8 | 893 | 900 |
| Place of Service/Place of Treatment [9] | 2 | 901 | 902 |
| Procedure Code [9] | 5 | 903 | 907 |
| Procedure Modifier Code 1 [9] | 2 | 908 | 909 |
| Procedure Modifier Code 2 [9] | 2 | 910 | 911 |
| Procedure Modifier Code 3 [9] | 2 | 912 | 913 |
| Procedure Modifier Code 4 [9] | 2 | 914 | 915 |
| Tooth Number or Letter [9] | 2 | 916 | 917 |
| Dental Number of Units/Visits [9] | 11 | 918 | 928 |
| Charged Amount [9] | 11 | 929 | 939 |
| Medicare Paid Amount [9] | 11 | 940 | 950 |
| Paid Amount [9] | 11 | 951 | 961 |
| Dental Claim/Encounter Indicator [9] | 1 | 962 | 962 |
| Service Start Date [10] | 8 | 963 | 970 |
| Service End Date [10] | 8 | 971 | 978 |
| Place of Service/Place of Treatment [10] | 2 | 979 | 980 |
| Procedure Code [10] | 5 | 981 | 985 |
| Procedure Modifier Code 1 [10] | 2 | 986 | 987 |
| Procedure Modifier Code 2 [10] | 2 | 988 | 989 |
| Procedure Modifier Code 3 [10] | 2 | 990 | 991 |
| Procedure Modifier Code 4 [10] | 2 | 992 | 993 |
| Tooth Number or Letter [10] | 2 | 994 | 995 |
| Dental Number of Units/Visits [10] | 11 | 996 | 1006 |

| MEDS Data Element Name | Length | Start | End |
|---|---|---|---|
| Charged Amount [10] | 11 | 1007 | 1017 |
| Medicare Paid Amount [10] | 11 | 1018 | 1028 |
| Paid Amount [10] | 11 | 1029 | 1039 |
| Dental Claim/Encounter Indicator [10] | 1 | 1040 | 1040 |
| FILLER | 1960 | 1041 | 3000 |
| **Professional Segment** | | | |
| Provider Specialty Code | 3 | 258 | 260 |
| ICD Version Code | 1 | 261 | 261 |
| Diagnosis Codes [1] | 7 | 262 | 268 |
| Diagnosis Codes [2] | 7 | 269 | 275 |
| Diagnosis Codes [3] | 7 | 276 | 282 |
| Diagnosis Codes [4] | 7 | 283 | 289 |
| Place of Service/Place of Treatment [1] | 2 | 290 | 291 |
| Service Start Date [1] | 8 | 292 | 299 |
| Service End Date [1] | 8 | 300 | 307 |
| Procedure Code [1] | 5 | 308 | 312 |
| Procedure Modifier Code 1 [1] | 2 | 313 | 314 |
| Procedure Modifier Code 2 [1] | 2 | 315 | 316 |
| Procedure Modifier Code 3 [1] | 2 | 317 | 318 |
| Procedure Modifier Code 4 [1] | 2 | 319 | 320 |
| Professional Number of Units/Visits [1] | 11 | 321 | 331 |
| NDC (Formulary) Code [1] | 11 | 332 | 342 |
| NDC (Formulary) Units [1] | 11 | 343 | 353 |
| Charged Amount [1] | 11 | 354 | 364 |
| Medicare Paid Amount [1] | 11 | 365 | 375 |
| Paid Amount [1] | 11 | 376 | 386 |
| Professional Claim/Encounter Indicator [1] | 1 | 387 | 387 |
| Place of Service/Place of Treatment [2] | 2 | 388 | 389 |
| Service Start Date [2] | 8 | 390 | 397 |
| Service End Date [2] | 8 | 398 | 405 |
| Procedure Code [2] | 5 | 406 | 410 |
| Procedure Modifier Code 1 [2] | 2 | 411 | 412 |
| Procedure Modifier Code 2 [2] | 2 | 413 | 414 |
| Procedure Modifier Code 3 [2] | 2 | 415 | 416 |
| Procedure Modifier Code 4 [2] | 2 | 417 | 418 |
| Professional Number of Units/Visits [2] | 11 | 419 | 429 |
| NDC (Formulary) Code [2] | 11 | 430 | 440 |
| NDC (Formulary) Units [2] | 11 | 441 | 451 |
| Charged Amount [2] | 11 | 452 | 462 |
| Medicare Paid Amount [2] | 11 | 463 | 473 |
| Paid Amount [2] | 11 | 474 | 484 |
| Professional Claim/Encounter Indicator [2] | 1 | 485 | 485 |
| Place of Service/Place of Treatment [3] | 2 | 486 | 487 |
| Service Start Date [3] | 8 | 488 | 495 |
| Service End Date [3] | 8 | 496 | 503 |
| Procedure Code [3] | 5 | 504 | 508 |
| Procedure Modifier Code 1 [3] | 2 | 509 | 510 |
| Procedure Modifier Code 2 [3] | 2 | 511 | 512 |
| Procedure Modifier Code 3 [3] | 2 | 513 | 514 |
| Procedure Modifier Code 4 [3] | 2 | 515 | 516 |

| MEDS Data Element Name | Length | Start | End |
|---|---|---|---|
| Professional Number of Units/Visits [3] | 11 | 517 | 527 |
| NDC (Formulary) Code [3] | 11 | 528 | 538 |
| NDC (Formulary) Units [3] | 11 | 539 | 549 |
| Charged Amount [3] | 11 | 550 | 560 |
| Medicare Paid Amount [3] | 11 | 561 | 571 |
| Paid Amount [3] | 11 | 572 | 582 |
| Professional Claim/Encounter Indicator [3] | 1 | 583 | 583 |
| Place of Service/Place of Treatment [4] | 2 | 584 | 585 |
| Service Start Date [4] | 8 | 586 | 593 |
| Service End Date [4] | 8 | 594 | 601 |
| Procedure Code [4] | 5 | 602 | 606 |
| Procedure Modifier Code 1 [4] | 2 | 607 | 608 |
| Procedure Modifier Code 2 [4] | 2 | 609 | 610 |
| Procedure Modifier Code 3 [4] | 2 | 611 | 612 |
| Procedure Modifier Code 4 [4] | 2 | 613 | 614 |
| Professional Number of Units/Visits [4] | 11 | 615 | 625 |
| NDC (Formulary) Code [4] | 11 | 626 | 636 |
| NDC (Formulary) Units [4] | 11 | 637 | 647 |
| Charged Amount [4] | 11 | 648 | 658 |
| Medicare Paid Amount [4] | 11 | 659 | 669 |
| Paid Amount [4] | 11 | 670 | 680 |
| Professional Claim/Encounter Indicator [4] | 1 | 681 | 681 |
| Place of Service/Place of Treatment [5] | 2 | 682 | 683 |
| Service Start Date [5] | 8 | 684 | 691 |
| Service End Date [5] | 8 | 692 | 699 |
| Procedure Code [5] | 5 | 700 | 704 |
| Procedure Modifier Code 1 [5] | 2 | 705 | 706 |
| Procedure Modifier Code 2 [5] | 2 | 707 | 708 |
| Procedure Modifier Code 3 [5] | 2 | 709 | 710 |
| Procedure Modifier Code 4 [5] | 2 | 711 | 712 |
| Professional Number of Units/Visits [5] | 11 | 713 | 723 |
| NDC (Formulary) Code [5] | 11 | 724 | 734 |
| NDC (Formulary) Units [5] | 11 | 735 | 745 |
| Charged Amount [5] | 11 | 746 | 756 |
| Medicare Paid Amount [5] | 11 | 757 | 767 |
| Paid Amount [5] | 11 | 768 | 778 |
| Professional Claim/Encounter Indicator [5] | 1 | 779 | 779 |
| Place of Service/Place of Treatment [6] | 2 | 780 | 781 |
| Service Start Date [6] | 8 | 782 | 789 |
| Service End Date [6] | 8 | 790 | 797 |
| Procedure Code [6] | 5 | 798 | 802 |
| Procedure Modifier Code 1 [6] | 2 | 803 | 804 |
| Procedure Modifier Code 2 [6] | 2 | 805 | 806 |
| Procedure Modifier Code 3 [6] | 2 | 807 | 808 |
| Procedure Modifier Code 4 [6] | 2 | 809 | 810 |
| Professional Number of Units/Visits [6] | 11 | 811 | 821 |
| NDC (Formulary) Code [6] | 11 | 822 | 832 |
| NDC (Formulary) Units [6] | 11 | 833 | 843 |
| Charged Amount [6] | 11 | 844 | 854 |
| Medicare Paid Amount [6] | 11 | 855 | 865 |

| MEDS Data Element Name | Length | Start | End |
|---|---|---|---|
| Paid Amount [6] | 11 | 866 | 876 |
| Professional Claim/Encounter Indicator [6] | 1 | 877 | 877 |
| Place of Service/Place of Treatment [7] | 2 | 878 | 879 |
| Service Start Date [7] | 8 | 880 | 887 |
| Service End Date [7] | 8 | 888 | 895 |
| Procedure Code [7] | 5 | 896 | 900 |
| Procedure Modifier Code 1 [7] | 2 | 901 | 902 |
| Procedure Modifier Code 2 [7] | 2 | 903 | 904 |
| Procedure Modifier Code 3 [7] | 2 | 905 | 906 |
| Procedure Modifier Code 4 [7] | 2 | 907 | 908 |
| Professional Number of Units/Visits [7] | 11 | 909 | 919 |
| NDC (Formulary) Code [7] | 11 | 920 | 930 |
| NDC (Formulary) Units [7] | 11 | 931 | 941 |
| Charged Amount [7] | 11 | 942 | 952 |
| Medicare Paid Amount [7] | 11 | 953 | 963 |
| Paid Amount [7] | 11 | 964 | 974 |
| Professional Claim/Encounter Indicator [7] | 1 | 975 | 975 |
| Place of Service/Place of Treatment [8] | 2 | 976 | 977 |
| Service Start Date [8] | 8 | 978 | 985 |
| Service End Date [8] | 8 | 986 | 993 |
| Procedure Code [8] | 5 | 994 | 998 |
| Procedure Modifier Code 1 [8] | 2 | 999 | 1000 |
| Procedure Modifier Code 2 [8] | 2 | 1001 | 1002 |
| Procedure Modifier Code 3 [8] | 2 | 1003 | 1004 |
| Procedure Modifier Code 4 [8] | 2 | 1005 | 1006 |
| Professional Number of Units/Visits [8] | 11 | 1007 | 1017 |
| NDC (Formulary) Code [8] | 11 | 1018 | 1028 |
| NDC (Formulary) Units [8] | 11 | 1029 | 1039 |
| Charged Amount [8] | 11 | 1040 | 1050 |
| Medicare Paid Amount [8] | 11 | 1051 | 1061 |
| Paid Amount [8] | 11 | 1062 | 1072 |
| Professional Claim/Encounter Indicator [8] | 1 | 1073 | 1073 |
| Place of Service/Place of Treatment [9] | 2 | 1074 | 1075 |
| Service Start Date [9] | 8 | 1076 | 1083 |
| Service End Date [9] | 8 | 1084 | 1091 |
| Procedure Code [9] | 5 | 1092 | 1096 |
| Procedure Modifier Code 1 [9] | 2 | 1097 | 1098 |
| Procedure Modifier Code 2 [9] | 2 | 1099 | 1100 |
| Procedure Modifier Code 3 [9] | 2 | 1101 | 1102 |
| Procedure Modifier Code 4 [9] | 2 | 1103 | 1104 |
| Professional Number of Units/Visits [9] | 11 | 1105 | 1115 |
| NDC (Formulary) Code [9] | 11 | 1116 | 1126 |
| NDC (Formulary) Units [9] | 11 | 1127 | 1137 |
| Charged Amount [9] | 11 | 1138 | 1148 |
| Medicare Paid Amount [9] | 11 | 1149 | 1159 |
| Paid Amount [9] | 11 | 1160 | 1170 |
| Professional Claim/Encounter Indicator [9] | 1 | 1171 | 1171 |
| Place of Service/Place of Treatment [10] | 2 | 1172 | 1173 |
| Service Start Date [10] | 8 | 1174 | 1181 |
| Service End Date [10] | 8 | 1182 | 1189 |

| MEDS Data Element Name | Length | Start | End |
|---|---|---|---|
| Procedure Code [10] | 5 | 1190 | 1194 |
| Procedure Modifier Code 1 [10] | 2 | 1195 | 1196 |
| Procedure Modifier Code 2 [10] | 2 | 1197 | 1198 |
| Procedure Modifier Code 3 [10] | 2 | 1199 | 1200 |
| Procedure Modifier Code 4 [10] | 2 | 1201 | 1202 |
| Professional Number of Units/Visits [10] | 11 | 1203 | 1213 |
| NDC (Formulary) Code [10] | 11 | 1214 | 1224 |
| NDC (Formulary) Units [10] | 11 | 1225 | 1235 |
| Charged Amount [10] | 11 | 1236 | 1246 |
| Medicare Paid Amount [10] | 11 | 1247 | 1257 |
| Paid Amount [10] | 11 | 1258 | 1268 |
| Professional Claim/Encounter Indicator [10] | 1 | 1269 | 1269 |
| FILLER | 1731 | 1270 | 3000 |
| **Trailer** | | | |
| Record Type | 2 | 1 | 2 |
| Submission Record Count | 9 | 3 | 11 |