	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
****	STATE MEDICAID RESEARCH FILES PERSONAL SUMMARY RECORD	REC	1025	1	1025	THE STATE MEDICAID RESEARCH FILES (SMRF) PERSONAL SUMMARY RECORD PROVIDES PERSON LEVEL INFORMATION WHICH INCLUDES SUMMARIZATIONS OF ELIGIBILITY AND PAID CLAIMS (UTILIZATION) DATA BY CALENDAR YEAR AND DATE OF SERVICE. THE FILE CONTAINS A RECORD FOR EACH UNIQUE PERSON (ELIGIBLE IDENTIFICATION NUMBER). THERE ARE A SUBSTANTIAL NUMBER OF ELIGIBLES WHO HAVE NO UTILIZATION IN A CALENDAR YEAR. FOR THESE INDIVIDUALS, CLAIMS-BASED DATA ELEMENTS ARE BLANK. THERE ARE ALSO A SMALL NUMBER OF ELIGIBLE PERSONS FOR WHOM THERE IS UTILIZATION, BUT NO CORRESPONDING ELIGIBILITY DATA IN MSIS. THESE PERSONS ARE IDENTIFIED BY THE DATA ELEMENT “MISSING ELIGIBILITY DATA SWITCH”.
***	ELIGIBLE SUMMARY REGION	REGION	257	1	257	SUMMARIZED INFORMATION FROM MSIS ELIGIBILITY FILES.
**	ELIGIBLE IDENTIFYING GROUP	GROUP	67	1	67	DATA ELEMENTS USED TO IDENTIFY A MEDICAID ELIGIBLE.
1.	ELIGIBLE IDENTIFICATION NUMBER	CHAR	20	1	20	UNIQUE IDENTIFICATION NUMBER USED TO IDENTIFY A MEDICAID ELIGIBLE IN THE MEDICAID STATISTICAL INFORMATION SYSTEM (MSIS). SOURCE: MSIS ELIGIBILITY FILES
2.	STATE ABBREVIATION CODE	CHAR	2	21	22	U. S. POSTAL SERVICE 2-CHARACTER ABBREVIATION FOR THE STATE MEDICAID AGENCY SUBMITTING THE DATA. CODES: AL = ALABAMA AK = ALASKA AZ = ARIZONA AR = ARKANSAS AS = AMERICAN SAMOA CA = CALIFORNIA CO = COLORADO CT = CONNECTICUT DE = DELAWARE DC = DISTRICT OF COLUMBIA FL = FLORIDA GA = GEORGIA GU = GUAM HI = HAWAII ID = IDAHO IL = ILLINOIS

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					IN = INDIANA IA = IOWA KS = KANSAS KY = KENTUCKY LA = LOUISIANA ME = MAINE MD = MARYLAND MA = MASSACHUSETTS MI = MICHIGAN MN = MINNESOTA MS = MISSISSIPPI MO = MISSOURI MT = MONTANA NE = NEBRASKA NV = NEVADA NH = NEW HAMPSHIRE NJ = NEW JERSEY NM = NEW MEXICO NY = NEW YORK NC = NORTH CAROLINA ND = NORTH DAKOTA OH = OHIO OK = OKLAHOMA OR = OREGON PA = PENNSYLVANIA PR = PUERTO RICO RI = RHODE ISLAND SC = SOUTH CAROLINA SD = SOUTH DAKOTA TN = TENNESSEE TX = TEXAS UT = UTAH VT = VERMONT VI = VIRGIN ISLANDS VA = VIRGINIA WA = WASHINGTON WV = WEST VIRGINIA WI = WISCONSIN WY = WYOMING
					SOURCE: MSIS ELIGIBILITY FILES

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
3. SMRF YEAR DATE	NUM	4	23	26	CALENDAR YEAR COVERED BY THE SMRF PERSONAL SUMMARY FILE 4 DIGITS EDIT-RULES: YYYY *USER NOTE: THIS DATA ELEMENT WAS CHANGED TO 4 CHARACTERS IN 1996* SOURCE: MSIS ELIGIBILITY FILES
4. ELIGIBLE TEMPORARY IDENTIFICATION NUMBER	CHAR	20	27	46	TEMPORARY PERSONAL IDENTIFICATION NUMBER ASSIGNED BY THE STATE TO AN ELIGIBLE PENDING ASSIGNMENT OF A PERMANENT IDENTIFICATION NUMBER. THIS DATA ELEMENT IS ONLY USED BY STATES THAT USE THE SOCIAL SECURITY NUMBER AS THE PERSONAL IDENTIFIER FOR MEDICAID REPORTING. EDIT-RULES: AS NEGOTIATED WITH EACH STATE. IF THERE IS NO TEMPORARY IDENTIFICATION NUMBER, THIS DATA ELEMENT SHOULD BE BLANK-FILLED. SOURCE: MSIS ELIGIBILITY FILES
5. ELIGIBLE SOCIAL SECURITY NUMBER	CHAR	9	47	55	SOCIAL SECURITY NUMBER OF THE MEDICAID ELIGIBLE. *USER NOTE: NOT AVAILABLE FOR WASHINGTON. FOR IOWA, AVAILABLE FOR DUAL ENROLLEES ONLY THROUGH 6/96 AND THEN ALL ENROLLEES BEGINNING 7/96 (88% OF ENROLLEES HAD SSNs IN THE 1996 IOWA DATA).* SOURCE: MSIS ELIGIBILITY FILES
6. ELIGIBLE STATE CASE NUMBER	CHAR	12	56	67	STATE-ASSIGNED NUMBER WHICH UNIQUELY IDENTIFIES THE MEDICAID CASE TO WHICH THE ENROLLEE BELONGS ON THE LAST DAY OF THE FEDERAL FISCAL YEAR. *USER NOTE: AVAILABLE ONLY FOR 10/98 THROUGH 12/98. BLANK FILLED OTHERWISE. MAY INCLUDE ALPHA CHARACTERS. DOES NOT NECESSARILY LINK ALL FAMILY MEMBERS TOGETHER. MAY CHANGE OVER TIME. THE DEFINITION MAY VARY ACROSS STATES. THERE ARE SINGLE-PERSON CASES (MOSTLY AGED AND BLIND/DISABLED) AND MULTI-PERSON CASES (MOSTLY TANF) IN WHICH EACH MEMBER OF THE CASE HAS THE SAME CASE NUMBER, BUT A UNIQUE MSIS IDENTIFICATION NUMBER.* SOURCE: MSIS ELIGIBILITY FILES

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
**	ELIGIBLE DEMOGRAPHIC GROUP	GROUP	28	68	95	DEMOGRAPHIC DATA FOR THE ELIGIBLE.
7.	ELIGIBLE BIRTH DATE	NUM	8	68	75	BIRTH DATE OF THE MEDICAID ELIGIBLE. 8 DIGITS EDIT-RULES: YYYYMMDD SOURCE: MSIS ELIGIBILITY FILES
8.	ELIGIBLE AGE GROUP CODE	NUM	1	76	76	AGE GROUP OF THE MEDICAID ELIGIBLE. 1 DIGIT CODES: 0 = UNDER 1 1 = AGES 1 TO 5 2 = AGES 6 TO 14 3 = AGES 15 TO 20 4 = AGES 21 TO 44 5 = AGES 45 TO 64 6 = AGES 65 TO 74 7 = AGES 75 TO 84 8 = AGES 85 AND OVER 9 = UNKNOWN/ERROR SOURCE: RECODED FROM MSIS ELIGIBILITY FILE USING ELIGIBLE BIRTH DATE (DATA ELEMENT #7) AND DECEMBER 31 OF THE FILE YEAR TO CALCULATE AGE GROUP.
9.	ELIGIBLE SEX CODE	NUM	1	77	77	GENDER OF THE MEDICAID ELIGIBLE. 1 DIGIT CODES: 1 = FEMALE 2 = MALE 9 = UNKNOWN/ERROR *USER NOTE: THESE CODES CHANGE TO F, M AND U IN THE 1999 MSIS DATA.* SOURCE: MSIS ELIGIBILITY FILES

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
10.	ELIGIBLE RACE/ETHNICITY CODE	NUM	1	78	78	RACE/ETHNICITY OF THE MEDICAID ELIGIBLE. 1 DIGIT CODES: 1 = WHITE, NOT OF HISPANIC ORIGIN (CHANGED TO “WHITE” BEGINNING 10/98) 2 = BLACK, NOT OF HISPANIC ORIGIN (CHANGED TO “BLACK OR AFRICAN AMERICAN” BEGINNING 10/98) 3 = AMERICAN INDIAN OR ALASKAN NATIVE 4 = ASIAN OR PACIFIC ISLANDER (CHANGED TO “ASIAN” BEGINNING 10/98) 5 = HISPANIC (CHANGED TO “HISPANIC OR LATINO - NO RACE INFORMATION AVAILABLE” BEGINNING 10/98) 6 = NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER (NEW CODE BEGINNING 10/98) 7 = HISPANIC OR LATINO AND ONE OR MORE RACES (NEW CODE BEGINNING 10/98) 8 = MORE THAN ONE RACE (NEW CODE BEGINNING 10/98) 9 = UNKNOWN *USER NOTE: SINCE SPECIFICATIONS FOR CODE VALUES = 7 AND 8 WERE NOT ISSUED BY HCFA UNTIL MAY 2000, THESE CODE VALUES MAY NOT APPEAR. THE METHODS OF COLLECTING INFORMATION ON RACE AND ETHNICITY DIFFER SUBSTANTIALLY ACROSS STATES AND TIME PERIODS.* SOURCE: STATE MSIS ELIGIBILITY FILES

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
11. ELIGIBLE SEX-RACE CODE	NUM	1	79	79	GENDER AND RACE OF THE MEDICAID ELIGIBLE. 1 DIGIT CODES: 1 = WHITE, MALE 2 = WHITE, FEMALE 3 = NON-WHITE, MALE 4 = NON-WHITE, FEMALE 5 = RACE UNKNOWN, MALE 6 = RACE UNKNOWN, FEMALE 7 = SEX UNKNOWN, WHITE 8 = SEX UNKNOWN, NON-WHITE 9 = SEX AND RACE UNKNOWN SOURCE: RECODED FROM MSIS ELIGIBILITY FILES. CROSSWALK: MSIS RACE=1 MAPS TO WHITE, MSIS RACE=2,3,4,5,6,7 AND 8 MAPS TO NON-WHITE, MSIS RACE=9 MAPS TO UNKNOWN. MSIS SEX=2 OR M MAPS TO MALE. MSIS SEX=1 OR F MAPS TO FEMALE. MSIS SEX=9 OR U MAPS TO UNKNOWN.
12. ELIGIBLE DEATH DATE	NUM	8	80	87	DEATH DATE OF THE MEDICAID ELIGIBLE. 8 DIGITS EDIT-RULES: YYYYMMDD USER NOTE: THIS DATA ELEMENT SHOULD BE USED WITH CAUTION SINCE THERE MAY BE UNDERREPORTING OF DEATHS IN THE MSIS ELIGIBILITY FILES. SOURCE: MSIS ELIGIBILITY FILES

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
13. ELIGIBLE RESIDENCE COUNTY CODE	CHAR	3	88	90	FEDERAL INFORMATION PROCESSING STANDARD (FIPS) CODE INDICATING THE ELIGIBLE'S COUNTY OF RESIDENCE. CODES: FIPS NUMERIC COUNTY CODES, OR 000 = ELIGIBLE RESIDES OUT OF STATE 999 = UNKNOWN/ERROR SOURCE: THIS CODE WAS DERIVED BY USING QUARTERLY OBSERVATIONS OF ELIGIBLE RESIDENCE COUNTY CODE FROM THE MSIS ELIGIBILITY FILE AND SELECTING THE FIRST MEANINGFUL CODE (NOT 0- OR 9-FILLED) BEGINNING WITH DECEMBER AND MOVING BACKWARDS IN TIME MONTH BY MONTH.
14. ELIGIBLE RESIDENCE ZIP CODE	NUM	5	91	95	UNITED STATES POSTAL ZIP CODE OF THE MEDICAID ELIGIBLE'S RESIDENCE. 5 DIGITS USER NOTE: MSIS VALIDATION ACTIVITIES WILL ACCEPT ZERO-FILLED RECORDS, SO FOR SMRF, IF THE MSIS RECORD IS EITHER ZERO-FILLED OR BLANK-FILLED, THE SMRF VALUE SHOULD BE RECODED AS 9-FILLED (‘99999’) SOURCE: THIS CODE WAS DERIVED BY USING QUARTERLY OBSERVATIONS OF ELIGIBLE RESIDENCE ZIP CODE FROM THE MSIS ELIGIBILITY FILE AND SELECTING THE FIRST MEANINGFUL CODE (NOT 0- OR 9-FILLED) BEGINNING WITH DECEMBER AND MOVING BACKWARD IN TIME MONTH BY MONTH.

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
**	ANNUAL ELIGIBLE MEDICAID AND OTHER HEALTH INSURANCE GROUP		17	96	113	MEDICAID, CROSSOVER (MEDICAID AND MEDICARE) AND OTHER HEALTH INSURANCE ELIGIBILITY DATA FOR THE ELIGIBLE.
15.	STATE SPECIFIC ELIGIBILITY CODE - MOST RECENT	CHAR	6	96	101	STATE SPECIFIC ELIGIBILITY CODE CLASSIFICATION UNDER WHICH THE MEDICAID ELIGIBLE IS COVERED - MOST RECENT OBSERVATION. *USER NOTES: THESE SOURCE CODES ARE GENERALLY NOT APPLICABLE FOR MOST RESEARCH ACTIVITIES. THE DATA ELEMENT CHANGES OVER TIME, VARIES ACROSS STATES IN TERMS OF THE LEVEL AND TYPE OF ELIGIBILITY DESCRIBED, REQUIRE A DETAILED KNOWLEDGE OF MEDICAID ELIGIBILITY AND REQUIRE AN UNDERSTANDING OF THE IDIOSYNCRACIES OF INDIVIDUAL STATE ELIGIBILITY SYSTEMS. THESE CODES HAVE BEEN MAPPED INTO SMRF UNIFORM ELIGIBILITY CODES. THEREFORE, MOST USERS WILL WANT TO USE SMRF UNIFORM ELIGIBILITY CODES. THROUGH 9/98 THIS DATA ELEMENT WAS 4 CHARACTERS IN LENGTH, LEFT-JUSTIFIED AND BLANK FILLED (TWO RIGHT POSITIONS). BEGINNING IN 10/98, IT IS 6 CHARACTERS IN LENGTH. THIS CODE VALUE IS APPENDED TO EACH CLAIM RECORD FOR THE ELIGIBLE PERSON, FROM THE SMRF PERSON SUMMARY FILE. THEREFORE, THIS CODE MAY NOT MATCH THE ELIGIBILITY GROUP IN WHICH THE PERSON WAS ENROLLED IN THE MONTH THE SERVICE WAS DELIVERED. FOR THIS REASON, SOME USERS MAY WANT TO USE THE STATE SPECIFIC ELIGIBILITY CODE FROM THE SMRF PERSON SUMMARY FILE.* SOURCE: THIS CODE WAS DERIVED BY USING MONTHLY OBSERVATIONS OF STATE SPECIFIC ELIGIBILITY FROM THE MSIS ELIGIBILITY FILE AND SELECTING THE FIRST MEANINGFUL CODE (NOT 0- OR 9-FILLED) BEGINNING WITH DECEMBER AND MOVING BACKWARDS IN TIME MONTH BY MONTH. IT HAS NOT BEEN RECODED FROM THE MSIS ELIGIBILITY FILE.

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
16.	SMRF UNIFORM ELIGIBILITY CODE - MOST RECENT	NUM	2	102	103	STATE MEDICAID RESEARCH FILES (SMRF) UNIFORM ELIGIBILITY CODE FOR THE MEDICAID ELIGIBLE - MOST RECENT OBSERVATION 2 DIGITS CODES: 00 = NOT ELIGIBLE 11 = AGED, CASH 12 = BLIND/DISABLED, CASH 14 = AFDC CHILD, CASH 16 = AFDC-U CHILD, CASH 15 = AFDC ADULT, CASH 17 = AFDC-U ADULT, CASH 21 = AGED, MEDICALLY NEEDY (MN) 22 = BLIND/DISABLED, MN 24 = AFDC CHILD, MN 25 = AFDC ADULT, MN 31 = AGED, POVERTY 32 = BLIND/DISABLED, POVERTY 34 = CHILD, POVERTY 35 = ADULT, POVERTY 41 = OTHER AGED 42 = OTHER BLIND/DISABLED 48 = FOSTER CARE CHILD 44 = OTHER CHILD 45 = OTHER ADULT 99 = UNKNOWN ELIGIBILITY *USER NOTE: THIS CODE LIST IS NEARLY THE SAME AS THE LIST FOR THE 1999 SMRF FILE, EXCEPT THAT CODES ARE ADDED FOR 1999 TO IDENTIFY SECTION 1115 DEMONSTRATION EXPANSION ELIGIBLES. FOR 1999, IT IS NOT NECESSARY TO MAP SMRF UNIFORM ELIGIBILITY INTO THESE CODES. CHANGES IN THE 1999 MSIS SPECIFICATIONS TO STATES RESULTED IN MSIS MAINTENANCE ASSISTANCE STATUS (MAS) AND BASIS OF ELIGIBILITY (BOE) CODES THAT DIRECTLY CORRESPOND.* SOURCE: THIS CODE WAS DERIVED BY USING MONTHLY OBSERVATIONS OF SMRF UNIFORM ELIGIBILITY GROUP (FOR ALL GROUPS INCLUDING 1115 DEMONSTRATION EXPANSION ELIGIBLES) AND SELECTING THE FIRST MEANINGFUL CODE (NOT 0- OR 9-FILLED) BEGINNING WITH DECEMBER AND MOVING BACKWARDS IN TIME MONTH BY MONTH.

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
17.	MISSING ELIGIBILITY DATA SWITCH	CHAR	1	104	104	INDICATES NO ELIGIBILITY DATA WERE FOUND FOR THIS CALENDAR YEAR CODES: BLANK = ELIGIBILITY DATA WERE FOUND 1 = NO ELIGIBILITY DATA WERE FOUND SOURCE: CODED AT HCFA USING MSIS ELIGIBILITY FILES
18.	ELIGIBLE MONTHS COUNT	NUM	2	105	106	TOTAL NUMBER OF MONTHS THE INDIVIDUAL WAS ELIGIBLE FOR MEDICAID DURING THE CALENDAR YEAR. 2 DIGITS *USER NOTE: THIS IS A NUMBER FROM 0 TO 12. IT IS GIVEN VALUE > 0 BASED ON EITHER (1) THE NUMBER OF MONTHS WITH CODES IN DATA ELEMENT #23 (STATE SPECIFIC ELIGIBILITY CODE), OR (2) IF THERE ARE NO MONTHS WITH CODES IN DATA ELEMENT #23, THEN THE NUMBER OF MONTHS WITH VALID CODES IN EITHER OF TWO MSIS DATA ELEMENTS "MAINTENANCE ASSISTANCE STATUS" (MAS) OR "BASIS OF ELIGIBILITY" (BOE). IF THERE IS NOT AN ELIGIBILITY RECORD, IT IS CODED WITH VALUE = 99 (UNKNOWN).* SOURCE: CODED AT HCFA USING MSIS ELIGIBILITY FILES
19.	ELIGIBLE PRIVATE INSURANCE MONTHS COUNT	NUM	2	107	108	TOTAL NUMBER OF MONTHS THE MEDICAID ELIGIBLE HAD PRIVATE INSURANCE COVERAGE DURING THE CALENDAR YEAR. 2 DIGITS *USER NOTE: THIS IS A NUMBER FROM 0 TO 12. IT IS GIVEN VALUE > 0 BASED ON THE NUMBER OF MONTHS WITH VALUE = 2 (ELIGIBLE HAD PRIVATE HEALTH INSURANCE COVERAGE PURCHASED BY A THIRD PARTY), 3 (ELIGIBLE HAD PRIVATE HEALTH INSURANCE COVERAGE PURCHASED BY THE STATE) OR 4 (BOTH 2 AND 3 APPLY) IN THE MSIS DATA ELEMENT "HEALTH INSURANCE"* SOURCE: CODED AT HCFA USING MSIS ELIGIBILITY FILES

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
20.	ELIGIBLE MEDICARE CROSSOVER CODE	NUM	1	109	109	INDICATES THAT THE ELIGIBLE IS OR HAS BEEN COVERED BY MEDICARE (KNOWN AS CROSSOVER, DUAL OR MEDICARE ELIGIBILITY) 1 DIGIT CODES: 0 = NO CROSSOVER 1 = DUAL ELIGIBILITY FLAG HAS A VALUE OF 1 (MEANING THAT THE PERSON IS OR HAS BEEN COVERED BY MEDICARE) 2 = MEDICARE DEDUCTIBLE OR COINSURANCE PAID BY MEDICAID ON AT LEAST ONE CLAIM DURING THE YEAR. 3 = BOTH 1 AND 2 APPLY 9 = ELIGIBLE'S MEDICARE STATUS IS UNKNOWN *USER NOTE: BEGINNING IN 10/98, MSIS CAPTURES GREATER DETAIL ON DUAL ELIGIBILITY. GIVEN THE IMPORTANCE OF CROSSOVER STATUS FOR SOME DATA USERS, THE EXPANDED DETAIL APPEARS AS DATA ELEMENT #21 IN THIS FILE. TO PROVIDE CONSISTENCY WITH EARLIER CODES FOR OTHER DATA USERS, THESE 2 CHARACTER CODES, AVAILABLE ONLY FOR 10/98 THROUGH 12/98, HAVE BEEN MAPPED INTO THE CODES LISTED ABOVE, AS FOLLOWS:* *TO FROM* *SMRF MSIS FY99* *CODE CODE (DUAL-ELIGIBLE-FLAG)* *0 = 00 ELIGIBLE IS NOT A MEDICARE BENEFICIARY.* *1 = 01 ELIGIBLE IS ENTITLED TO MEDICARE – QMB ONLY* *1 = 02 ELIGIBLE IS ENTITLED TO MEDICARE – QMB AND FULL MEDICAID COVERAGE* *1 = 03 ELIGIBLE IS ENTITLED TO MEDICARE – SLMB ONLY* *1 = 04 ELIGIBLE IS ENTITLED TO MEDICARE – SLMB AND FULL MEDICAID COVERAGE* *1 = 05 ELIGIBLE IS ENTITLED TO MEDICARE – QDWI* *1 = 06 ELIGIBLE IS ENTITLED TO MEDICARE – QUALIFYING INDIVIDUAL (1)* *1 = 07 ELIGIBLE IS ENTITLED TO MEDICARE – QUALIFYING INDIVIDUAL (2)* *1 = 08 ELIGIBLE IS ENTITLED TO MEDICARE – OTHER DUAL ELIGIBLE* *1 = 09 ELIGIBLE IS ENTITLED TO MEDICARE – DUAL ELIGIBILITY CATEGORY UNK.* *9 = 99 ELIGIBLE'S MEDICARE STATUS IS UNKNOWN* *ONCE THIS MAPPING IS COMPLETED, VALUE = 0 IS CHANGED TO VALUE = 2 AND VALUE = 1 IS CHANGED TO VALUE = 3 IF THERE WAS MEDICARE DEDUCTIBLE OR COINSURANCE PAID BY MEDICAID FOR AT LEAST ONE CLAIM DURING THE YEAR.*

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					SOURCE: THE DUAL ELIGIBILITY FLAG IS OBTAINED FROM MSIS ELIGIBILITY FILES AND DEDUCTIBLE OR COINSURANCE PAID AMOUNTS ARE OBTAINED FROM SMRF CLAIMS DATA.
21. ELIGIBLE MEDICARE CROSSOVER CODE - NEW VALUES IN 1999	CHAR	2	110	111	INDICATES THAT THE ELIGIBLE IS OR HAS BEEN COVERED BY MEDICARE (KNOWN AS CROSSOVER, DUAL OR MEDICARE ELIGIBILITY) 2 CHARACTERS CODES: 00 = ELIGIBLE IS NOT A MEDICARE BENEFICIARY 01 = ELIGIBLE IS ENTITLED TO MEDICARE – QMB ONLY 02 = ELIGIBLE IS ENTITLED TO MEDICARE – QMB AND FULL MEDICARE COVERAGE 03 = ELIGIBLE IS ENTITLED TO MEDICARE – SLMB ONLY 04 = ELIGIBLE IS ENTITLED TO MEDICARE – SLMB AND FULL MEDICARE COVERAGE 05 = ELIGIBLE IS ENTITLED TO MEDICARE – QDWI 06 = ELIGIBLE IS ENTITLED TO MEDICARE – QUALIFYING INDIVIDUALS (1) 07 = ELIGIBLE IS ENTITLED TO MEDICARE – QUALIFYING INDIVIDUALS (2) 08 = ELIGIBLE IS ENTITLED TO MEDICARE – OTHER DUAL ELIGIBLES 09 = ELIGIBLE IS ENTITLED TO MEDICARE – DUAL ELIGIBILITY CATEGORY UNKNOWN 99 = ELIGIBLE'S MEDICARE STATUS IS UNKNOWN *USER NOTE: THIS DATA ELEMENT WILL BE BLANK-FILLED FOR 1996 AND 1997. IT IS TAKEN DIRECTLY FROM THE MSIS DATA ELEMENT "DUAL ELIGIBLE FLAG". THERE IS ONE OBSERVATION IN MSIS FOR 10/98 THROUGH 12/98. IF THERE IS NO ELIGIBLE RECORD FOR THE ENROLLEE FROM 10/98 THROUGH 12/98, IT IS BLANK-FILLED.* SOURCE: MSIS ELIGIBILITY FILES

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
22.	ELIGIBLE PRE-PAID PLAN MONTHS COUNT	NUM	2	112	113	TOTAL NUMBER OF MONTHS THE MEDICAID ELIGIBLE WAS ENROLLED IN AN HMO OR OTHER PRE-PAID PLAN DURING THE CALENDAR YEAR. 2 DIGITS USER NOTE: THIS IS A NUMBER FROM 0 TO 12. MONTHS OF ENROLLMENT IN PRIMARY CARE CASE MANAGEMENT (PCCM) ARE NOT COUNTED AS PRE-PAID PLAN MONTHS BECAUSE SERVICES RENDERED TO PERSONS IN A PCCM ARE USUALLY PAID ON A FEE-FOR-SERVICE BASIS. EVERY MONTH WHICH HAS ONE OF THE FOLLOWING SMRF ELIGIBLE PRE-PAID PLAN CODES IS COUNTED: 010 = ENROLLED IN A PREPAID HEALTH PLAN (PHP) ONLY 011 = ENROLLED IN PCCM AND A PHP 100 = ENROLLED IN AN HMO/HEALTH INSURING ORGANIZATION (HIO) ONLY 110 = ENROLLED IN AN HMO/HIO AND PHP 777 = ENROLLED IN AN OTHER MANAGED CARE OR CAPITATION PLAN SOURCE: CODED AT HCFA USING MSIS ELIGIBILITY FILES

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
**	MONTHLY STATE SPECIFIC ELIGIBILITY GROUP	GROUP	72	114	185	STATE SPECIFIC ELIGIBILITY CODE CLASSIFICATION UNDER WHICH THE MEDICAID ELIGIBLE IS COVERED FROM JANUARY THROUGH DECEMBER. THE EXAMPLE IS FOR JANUARY. JANUARY (POSITIONS 114 TO 119) FEBRUARY (POSITIONS 120 TO 125) MARCH (POSITIONS 126 TO 131) APRIL (POSITIONS 132 TO 137) MAY (POSITIONS 138 TO 143) JUNE (POSITIONS 144 TO 149) JULY (POSITIONS 150 TO 155) AUGUST (POSITIONS 156 TO 161) SEPTEMBER (POSITIONS 162 TO 167) OCTOBER (POSITIONS 168 TO 173) NOVEMBER (POSITIONS 174 TO 179) DECEMBER (POSITIONS 180 TO 185)
23.	STATE SPECIFIC ELIGIBILITY CODE	CHAR	6	114	119	STATE SPECIFIC ELIGIBILITY CODE CLASSIFICATION FOR THE MEDICAID ELIGIBLE AND FOR THE MONTH 6 CHARACTERS *USER NOTES: THESE SOURCE CODES ARE GENERALLY NOT APPLICABLE FOR MOST RESEARCH ACTIVITIES. THE DATA ELEMENT CHANGES OVER TIME, VARIES ACROSS STATES IN TERMS OF THE LEVEL AND TYPE OF ELIGIBILITY DESCRIBED, REQUIRES A DETAILED KNOWLEDGE OF MEDICAID ELIGIBILITY AND REQUIRES AN UNDERSTANDING OF THE IDIOSYNCRACIES OF INDIVIDUAL STATE ELIGIBILITY SYSTEMS. THESE CODES HAVE BEEN MAPPED INTO SMRF UNIFORM ELIGIBILITY CODES. THEREFORE, MOST USERS WILL WANT TO USE SMRF UNIFORM ELIGIBILITY CODES. THROUGH 9/98 THIS DATA ELEMENT WAS 4 CHARACTERS IN LENGTH, LEFT-JUSTIFIED AND BLANK FILLED (TWO RIGHT POSITIONS). BEGINNING IN 10/98, IT IS 6 CHARACTERS IN LENGTH. THIS CODE VALUE IS APPENDED TO EACH RECORD FOR THE ELIGIBLE PERSON, FROM THE MSIS ELIGIBILITY FILES.* SOURCE: MSIS ELIGIBILITY FILES

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
**	MONTHLY SMRF UNIFORM ELIGIBILITY GROUP	GROUP	24	186	209	STATE MEDICAID RESEARCH FILES (SMRF) UNIFORM ELIGIBILITY CODE FOR THE MEDICAID ELIGIBLE FROM JANUARY THROUGH DECEMBER. THE EXAMPLE IS FOR JANUARY. JANUARY (POSITIONS 186 TO 187) FEBRUARY (POSITIONS 188 TO 189) MARCH (POSITIONS 190 TO 191) APRIL (POSITIONS 192 TO 193) MAY (POSITIONS 194 TO 195) JUNE (POSITIONS 196 TO 197) JULY (POSITIONS 198 TO 199) AUGUST (POSITIONS 200 TO 201) SEPTEMBER (POSITIONS 202 TO 203) OCTOBER (POSITIONS 204 TO 205) NOVEMBER (POSITIONS 206 TO 207) DECEMBER (POSITIONS 208 TO 209)
24.	SMRF UNIFORM ELIGIBILITY CODE	NUM	2	186	187	STATE MEDICAID RESEARCH FILES (SMRF) UNIFORM ELIGIBILITY CODE FOR THE MEDICAID ELIGIBLE AND FOR THE MONTH 2 DIGITS CODES: 00 = NOT ELIGIBLE 11 = AGED, CASH 12 = BLIND/DISABLED, CASH 14 = AFDC CHILD, CASH 16 = AFDC-U CHILD, CASH 15 = AFDC ADULT, CASH 17 = AFDC-U ADULT, CASH 21 = AGED, MEDICALLY NEEDY (MN) 22 = BLIND/DISABLED, MN 24 = AFDC CHILD, MN 25 = AFDC ADULT, MN 31 = AGED, POVERTY 32 = BLIND/DISABLED, POVERTY 34 = CHILD, POVERTY 35 = ADULT, POVERTY 41 = OTHER AGED 42 = OTHER BLIND/DISABLED

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					48 = FOSTER CARE CHILD 44 = OTHER CHILD 45 = OTHER ADULT 99 = UNKNOWN ELIGIBILITY *USER NOTE: THIS CODE LIST IS NEARLY THE SAME AS THE LIST FOR THE 1999 SMRF FILE, EXCEPT THAT CODES ARE ADDED FOR 1999 TO IDENTIFY SECTION 1115 DEMONSTRATION EXPANSION ELIGIBLES. FOR 1999, IT IS NOT NECESSARY TO MAP SMRF UNIFORM ELIGIBILITY INTO THESE CODES. CHANGES IN THE 1999 MSIS SPECIFICATIONS TO STATES RESULTED IN MSIS MAINTENANCE ASSISTANCE STATUS (MAS) AND BASIS OF ELIGIBILITY (BOE) CODES THAT DIRECTLY CORRESPOND.* SOURCE: CODED AT HCFA USING MSIS STATE SPECIFIC ELIGIBILITY CODES AND OTHER ELIGIBILITY DATA ELEMENTS, AS NECESSARY (FOR ALL GROUPS INCLUDING 1115 DEMONSTRATION EXPANSION ELIGIBLES).

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
**	MONTHLY ELIGIBLE PRIVATE INSURANCE GROUP	GROUP	12	210	221	INDICATES WHICH MONTHS THE MEDICAID ELIGIBLE HAD PRIVATE INSURANCE COVERAGE FROM JANUARY THROUGH DECEMBER. THE EXAMPLE IS FOR JANUARY. JANUARY (POSITION 210) FEBRUARY (POSITION 211) MARCH (POSITION 212) APRIL (POSITION 213) MAY (POSITION 214) JUNE (POSITION 215) JULY (POSITION 216) AUGUST (POSITION 217) SEPTEMBER (POSITION 218) OCTOBER (POSITION 219) NOVEMBER (POSITION 220) DECEMBER (POSITION 221)
25.	ELIGIBLE PRIVATE INSURANCE CODE	NUM	1	210	210	CODE INDICATING IF THE ELIGIBLE HAD PRIVATE INSURANCE DURING THE MONTH 1 DIGIT CODES: 0 = NOT ELIGIBLE FOR MEDICAID 1 = NO PRIVATE INSURANCE COVERAGE 2 = PRIVATE INSURANCE PURCHASED BY THIRD PARTY 3 = PRIVATE INSURANCE PURCHASED BY STATE 4 = BOTH 2 AND 3 APPLY (1/96 THROUGH 9/98) EITHER (1) BOTH 2 AND 3 APPLY OR (2) 2 AND 3 APPLY AND FUNDING SOURCE UNKNOWN (10/98 THROUGH 12/98) 9 = INVALID OR MISSING DATA SOURCE: MSIS ELIGIBILITY FILES

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
**	MONTHLY ELIGIBLE PRE-PAID PLAN GROUP	GROUP	36	222	257	INDICATES WHICH MONTHS THE MEDICAID ELIGIBLE WAS ENROLLED IN AN HMO OR OTHER PRE-PAID PLAN FROM JANUARY THROUGH DECEMBER. THE EXAMPLE IS FOR JANUARY. JANUARY (POSITIONS 222 TO 224) FEBRUARY (POSITIONS 225 TO 227) MARCH (POSITIONS 228 TO 230) APRIL (POSITIONS 231 TO 233) MAY (POSITIONS 234 TO 236) JUNE (POSITIONS 237 TO 239) JULY (POSITIONS 240 TO 242) AUGUST (POSITIONS 243 TO 245) SEPTEMBER (POSITIONS 246 TO 248) OCTOBER (POSITIONS 249 TO 251) NOVEMBER (POSITIONS 252 TO 254) DECEMBER (POSITIONS 255 TO 257)
26.	ELIGIBLE PRE-PAID PLAN CODE	NUM	3	222	224	CODE INDICATING WHETHER AN ELIGIBLE WAS ENROLLED IN AN HMO OR OTHER PREPAID HEALTH PLAN DURING THE MONTH. FOR THE PURPOSE OF THIS DATA ELEMENT, AN HMO OR PREPAID HEALTH PLAN (PHP) IS DEFINED AS A LICENSED PROVIDER OF MEDICAL CARE THAT DELIVERS SERVICES BASED ON PREMIUM PAYMENTS. 3 DIGITS CODES 000 = NOT ELIGIBLE FOR MEDICAID 001 = ENROLLED IN PRIMARY CARE CASE MANAGEMENT (PCCM) ONLY 010 = ENROLLED IN A PREPAID HEALTH PLAN (PHP) ONLY 011 = ENROLLED IN PCCM AND A PHP 100 = ENROLLED IN AN HMO/HEALTH INSURING ORGANIZATION (HIO) ONLY 110 = ENROLLED IN AN HMO/HIO AND PHP 777 = ENROLLED IN AN OTHER MANAGED CARE OR CAPITATION PLAN 888 = NOT ENROLLED IN AN HMO/HIO, PHP OR PCCM 999 = INVALID OR MISSING DATA *USER NOTE: CODE VALUES 011 AND 110 ARE NECESSARY BECAUSE MSIS COLLECTS INFORMATION ON SIMULTANEOUS ENROLLMENT IN AS MANY AS TO 4 PLANS BEGINNING IN 10/98. IT IS NOT NECESSARY TO DEFINE CODE VALUES FOR PERSONS ENROLLED*

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					SIMULTANEOUSLY IN HMO/HIO AND PCCM PLANS (OR HMO/HIO AND PCCM AND PHP) BECAUSE IT IS UNLIKELY THAT A PERSON WOULD BE ENROLLED SIMULTANEOUSLY IN AN HMO AND A PCCM PLAN. MSIS CODES 500 (ELIGIBLE WAS ENROLLED IN AN OTHER CAPITATION PLAN WITH COVERAGE PURCHASED BY THE STATE) AND 800 (ELIGIBLE WAS ENROLLED IN AN OTHER CAPITATION PLAN WITH COVERAGE PURCHASED BY A THIRD PARTY), REPORTED IN MSIS FROM 1/96 TO 9/97, WERE NOT USED TO CREATE THESE CODE VALUES. THIS IS BECAUSE THESE CODES WERE USED BY ONLY NINE STATES, AND IT IS NOT CLEAR WHAT TYPES OF PLANS WERE BEING REPORTED FOR THESE CODE VALUES.
					FOR THIS DATA ELEMENT, CODE MAPPINGS ARE AS FOLLOWS:
					TO FROM SMRF MSIS FY97 (10/96 THROUGH 9/97) CODE CODE (HMO-ENROLLMENT)
					000 = 000 NOT ELIGIBLE FOR MEDICAID 001 = N/A NO CODING FOR ENROLLMENT IN PCCM (1/96 THROUGH 9/97) 010 = 200 ELIGIBLE WAS ENROLLED IN A PREPAID HEALTH PLAN WITH COVERAGE PURCHASED BY THE STATE 010 = 700 ELIGIBLE WAS ENROLLED IN A PREPAID HEALTH PLAN WITH COVERAGE PURCHASED BY A THIRD PARTY 011 = N/A NO CODING FOR ENROLLMENT IN MORE THAN ONE TYPE OF PLAN (1/96 THROUGH 9/97) 100 = 100 ELIGIBLE WAS ENROLLED IN A PRIVATE HMO WITH COVERAGE PURCHASED BY THE STATE 100 = 600 ELIGIBLE WAS ENROLLED IN A PRIVATE HMO WITH COVERAGE PURCHASED BY A THIRD PARTY 110 = N/A NO CODING FOR ENROLLMENT IN MORE THAN ONE TYPE OF PLAN 777 = 500 ELIGIBLE WAS ENROLLED IN AN OTHER CAPITATION PLAN WITH COVERAGE PURCHASED BY THE STATE. 777 = 800 ELIGIBLE WAS ENROLLED IN AN OTHER CAPITATION PLAN WITH COVERAGE PURCHASED BY A THIRD PARTY 888 = 001 ELIGIBLE WAS NOT ENROLLED IN A PRIVATE HMO, PHP OR OTHER CAPITATION PLAN 999 = 999 THE STATE HAD ONLY INVALID OR MISSING INFORMATION

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					TO FROM *SMRF MSIS FY98 (10/97 THROUGH 9/98)* *CODE CODE (HMO-ENROLLMENT)* *000 = 00 NOT ELIGIBLE (DATA ELEMENT #24 SMRF UNIFORM ELIGIBILITY CODE).* *001 = 001 ELIGIBLE WAS ENROLLED IN A PCCM PLAN ONLY* *010 = 010 ELIGIBLE WAS ENROLLED IN A PREPAID HEALTH PLAN (PHP) ONLY* *011 = 011 ELIGIBLE WAS ENROLLED IN BOTH A PCCM AND A PHP* *100 = 100 ELIGIBLE WAS ENROLLED IN AN HMO/HEALTH INSURING ORGANIZATION (HIO) ONLY* *100 = 101 ELIGIBLE WAS ENROLLED IN AN HMO/HEALTH INSURING ORGANIZATION (HIO) AND A PCCM* *110 = 110 ELIGIBLE WAS ENROLLED IN AN HMO/HEALTH INSURING ORGANIZATION (HIO) AND A PHP* *110 = 111 ELIGIBLE WAS ENROLLED IN AN HMO/HEALTH INSURING ORGANIZATION (HIO) AND A PHP AND A PCCM* *777 = N/A NO CODING FOR ENROLLMENT IN OTHER CAPITATION (10/97 THROUGH 9/98)* *888 = 000 NOT ENROLLED IN ANY MANAGED CARE PLAN TYPE FOR THE MONTH* *999 = 999 THE STATE HAD ONLY INVALID OR MISSING INFORMATION* *FOR MSIS FY99 (10/98 THROUGH 12/98), PLAN-TYPE CODES CAN BE CATEGORIZED AS FOLLOWS:* *COMPREHENSIVE PLANS:* *01 = ELIGIBLE IS ENROLLED IN A MEDICAL OR COMPREHENSIVE MANAGED CARE PLAN THIS MONTH (E.G. HMO)* *06 = ELIGIBLE IS ENROLLED IN A PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)* *PREPAID HEALTH PLANS (PHPs):* *02 = ELIGIBLE IS ENROLLED IN A DENTAL MANAGED CARE PLAN THIS MONTH.* *03 = ELIGIBLE IS ENROLLED IN A BEHAVIORAL HEALTH MANAGED CARE PLAN THIS MONTH.* *04 = ELIGIBLE IS ENROLLED IN A PRENATAL/DELIVERY MANAGED CARE PLAN THIS MONTH.* *05 = ELIGIBLE IS ENROLLED IN A LONG-TERM CARE MANAGED CARE PLAN THIS MONTH.* *PRIMARY CARE CASE MANAGEMENT (PCCMs):* *07 = ELIGIBLE IS ENROLLED IN A PRIMARY CARE CASE MANAGEMENT MANAGED CARE PLAN THIS MONTH* *OTHER PLANS:* *08 = ELIGIBLE IS ENROLLED IN AN OTHER MANAGED CARE PLAN THIS MONTH*

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					GIVEN THIS CHARACTERIZATION, THE CODE MAPS, FROM FY99 MSIS (PLAN-TYPE) TO SMRF ARE AS FOLLOWS:
					000 = 00 NOT ELIGIBLE (DATA ELEMENT #24 SMRF UNIFORM ELIGIBILITY CODE).
					001 = ELIGIBLE WAS ENROLLED IN A PCCM (07), ONLY
					010 = ELIGIBLE WAS ENROLLED IN A PHP (02, 03, 04 AND/OR 05), ONLY
					010 = ELIGIBLE WAS ENROLLED IN A PHP (02, 03, 04 AND/OR 05), AND AN OTHER PLAN (08)
					011 = ELIGIBLE WAS ENROLLED IN A PHP (02, 03, 04 AND/OR 05), AND A PCCM (07)
					011 = ELIGIBLE WAS ENROLLED IN A PHP (02, 03, 04 AND/OR 05), AND A PCCM (07) AND AN OTHER PLAN (08)
					011 = ELIGIBLE WAS ENROLLED IN A PCCM (07) AND AN OTHER PLAN (08)
					100 = ELIGIBLE WAS ENROLLED IN A COMPREHENSIVE PLAN (01 AND/OR 06), ONLY
					110 = ELIGIBLE WAS ENROLLED IN A COMPREHENSIVE PLAN (01 AND/OR 06), AND A PHP (02, 03, 04 AND/OR 05)
					110 = ELIGIBLE WAS ENROLLED IN A COMPREHENSIVE PLAN (01 AND/OR 06), AND AN OTHER PLAN (08)
					110 = ELIGIBLE WAS ENROLLED IN A COMPREHENSIVE PLAN (01 AND/OR 06), AND A PNP (02, 03, 04 AND/OR 05), AND A PCCM (07)
					110 = ELIGIBLE WAS ENROLLED IN A COMPREHENSIVE PLAN (01 AND/OR 06), AND A PHP (02, 03, 04 AND/OR 05), AND AN OTHER PLAN (08)
					110 = ELIGIBLE WAS ENROLLED IN A COMPREHENSIVE PLAN (01 AND/OR 06), AND A PCCM (07) AND AN OTHER PLAN (08)
					110 = ELIGIBLE WAS ENROLLED IN A COMPREHENSIVE PLAN (01 AND/OR 06), AND A PHP (02, 03, 04 AND/OR 05), AND A PCCM (07), AND AN OTHER PLAN (08)
					777 = ELIGIBLE WAS ENROLLED IN AN OTHER PLAN (08), ONLY
					888 = 88 NOT APPLICABLE, INDIVIDUAL IS ELIGIBLE FOR MEDICAID, BUT IS NOT ENROLLED IN A MANAGED CARE PLAN THIS MONTH
					999 = 99 ELIGIBLE'S MANAGED CARE PLAN STATUS IS UNKNOWN
					NOTE THAT THE VALUE OF SMRF CODE = 000 (NOT ELIGIBLE) VALUES FOR 10/97 TO 9/98 AND 10/98 TO 12/98 ARE DETERMINED BY THE SMRF UNIFORM ELIGIBILITY CODE (DATA ELEMENT #24). THIS IS BECAUSE A STATE MAY IDENTIFY A PERSON WITH A PARTICULAR MANAGED CARE PLAN EVEN IF THAT PERSON IS NOT ENROLLED IN MEDICAID DURING THE MONTH. THIS IS SO THAT MEDICAID ENROLLS THAT PERSON IN THE CORRECT MANAGED CARE PLAN WHEN THEY ARE RE-ENROLLED IN MEDICAID.
					SOURCE: MSIS ELIGIBILITY FILES

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
***	RECIPIENT CLAIMS SUMMARY REGION	REGION	768	258	1025	SUMMARIZED UTILIZATION AND PAYMENT DATA (INCLUDING PREMIUM PAYMENTS) FOR THE RECIPIENT FOR THE CALENDAR YEAR FROM MSIS CLAIMS FILES. UNLESS OTHERWISE NOTED, THESE DATA ELEMENTS EXCLUDE ENCOUNTER RECORDS (TYPE OF CLAIM = 3) AND SERVICE TRACKING CLAIMS (TYPE OF CLAIM = 4) AND INCLUDE ALL OTHER TYPES OF CLAIMS. THIS MEANS THAT AMOUNTS FROM INDIVIDUAL CLAIMS ARE ADDED TO COUNTS EVEN IF THOSE AMOUNTS ARE ZERO (OR NEGATIVE AS MAY BE THE CASE WITH UNAPPLIED ADJUSTMENTS - TYPE OF CLAIM = 2). THE EFFECT OF THIS DECISION IS TO CAPTURE MEDICAID PAID AMOUNTS IN THE PAYMENT SUMMARIES, REGARDLESS OF WHETHER MEDICAID PAID THE FULL BILL OR WHETHER THERE WERE OTHER PAYMENTS WHICH REDUCED THE MEDICAID PAYMENT (E.G. THIRD PARTY COVERAGE, OUT-OF-POCKET AND/OR SPEND DOWN AMOUNTS, MEDICARE PART A OR PART B PAYMENTS, ETC.). AN IMPORTANT EXCEPTION OCCURS IN DATA ELEMENTS #50-53 WHICH ARE COUNTS OF ENCOUNTER RECORDS (TYPE OF CLAIM = 3).
27.	RECIPIENT INDICATOR	NUM	1	258	258	INDICATOR TO SHOW IF AND HOW THE ELIGIBLE RECEIVED A MEDICAID SERVICE DURING THE CALENDAR YEAR. 1 DIGIT CODES: 0 = NO MEDICAID PAYMENT OR SERVICE USE FOR THIS ELIGIBLE 1 = ELIGIBLE HAD ONE OR MORE MEDICAID COVERED SERVICE(S), WHERE MEDICAID PAYMENT WAS > $0 IN AT LEAST ONE OF THOSE SERVICE(S). 2 = ELIGIBLE HAD ONE OR MORE MEDICAID COVERED SERVICE(S), BUT MEDICAID PAYMENT WAS NEVER > $0 FOR ANY OF THOSE SERVICE(S). *USER NOTE: SEE DATA ELEMENT #45 IN THE "TYPE OF SERVICE TABLE GROUP" WHICH IS SIMILAR TO DATA ELEMENT #27, EXCEPT THAT DATA ELEMENT #45 IS CREATED BY TYPE OF SERVICE, FOR EACH OF THE LISTED TYPES OF SERVICES.* *SOURCE MSIS FILES CONTAIN RECORDS WITH MEDICAID PAYMENT AMOUNT = $0 IF THE SERVICE WAS COVERED, BUT FULL PAYMENT WAS MADE BY ANOTHER PAYER (E.G. THIRD PARTY LIABILITY).* SOURCE: CREATED USING MSIS CLAIMS FILES

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
**	INPATIENT HOSPITAL UTILIZATION SUMMARY	GROUP	18	259	276	INPATIENT HOSPITAL DISCHARGE, STAY, LENGTH OF STAY AND COVERED DAYS COUNTS

IN THE SMRF INPATIENT HOSPITAL FILE, INTERIM CLAIM RECORDS ARE COMBINED INTO A HOSPITAL STAY RECORD IF THEY HAVE THE SAME MSIS ELIGIBLE IDENTIFICATION NUMBER, THE SAME PROVIDER IDENTIFICATION NUMBER AND ARE FOR CONTIGUOUS OR OVERLAPPING PERIODS OF TIME. CLAIMS ARE DEFINED TO BE CONTIGUOUS IF THE ENDING DATE OF SERVICE ON A PREVIOUS CLAIM IS THE SAME DAY OR THE DAY BEFORE THE BEGINNING DATE OF SERVICE FOR THE NEXT CLAIM. HOWEVER, CONTIGUOUS CLAIMS ARE NOT COMBINED INTO THE SAME STAY IF THE "PATIENT STATUS CODE" INDICATES THAT THE PATIENT WAS DISCHARGED AND WAS ADMITTED AGAIN ON THE SAME DAY (OR THE NEXT DAY).

IT IS POSSIBLE THAT SOME PATIENTS ARE ACTUALLY DISCHARGED (AND SOMETIMES READMITTED) BUT THEIR RECORDS DO NOT INDICATE A STATUS OF DISCHARGED BECAUSE THE RECORDS ARE EITHER CODED INCORRECTLY OR SIMPLY MISSING THE STATUS OF DISCHARGED. IN THESE INSTANCES, SEPARATE CONTIGUOUS STAYS MAY BE COMBINED INCORRECTLY.

SEPARATE HOSPITAL STAY RECORDS ARE CREATED FOR SETS OF INTERIM CLAIMS FOR MOTHERS AND INFANTS WHO USE THE SAME MSIS ELIGIBLE IDENTIFICATION NUMBER, BUT HAVE SEPARATE CLAIMS. IN CONTRAST, SOME STAYS FOR THE MOTHER'S DELIVERY AND INFANT'S NEWBORN WILL BE COMBINED. THIS IS BECAUSE THE PROVIDER HAS SUBMITTED CLAIMS WHICH INCLUDE SERVICES FOR THE MOTHER AND INFANT SO THAT IT IS NOT POSSIBLE TO GENERATE SEPARATE STAY RECORDS.

THERE ARE CIRCUMSTANCES WHERE SEPARATE STAY RECORDS MAY BE CREATED FOR THE SAME HOSPITAL STAY:

(1) IF THERE ARE MULTIPLE INTERIM CLAIMS WITH THE SAME ADMISSION DATE, BUT ONE OF THE INTERIM CLAIMS DURING THE SAY IS MISSING, SEPARATE STAY RECORDS WILL BE CREATED. THIS IS BECAUSE THERE IS A GAP OF ONE OR MORE DAYS BETWEEN THE ENDING DATE OF SERVICE ON ONE RECORD AND THE BEGINNING DATE OF SERVICE ON ANOTHER.

(2) SOMETIMES, A HOSPITAL WILL SUBMIT A BILL FOR THE "CROSSOVER" PORTION OF A STAY USING THEIR MEDICARE PROVIDER IDENTIFIER AND WILL SUBMIT A SECOND BILL FOR THE "NON-CROSSOVER" PORTION OF THE SAME STAY USING THEIR MEDICAID PROVIDER IDENTIFIER. IN THIS SITUATION, SEPARATE STAY RECORDS ARE CREATED, BECAUSE THE RECORDS HAVE DIFFERENT PROVIDER IDENTIFIERS.

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					(3) IF A HOSPITAL SUBMITS SEPARATE BILLS FROM DIFFERENT COST CENTERS IN THE HOSPITAL (E.G. ANCILLARY VERSUS ACCOMMODATION SERVICES), USING DIFFERENT PROVIDER IDENTIFIERS FOR THE COST CENTERS, SEPARATE STAY RECORDS ARE CREATED. FOR ALL CLAIMS IN A COMBINED SET: (1) MEDICAID PAYMENTS AND COVERED DAYS ARE SUMMED, (2) ALL DIAGNOSIS AND PROCEDURE CODES ARE PICKED UP FROM THE INTERIM CLAIMS, AND (3) DEMOGRAPHIC INFORMATION AND THE DATE OF PAYMENT ARE TAKEN FROM THE LAST CLAIM IN THE SET. THE FILE FOR A GIVEN YEAR CONTAINS STAY RECORDS WHERE THE LAST DATE OF SERVICE IS IN THAT YEAR (EVEN IF THE STAY BEGAN IN A PREVIOUS YEAR).
28. RECIPIENT TOTAL INPATIENT DISCHARGE COUNT	NUM	3	259	261	TOTAL NUMBER OF INPATIENT HOSPITAL DISCHARGES, FOR THE CALENDAR YEAR. 3 DIGITS SIGNED U*SER NOTE: THIS DATA ELEMENT COUNTS THE NUMBER OF INPATIENT HOSPITAL (TOS = 1) STAYS WITH A DISCHARGE STATUS > 1 (ANY CODE OTHER THAN 1 = STILL A PATIENT). SINCE SOME COMPLETED STAYS MAY NOT HAVE A DISCHARGE STATUS > 1, DUE TO INCOMPLETE REPORTING, THIS COUNT MAY DIFFER FROM THE COUNT IN DATA ELEMENT #29. FOR THIS REASON AND OTHER REASONS DISCUSSED ABOVE, THIS DATA ELEMENT MAY UNDERCOUNT THE ACTUAL NUMBER OF COMPLETE HOSPITAL STAYS.* SOURCE: CREATED USING MSIS INPATIENT HOSPITAL CLAIMS (TOS = 1).
29. RECIPIENT TOTAL INPATIENT STAY COUNT	NUM	3	262	264	TOTAL NUMBER OF INPATIENT HOSPITAL STAYS, FOR THE CALENDAR YEAR. *USER NOTE: THIS DATA ELEMENT COUNTS THE NUMBER OF INPATIENT HOSPITAL (TOS = 1) STAYS, REGARDLESS OF DISCHARGE STATUS. SINCE SOME COMPLETED STAYS MAY NOT HAVE A DISCHARGE STATUS >1, DUE TO INCOMPLETE REPORTING, THIS COUNT MAY DIFFER FROM THE COUNT IN DATA ELEMENT #28. FOR REASONS DISCUSSED ABOVE, THIS DATA ELEMENT MAY OVERCOUNT THE ACTUAL NUMBER OF COMPLETE HOSPITAL STAYS.* 3 DIGITS SIGNED SOURCE: CREATED USING MSIS INPATIENT HOSPITAL CLAIMS (TOS = 1).

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
30.	RECIPIENT TOTAL INPATIENT LENGTH OF STAY (LOS), IN DAYS (FOR DISCHARGES)	NUM	3	265	267	TOTAL LENGTH OF STAY, IN DAYS, FOR INPATIENT HOSPITAL DISCHARGES, FOR THE CALENDAR YEAR. 3 DIGITS SIGNED *USER NOTE: THIS DATA ELEMENT COUNTS THE NUMBER OF DAYS FOR INPATIENT HOSPITAL (TOS = 1) STAYS WITH A DISCHARGE STATUS > 1 (ANY CODE OTHER THAN 1 = STILL A PATIENT). SINCE SOME COMPLETED STAYS MAY NOT HAVE A DISCHARGE STATUS > 1, DUE TO INCOMPLETE REPORTING, THIS COUNT MAY DIFFER FROM THE COUNT IN DATA ELEMENT #31.* SOURCE: CREATED USING THE NUMBER OF DAYS FROM FIRST DATE OF SERVICE TO THE LAST DATE OF SERVICE (+1 DAY IF THEY OCCUR ON THE SAME DAY) FROM MSIS CLAIMS FOR TOS = 1 (INPATIENT HOSPITAL). IF EITHER FIRST DATE OF SERVICE OR DATE OF DISCHARGE ARE “BAD”, LOS IS ZERO-FILLED. LOS IS CALCULATED FOR CROSSOVER CLAIMS.
31.	RECIPIENT TOTAL INPATIENT LENGTH OF STAY (LOS), IN DAYS (FOR STAYS)	NUM	3	268	270	TOTAL LENGTH OF STAY, IN DAYS, FOR INPATIENT HOSPITAL STAYS, FOR THE CALENDAR YEAR. 3 DIGITS SIGNED *USER NOTE: THIS DATA ELEMENT COUNTS THE NUMBER OF DAYS FOR INPATIENT HOSPITAL (TOS = 1) STAYS, REGARDLESS OF DISCHARGE STATUS. SINCE SOME COMPLETED STAYS MAY NOT HAVE A DISCHARGE STATUS > 1, DUE TO INCOMPLETE REPORTING, THIS COUNT MAY DIFFER FROM THE COUNT IN DATA ELEMENT #30.* SOURCE: CREATED USING THE NUMBER OF DAYS FROM FIRST DATE OF SERVICE TO THE LAST DATE OF SERVICE (+1 DAY IF THEY OCCUR ON THE SAME DAY) FROM MSIS CLAIMS FOR TOS = 1 (INPATIENT HOSPITAL). IF EITHER FIRST DATE OR LAST DATE OF SERVICE ARE “BAD”, LOS IS ZERO-FILLED. LOS IS CALCULATED FOR CROSSOVER CLAIMS.

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
32.	RECIPIENT TOTAL INPATIENT COVERED DAY COUNT (FOR DISCHARGES)	NUM	3	271	273	TOTAL MEDICAID COVERED DAYS OF CARE FOR INPATIENT HOSPITAL DISCHARGES, FOR THE CALENDAR YEAR. 3 DIGITS SIGNED *USER NOTE: THIS DATA ELEMENT COUNTS THE NUMBER OF MEDICAID COVERED INPATIENT DAYS FOR INPATIENT HOSPITAL (TOS = 1) STAYS WITH A DISCHARGE STATUS > 1 (ANY CODE OTHER THAN 1 = STILL A PATIENT). SINCE SOME COMPLETED STAYS MAY NOT HAVE A DISCHARGE STATUS > 1, DUE TO INCOMPLETE REPORTING, THIS COUNT MAY DIFFER FROM THE COUNT IN DATA ELEMENT #33.* SOURCE: CREATED USING MEDICAID COVERED INPATIENT DAYS FOR CLAIMS FROM MSIS CLAIMS FOR TOS = 1 (INPATIENT HOSPITAL SERVICES). AS THIS COUNT IS BEING AGGREGATED ACROSS CLAIMS, THERE ARE TWO DECISION RULES THAT APPLY: (1) IF AN INDIVIDUAL CLAIM IS A MEDICARE CROSSOVER CLAIM, THEN COVERED DAYS IS SET VALUE = 0, AND (2) IF AN INDIVIDUAL CLAIM IS NOT A MEDICARE CROSSOVER CLAIM AND COVERED DAYS ARE MISSING, THEN COVERED DAYS IS SET VALUE = THE NUMBER OF DAYS FROM BEGINNING TO ENDING DATE OF SERVICE (+1 DAY IF THEY OCCUR ON THE SAME DAY).
33.	RECIPIENT TOTAL INPATIENT COVERED DAY COUNT (FOR STAYS)	NUM	3	274	276	TOTAL MEDICAID COVERED DAYS OF CARE FOR INPATIENT HOSPITAL STAYS, FOR THE CALENDAR YEAR. 3 DIGITS SIGNED *USER NOTE: THIS DATA ELEMENT COUNTS THE NUMBER OF MEDICAID COVERED INPATIENT (TOS = 1) DAYS FOR INPATIENT HOSPITAL STAYS, REGARDLESS OF DISCHARGE STATUS. SINCE SOME COMPLETED STAYS MAY NOT HAVE A DISCHARGE STATUS > 1, DUE TO INCOMPLETE REPORTING, THIS COUNT MAY DIFFER FROM THE COUNT IN DATA ELEMENT #32.* SOURCE: CREATED USING MEDICAID COVERED INPATIENT DAYS FOR CLAIMS FROM MSIS CLAIMS FOR TOS = 1 (INPATIENT HOSPITAL SERVICES). AS THIS COUNT IS BEING AGGREGATED ACROSS CLAIMS, THERE ARE TWO DECISION RULES THAT APPLY: (1) IF AN INDIVIDUAL CLAIM IS A MEDICARE CROSSOVER CLAIM, THEN COVERED DAYS IS SET VALUE = 0, AND (2) IF AN INDIVIDUAL CLAIM IS NOT A MEDICARE CROSSOVER CLAIM AND COVERED DAYS IS MISSING, THEN COVERED DAYS IS SET VALUE = THE NUMBER OF DAYS FROM BEGINNING TO ENDING DATE OF SERVICE (+1 DAY IF THEY OCCUR ON THE SAME DAY).

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
**	LONG TERM CARE UTILIZATION SUMMARY	GROUP	15	277	291	DAY COUNTS FOR SELECTED TYPES OF LONG TERM CARE SERVICES.
34.	RECIPIENT LONG TERM CARE MENTAL HOSPITAL FOR THE AGED COVERED DAY COUNT	NUM	3	277	279	TOTAL NUMBER OF MEDICAID COVERED DAYS FOR THE RECIPIENT IN A MENTAL HOSPITAL FOR THE AGED (NOT A HOSPITAL) FOR THE CALENDAR YEAR. 3 DIGITS SIGNED SOURCE: CREATED USING THE NUMBER OF MEDICAID COVERED INPATIENT DAYS FROM MSIS CLAIMS FOR TOS = 2 (MENTAL HOSPITAL SERVICES FOR THE AGED). THE TOTAL IS EDITED TO BE <= 365 DAYS. AS THIS COUNT IS BEING AGGREGATED ACROSS CLAIMS, THERE IS A DECISION RULE THAT APPLIES: IF, IN AN INDIVIDUAL CLAIM, THE SUM OF COPAYMENTS AND DEDUCTIBLES IS GREATER THAN OR EQUAL TO MEDICAID PAYMENTS (E.G. IN A CROSSOVER CLAIM), THEN THESE DAYS ARE SET VALUE = 0. THIS IS BECAUSE MEDICAID WOULD BE PAYING ONLY COPAYMENT OR DEDUCTIBLE AMOUNTS, NOT FOR ACTUAL COVERED DAYS OF STAY. FOR 1995 AND EARLIER YEARS, THESE DAYS WERE NOT SET VALUE = 0 FOR CROSSOVER CLAIMS. IF THE CLAIM IS NOT A MEDICARE CROSSOVER CLAIM AND THESE DAYS ARE MISSING, THE CLAIM IS NOT EDITED. THIS IS BECAUSE IT IS NOT POSSIBLE TO DETERMINE WHETHER THE CLAIM IS FOR ACTUAL DAYS OF STAY (ROOM AND BOARD) OR ANCILLARY SERVICES (DURING THE STAY). BECAUSE OF THIS AMBIGUITY, EDITING THE CLAIM COULD INTRODUCE ERRORS AND/OR DOUBLE COUNT THESE DAYS.

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
35.	RECIPIENT LONG TERM CARE INPATIENT PSYCHIATRIC FACILITY (AGE<21) COVERED DAY COUNT	NUM	3	280	282	TOTAL NUMBER OF MEDICAID COVERED DAYS FOR THE RECIPIENT IN AN INPATIENT PSYCHIATRIC FACILITY FOR INDIVIDUALS UNDER THE AGE OF 21 (NOT A HOSPITAL) FOR THE CALENDAR YEAR. 3 DIGITS SIGNED SOURCE: CREATED USING THE NUMBER OF MEDICAID COVERED INPATIENT DAYS FROM MSIS CLAIMS FOR THE TOS = 4 (INPATIENT PSYCHIATRIC FACILITY FOR INDIVIDUALS UNDER THE AGE OF 21). THE TOTAL IS EDITED TO BE <= 365 DAYS. AS THIS COUNT IS BEING AGGREGATED ACROSS CLAIMS, THERE IS A DECISION RULE THAT APPLIES: IF, IN AN INDIVIDUAL CLAIM, THE SUM OF COPAYMENTS AND DEDUCTIBLES IS GREATER THAN OR EQUAL TO MEDICAID PAYMENTS (E.G. IN A CROSSOVER CLAIM), THEN THESE DAYS ARE SET VALUE = 0. THIS IS BECAUSE MEDICAID WOULD BE PAYING ONLY COPAYMENT OR DEDUCTIBLE AMOUNTS, NOT FOR ACTUAL COVERED DAYS OF STAY. FOR 1995 AND EARLIER YEARS, THESE DAYS WERE NOT SET VALUE = 0 FOR CROSSOVER CLAIMS. IF THE CLAIM IS NOT A MEDICARE CROSSOVER CLAIM AND THESE DAYS ARE MISSING, THE CLAIM IS NOT EDITED. THIS IS BECAUSE IT IS NOT POSSIBLE TO DETERMINE WHETHER THE CLAIM IS FOR ACTUAL DAYS OF STAY (ROOM AND BOARD) OR ANCILLARY SERVICES (DURING THE STAY). BECAUSE OF THIS AMBIGUITY, EDITING THE CLAIM COULD INTRODUCE ERRORS AND/OR DOUBLE COUNT THESE DAYS.

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
36.	RECIPIENT INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED - ICF-MR - COVERED DAY COUNT	NUM	3	283	285	TOTAL NUMBER OF MEDICAID COVERED DAYS FOR THE RECIPIENT IN AN INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED - ICF-MR - FOR THE CALENDAR YEAR. 3 DIGITS SIGNED *USER NOTE: THIS COUNT EXCLUDE LEAVE DAYS. IF MEDICAID PAYMENTS WERE WERE MADE FOR LEAVE DAYS, PAYMENTS PER DAY (USING THESE DAY COUNTS) MAY BE OVERSTATED. CONVERSELY, IF MEDICAID DID NOT PAY FOR LEAVE DAYS AND LEAVE DAYS WERE ADDED TO COVERED DAY COUNTS, PAYMENTS PER DAY MAY BE UNDERSTATED. STATES MAY PAY LOWER AMOUNTS THAN STANDARD DAY RATES OR MAY NOT PAY AT ALL FOR LEAVE DAYS. SINCE IT IS NOT POSSIBLE TO DETERMINE WHEN TO ADD (AND WHEN NOT TO ADD) LEAVE DAYS TO COVERED DAY COUNTS.* SOURCE: CREATED USING THE NUMBER OF MEDICAID NURSING FACILITY DAYS FROM MSIS CLAIMS FOR THE TOS = 5 (INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED - ICF-MR). THE TOTAL IS EDITED TO BE <= 365 DAYS. AS THIS COUNT IS BEING AGGREGATED ACROSS CLAIMS, THERE IS A DECISION RULE THAT APPLIES: IF, IN AN INDIVIDUAL CLAIM, THE SUM OF COPAYMENTS AND DEDUCTIBLES IS GREATER THAN OR EQUAL TO MEDICAID PAYMENTS (E.G. IN A CROSSOVER CLAIM), THEN THESE DAYS ARE SET VALUE = 0. THIS IS BECAUSE MEDICAID WOULD BE PAYING ONLY COPAYMENT OR DEDUCTIBLE AMOUNTS, NOT FOR ACTUAL COVERED DAYS OF STAY. FOR 1995 AND EARLIER YEARS, THESE DAYS WERE NOT SET VALUE = 0 FOR CROSSOVER CLAIMS. IF THE CLAIM IS NOT A MEDICARE CROSSOVER CLAIM AND THESE DAYS ARE MISSING, THE CLAIM IS NOT EDITED. THIS IS BECAUSE IT IS NOT POSSIBLE TO DETERMINE WHETHER THE CLAIM IS FOR ACTUAL DAYS OF STAY (ROOM AND BOARD) OR ANCILLARY SERVICES (DURING THE STAY). BECAUSE OF THIS AMBIGUITY, EDITING THE CLAIM COULD INTRODUCE ERRORS AND/OR DOUBLE COUNT THESE DAYS.

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
37. RECIPIENT NURSING FACILITY - NF - COVERED DAY COUNT	NUM	3	286	288	TOTAL NUMBER OF MEDICAID COVERED DAYS FOR THE RECIPIENT IN AN NURSING FACILITY FOR THE CALENDAR YEAR. 3 DIGITS SIGNED *USER NOTE: THIS COUNT EXCLUDE LEAVE DAYS. IF MEDICAID PAYMENTS WERE WERE MADE FOR LEAVE DAYS, PAYMENTS PER DAY (USING THESE DAY COUNTS) MAY BE OVERSTATED. CONVERSELY, IF MEDICAID DID NOT PAY FOR LEAVE DAYS AND LEAVE DAYS WERE ADDED TO COVERED DAY COUNTS, PAYMENTS PER DAY MAY BE UNDERSTATED. STATES MAY PAY LOWER AMOUNTS THAN STANDARD DAY RATES OR MAY NOT PAY AT ALL FOR LEAVE DAYS. SINCE IT IS NOT POSSIBLE TO DETERMINE WHEN TO ADD (AND WHEN NOT TO ADD) LEAVE DAYS TO COVERED DAY COUNTS.* SOURCE: CREATED USING THE NUMBER OF MEDICAID NURSING FACILITY DAYS FROM MSIS CLAIMS FOR THE TOS = 7 (NURSING FACILITY SERVICES - NFS - ALL OTHER). THE TOTAL IS EDITED TO BE <= 365 DAYS. AS THIS COUNT IS BEING AGGREGATED ACROSS CLAIMS, THERE IS A DECISION RULE THAT APPLIES: IF, IN AN INDIVIDUAL CLAIM, THE SUM OF COPAYMENTS AND DEDUCTIBLES IS GREATER THAN OR EQUAL TO MEDICAID PAYMENTS (E.G. IN A CROSSOVER CLAIM), THEN THESE DAYS ARE SET VALUE = 0. THIS IS BECAUSE MEDICAID WOULD BE PAYING ONLY COPAYMENT OR DEDUCTIBLE AMOUNTS, NOT FOR ACTUAL COVERED DAYS OF STAY. FOR 1995 AND EARLIER YEARS, THESE DAYS WERE NOT SET VALUE = 0 FOR CROSSOVER CLAIMS. IF THE CLAIM IS NOT A MEDICARE CROSSOVER CLAIM AND THESE DAYS ARE MISSING, THE CLAIM IS NOT EDITED. THIS IS BECAUSE IT IS NOT POSSIBLE TO DETERMINE WHETHER THE CLAIM IS FOR ACTUAL DAYS OF STAY (ROOM AND BOARD) OR ANCILLARY SERVICES (DURING THE STAY). BECAUSE OF THIS AMBIGUITY, EDITING THE CLAIM COULD INTRODUCE ERRORS AND/OR DOUBLE COUNT THESE DAYS.
38. RECIPIENT LONG TERM CARE COVERED DAY COUNT	NUM	3	289	291	TOTAL NUMBER OF MEDICAID COVERED DAYS FOR THE RECIPIENT IN A LONG TERM CARE FACILITY (NOT A HOSPITAL), FOR THE CALENDAR YEAR. 3 DIGITS SIGNED SOURCE: CREATED BY SUMMING THE COVERED DAY COUNTS FROM DATA ELEMENT #34 (RECIPIENT MENTAL HOSPITAL FOR THE AGED COVERED DAY COUNT), DATA ELEMENT #35 (RECIPIENT INPATIENT PSYCHIATRIC FACILITY (AGE < 21) COVERED DAY COUNT), DATA ELEMENT #36 (RECIPIENT INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED - ICF-MR - COVERED DAY COUNT) AND DATA ELEMENT #37 (RECIPIENT NURSING FACILITY - NF - COVERED DAY COUNT). THE TOTAL IS EDITED TO BE <= 365 DAYS.

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
**	CLAIMS PAYMENT SUMMARY	GROUP	29	292	320	THE DATA ELEMENTS IN THIS GROUP SUMMARIZE CLAIMS COUNTS AND PAYMENT AMOUNTS. THROUGH 1995, THESE SMRF DATA ELEMENTS INCLUDED COUNTS OF ENCOUNTER RECORDS (TYPE OF CLAIM = 3). HOWEVER, STATE MEDICAID AGENCIES OFTEN DID NOT SUBMIT ENCOUNTER RECORDS WITH OTHER MSIS DATA PRIOR TO 1999. AS NOTED ABOVE, ENCOUNTER RECORDS ARE EXCLUDED FROM BEING COUNTED IN THESE DATA ELEMENTS BEGINNING IN 1996.
39.	RECIPIENT TOTAL MEDICAID CLAIM COUNT	NUM	5	292	296	RECIPIENT'S TOTAL NUMBER OF CLAIMS FOR THE CALENDAR YEAR. 5 DIGITS SIGNED SOURCE: MSIS CLAIMS FILES.
40.	RECIPIENT TOTAL MEDICAID PAYMENT AMOUNT	NUM	8	297	304	TOTAL AMOUNT OF MONEY PAID BY MEDICAID FOR THE RECIPIENT DURING THE CALENDAR YEAR. 8 DIGITS SIGNED SOURCE: MSIS CLAIMS FILES
41.	RECIPIENT TOTAL MEDICAID CHARGE AMOUNT	NUM	8	305	312	TOTAL AMOUNT OF CHARGES BY PROVIDERS TO MEDICAID FOR THE RECIPIENT DURING THE CALENDAR YEAR. 8 DIGITS SIGNED SOURCE: MSIS CLAIMS FILES
42.	RECIPIENT TOTAL THIRD PARTY PAYMENT AMOUNT	NUM	8	313	320	TOTAL NON-MEDICAID PAYMENTS FOR SERVICES FOR THE RECIPIENT DURING THE CALENDAR YEAR. 8 DIGITS SIGNED *USER NOTE: THERE MAY BE SUBSTANTIAL VARIATION IN THE REPORTING OF THIRD PARTY LIABILITY (TPL) AMOUNTS ACROSS STATES. THIS IS BECAUSE STATES USE DIFFERENT METHODS OF COLLECTING TPL PAYMENTS. SOME STATES MAY REQUIRE PROVIDERS TO THOROUGHLY PURSUE COLLECTION OF TPL PAYMENTS BEFORE CLAIMS ARE ADJUDICATED FOR MEDICAID PAYMENT. OTHER STATES MAY DESIRE TO PAY PROVIDERS PROMPTLY AND THEN RECOVER TPL PAYMENTS FROM OTHER PAYERS. FOR THESE REASONS, THE EXTENT TO WHICH TPL COLLECTIONS ARE ACCURATELY REPORTED IN MSIS IS UNKNOWN.* SOURCE: MSIS CLAIMS FILES

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
**	RECIPIENT DELIVERY SUMMARY	GROUP	1	321	321	THE DATA ELEMENTS IN THIS GROUP PROVIDE INFORMATION ABOUT WHETHER OR NOT THE ENROLLEE HAD A DELIVERY IN THE CALENDAR YEAR.
43.	RECIPIENT DELIVERY CODE	NUM	1	321	321	CODE INDICATING WHETHER OR NOT THE ELIGIBLE HAD AT LEAST ONE INPATIENT HOSPITAL STAY IN THE YEAR WITH A MATERNAL DELIVERY CODE. 1 DIGIT CODES: 0 = NO SMRF INPATIENT STAY DURING THE YEAR WITH A MATERNAL DELIVERY CODE. 1 = AT LEAST ONE SMRF INPATIENT STAY DURING THE YEAR WITH A MATERNAL DELIVERY CODE. *USER NOTE: SOME INPATIENT HOSPITAL DELIVERY CLAIMS ARE FOR THE MOTHER ONLY AND SOME INCLUDE THE NEWBORN AS WELL. IN THE 1992-95 SMRF FILES THERE WAS ALSO A FIELD CONTAINING A SUMMARY OF THE MEDICAID AMOUNT PAID FOR ALL DELIVERY CLAIMS. THAT DATA ELEMENT HAS BEEN ELIMINATED IN THE 1996-98 SMRF FILES SINCE IT MAY MISREPRESENT DELIVERY EXPENDITURES FOR A NUMBER OF REASONS, INCLUDING:* *- BOTH THE NEWBORN AND MOTHER'S EXPENDITURES ARE INCLUDED ON COMBINED MOTHER/NEWBORN CLAIMS.* *- ONLY THE MOTHER'S EXPENDITURES ARE INCLUDED WHEN THERE ARE SEPARATE CLAIMS FOR MOTHERS AND NEWBORNS.* *- THERE ARE SOMETIMES MULTIPLE INPATIENT HOSPITAL DELIVERY CLAIMS FOR ONE DELIVERY (E.G. FALSE LABOR OR COMPLICATIONS AFTER DELIVERY) DUE TO MISCODING ON THE CLAIMS. IN THESE INSTANCES, ALL OF THESE EXPENDITURES ARE INCLUDED.* *ONLY A VERY SMALL PERCENTAGE OF DELIVERIES OCCUR IN PLACES OF SERVICE OTHER THAN THE INPATIENT HOSPITAL.* SOURCE: CREATED USING MSIS CLAIMS DATA ELEMENTS FROM THE INPATIENT HOSPITAL FILE ONLY, SINCE ONLY A SMALL PERCENTAGE OF DELIVERIES OCCUR IN OTHER PLACES OF SERVICE. DETAILED DOCUMENTATION ON THE ALGORITHM TO CREATE THIS DATA ELEMENT CAN BE FOUND IN THE "APPENDIX".

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
**	TYPE OF SERVICE DATA	GROUP	660	322	981	22 OCCURRENCES; ONE FOR EACH OF THE SMRF TYPES OF SERVICE, AS FOLLOWS:

01 = INPATIENT HOSPITAL (POSITIONS 322 TO 351)
RECIPIENT INDICATOR (POSITION 322)
RECIPIENT CLAIM COUNT (POSITIONS 323 TO 327)
RECIPIENT PAYMENT AMOUNT (POSITIONS 328 TO 335)
RECIPIENT CHARGE AMOUNT (POSITIONS 336 TO 343)
RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 344 TO 351)

02 = MENTAL HOSPITAL SERVICES FOR THE AGED (POSITIONS 352 TO 381)
RECIPIENT INDICATOR (POSITION 352)
RECIPIENT CLAIM COUNT (POSITIONS 353 TO 357)
RECIPIENT PAYMENT AMOUNT (POSITIONS 358 TO 365)
RECIPIENT CHARGE AMOUNT (POSITIONS 366 TO 373)
RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 374 TO 381)

04 = INPATIENT PSYCHIATRIC FACILITY FOR INDIVIDUALS UNDER THE AGE OF 21 (POSITIONS 382 TO 411)
RECIPIENT INDICATOR (POSITION 382)
RECIPIENT CLAIM COUNT (POSITIONS 383 TO 387)
RECIPIENT PAYMENT AMOUNT (POSITIONS 388 TO 395)
RECIPIENT CHARGE AMOUNT (POSITIONS 396 TO 403)
RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 404 TO 411)

05 = INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED (POSITIONS 412 TO 441)
RECIPIENT INDICATOR (POSITION 412)
RECIPIENT CLAIM COUNT (POSITIONS 413 TO 417)
RECIPIENT PAYMENT AMOUNT (POSITIONS 418 TO 425)
RECIPIENT CHARGE AMOUNT (POSITIONS 426 TO 433)
RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 434 TO 441)

07 = NURSING FACILITY SERVICES - ALL OTHER (POSITIONS 442 TO 471)
RECIPIENT INDICATOR (POSITION 442)
RECIPIENT CLAIM COUNT (POSITIONS 443 TO 447)
RECIPIENT PAYMENT AMOUNT (POSITIONS 448 TO 455)
RECIPIENT CHARGE AMOUNT (POSITIONS 456 TO 463)
RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 464 TO 471)

08 = PHYSICIANS (POSITIONS 472 TO 501)
RECIPIENT INDICATOR (POSITION 472)
RECIPIENT CLAIM COUNT (POSITIONS 473 TO 477)
RECIPIENT PAYMENT AMOUNT (POSITIONS 478 TO 485)
RECIPIENT CHARGE AMOUNT (POSITIONS 486 TO 493)
RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 494 TO 501)

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					09 = DENTAL (POSITIONS 502 TO 531)
					RECIPIENT INDICATOR (POSITION 502)
					RECIPIENT CLAIM COUNT (POSITIONS 503 TO 507)
					RECIPIENT PAYMENT AMOUNT (POSITIONS 508 TO 515)
					RECIPIENT CHARGE AMOUNT (POSITIONS 516 TO 523)
					RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 524 TO 531)
					10 = OTHER PRACTITIONERS (POSITIONS 532 TO 561)
					RECIPIENT INDICATOR (POSITION 532)
					RECIPIENT CLAIM COUNT (POSITIONS 533 TO 537)
					RECIPIENT PAYMENT AMOUNT (POSITIONS 538 TO 545)
					RECIPIENT CHARGE AMOUNT (POSITIONS 546 TO 553)
					RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 554 TO 561)
					11 = OUTPATIENT HOSPITAL (POSITIONS 562 TO 591)
					RECIPIENT INDICATOR (POSITION 562)
					RECIPIENT CLAIM COUNT (POSITIONS 563 TO 567)
					RECIPIENT PAYMENT AMOUNT (POSITIONS 568 TO 575)
					RECIPIENT CHARGE AMOUNT (POSITIONS 576 TO 583)
					RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 584 TO 591)
					12 = CLINIC (POSITIONS 592 TO 621)
					RECIPIENT INDICATOR (POSITION 592)
					RECIPIENT CLAIM COUNT (POSITIONS 593 TO 597)
					RECIPIENT PAYMENT AMOUNT (POSITIONS 598 TO 605)
					RECIPIENT CHARGE AMOUNT (POSITIONS 606 TO 613)
					RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 614 TO 621)
					13 = HOME HEALTH (POSITIONS 622 TO 651)
					RECIPIENT INDICATOR (POSITION 622)
					RECIPIENT CLAIM COUNT (POSITIONS 623 TO 627)
					RECIPIENT PAYMENT AMOUNT (POSITIONS 628 TO 635)
					RECIPIENT CHARGE AMOUNT (POSITIONS 636 TO 643)
					RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 644 TO 651)
					14 = FAMILY PLANNING (POSITIONS 652 TO 681)
					RECIPIENT INDICATOR (POSITION 652)
					RECIPIENT CLAIM COUNT (POSITIONS 653 TO 657)
					RECIPIENT PAYMENT AMOUNT (POSITIONS 658 TO 665)
					RECIPIENT CHARGE AMOUNT (POSITIONS 666 TO 673)
					RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 674 TO 681)

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					15 = LAB AND X-RAY (POSITIONS 682 TO 711)
					RECIPIENT INDICATOR (POSITION 682)
					RECIPIENT CLAIM COUNT (POSITIONS 683 TO 687)
					RECIPIENT PAYMENT AMOUNT (POSITIONS 688 TO 695)
					RECIPIENT CHARGE AMOUNT (POSITIONS 696 TO 703)
					RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 704 TO 711)
					16 = PRESCRIBED DRUGS (POSITIONS 712 TO 741)
					RECIPIENT INDICATOR (POSITION 712)
					RECIPIENT CLAIM COUNT (POSITIONS 713 TO 717)
					RECIPIENT PAYMENT AMOUNT (POSITIONS 718 TO 725)
					RECIPIENT CHARGE AMOUNT (POSITIONS 726 TO 733)
					RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 734 TO 741)
					17 = EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT)
					(POSITIONS 742 TO 771)
					RECIPIENT INDICATOR (POSITION 742)
					RECIPIENT CLAIM COUNT (POSITIONS 743 TO 747)
					RECIPIENT PAYMENT AMOUNT (POSITIONS 748 TO 755)
					RECIPIENT CHARGE AMOUNT (POSITIONS 756 TO 763)
					RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 764 TO 771)
					18 = RURAL HEALTH SERVICES (POSITIONS 772 TO 801)
					RECIPIENT INDICATOR (POSITION 772)
					RECIPIENT CLAIM COUNT (POSITIONS 773 TO 777)
					RECIPIENT PAYMENT AMOUNT (POSITIONS 778 TO 785)
					RECIPIENT CHARGE AMOUNT (POSITIONS 786 TO 793)
					RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 794 TO 801)
					19 = OTHER SERVICES (POSITIONS 802 TO 831)
					RECIPIENT INDICATOR (POSITION 802)
					RECIPIENT CLAIM COUNT (POSITIONS 803 TO 807)
					RECIPIENT PAYMENT AMOUNT (POSITIONS 808 TO 815)
					RECIPIENT CHARGE AMOUNT (POSITIONS 816 TO 823)
					RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 824 TO 831)
					20 = PREMIUM PAYMENT ([POSITIONS 832 TO 861)
					RECIPIENT INDICATOR (POSITION 832)
					RECIPIENT CLAIM COUNT (POSITIONS 833 TO 837)
					RECIPIENT PAYMENT AMOUNT (POSITIONS 838 TO 845)
					RECIPIENT CHARGE AMOUNT (POSITIONS 846 TO 853)
					RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 854 TO 861)

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

21 = DME AND SUPPLIES (POSITIONS 862 TO 891)
RECIPIENT INDICATOR (POSITION 862)
RECIPIENT CLAIM COUNT (POSITIONS 863 TO 867)
RECIPIENT PAYMENT AMOUNT (POSITIONS 868 TO 875)
RECIPIENT CHARGE AMOUNT (POSITIONS 876 TO 883)
RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 884 TO 891)
22 = CASE MANAGEMENT SERVICES (POSITIONS 892 TO 921)
RECIPIENT INDICATOR (POSITION 892)
RECIPIENT CLAIM COUNT (POSITIONS 893 TO 897)
RECIPIENT PAYMENT AMOUNT (POSITIONS 898 TO 905)
RECIPIENT CHARGE AMOUNT (POSITIONS 906 TO 913)
RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 914 TO 921)
23 = TRANSPORTATION (POSITIONS 922 TO 951)
RECIPIENT INDICATOR (POSITION 922)
RECIPIENT CLAIM COUNT (POSITIONS 923 TO 927)
RECIPIENT PAYMENT AMOUNT (POSITIONS 928 TO 935)
RECIPIENT CHARGE AMOUNT (POSITIONS 936 TO 943)
RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 944 TO 951)
99 = UNKNOWN (POSITIONS 952 TO 981)
RECIPIENT INDICATOR (POSITION 952)
RECIPIENT CLAIM COUNT (POSITIONS 953 TO 957)
RECIPIENT PAYMENT AMOUNT (POSITIONS 958 TO 965)
RECIPIENT CHARGE AMOUNT (POSITIONS 966 TO 973)
RECIPIENT THIRD PARTY PAYMENT AMOUNT (POSITIONS 974 TO 981)

USER NOTE: FOR TYPE OF SERVICE = 17 (EPSDT), THERE IS SUBSTANTIAL VARIATION IN REPORTING ACROSS STATES.

THE FOLLOWING TYPES OF SERVICE ARE OBSOLETE:

03 = SKILLED NURSING FACILITY / INTERMEDIATE CARE FACILITY SERVICES FOR THE AGED
06 = INTERMEDIATE CARE FACILITY - ICF - ALL OTHER

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
*	TYPE OF SERVICE TABLE GROUP	GROUP	30	322	351	DATA ELEMENTS #44-48 OCCUR 22 TIMES, ONCE FOR EACH TYPE OF SERVICE LISTED ABOVE. THE EXAMPLES ARE FOR THE FIRST TYPE OF SERVICE, TOS = 01 (INPATIENT HOSPITAL).
44.	RECIPIENT TYPE OF SERVICE INDICATOR	NUM	1	322	322	INDICATOR TO SHOW IF AND HOW THE ELIGIBLE RECEIVED A MEDICAID SERVICE DURING THE CALENDAR YEAR, FOR THIS TYPE OF SERVICE 1 DIGIT 0 = NO MEDICAID PAYMENT OR SERVICE USE FOR THIS ELIGIBLE 1 = ELIGIBLE HAD ONE OR MORE MEDICAID COVERED SERVICE(S) OF THIS TYPE, WHERE MEDICAID PAYMENT WAS > $0 IN AT LEAST ONE OF THOSE SERVICE(S). 2 = ELIGIBLE HAD ONE OR MORE MEDICAID COVERED SERVICE(S) OF THIS TYPE, BUT MEDICAID PAYMENT WAS NEVER > $0 FOR ANY OF THOSE SERVICE(S). *USER NOTE: SEE DATA ELEMENT #27 WHICH IS SIMILAR TO DATA ELEMENT #44, EXCEPT THAT DATA ELEMENT #44 IS CREATED BY TYPE OF SERVICE, FOR EACH OF THE LISTED TYPES OF SERVICES.* *SOURCE MSIS FILES CONTAIN RECORDS WITH MEDICAID PAYMENT AMOUNT = $0 IF THE SERVICE WAS COVERED, BUT FULL PAYMENT WAS MADE BY ANOTHER PAYER (E.G. THIRD PARTY LIABILITY).* SOURCE: CREATED USING MSIS CLAIMS FILES
45.	RECIPIENT TYPE OF SERVICE CLAIM COUNT	NUM	5	323	327	TOTAL NUMBER OF CLAIMS FOR THE RECIPIENT FOR A SPECIFIED TYPE OF SERVICE. 5 DIGITS SIGNED SOURCE: MSIS CLAIMS FILES
46.	RECIPIENT TYPE OF SERVICE PAYMENT AMOUNT	NUM	8	328	335	TOTAL MEDICAID PAYMENTS FOR THIS TYPE OF SERVICE FOR THE RECIPIENT DURING THE CALENDAR YEAR. 8 DIGITS SIGNED SOURCE: MSIS CLAIMS FILES

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
47.	RECIPIENT TYPE OF SERVICE CHARGE AMOUNT	NUM	8	336	343	TOTAL AMOUNT OF CHARGES UNDER THIS TYPE OF SERVICE FOR THE RECIPIENT DURING THE CALENDAR YEAR. 8 DIGITS SIGNED SOURCE: MSIS CLAIMS FILES
48.	RECIPIENT TYPE OF SERVICE THIRD PARTY PAYMENT AMOUNT	NUM	8	344	351	TOTAL NON-MEDICAID PAYMENTS FOR THIS TYPE OF SERVICE FOR THE RECIPIENT DURING THE CALENDAR YEAR. 8 DIGITS SIGNED SOURCE: MSIS CLAIMS FILES

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
**	ENCOUNTER RECORD SUMMARY	GROUP	20	982	1001	THE DATA ELEMENTS IN THIS GROUP PROVIDE COUNTS OF ENCOUNTER RECORDS (TYPE OF CLAIM = 3), BY MAJOR TYPES OF SERVICES, AND IS THE EXCEPTION NOTED ABOVE AT THE BEGINNING OF THE "RECIPIENT CLAIMS SUMMARY REGION".
49.	RECIPIENT TOTAL MEDICAID INPATIENT HOSPITAL ENCOUNTER RECORD COUNT.	NUM	5	982	986	RECIPIENT'S TOTAL NUMBER OF INPATIENT HOSPITAL ENCOUNTER RECORDS FOR THE CALENDAR YEAR. SOURCE: MSIS CLAIMS FILES.
50.	RECIPIENT TOTAL MEDICAID LONG-TERM CARE ENCOUNTER RECORD COUNT.	NUM	5	987	991	RECIPIENT'S TOTAL NUMBER OF LONG-TERM CARE ENCOUNTER RECORDS FOR THE CALENDAR YEAR. SOURCE: MSIS CLAIMS FILES
51.	RECIPIENT TOTAL MEDICAID OTHER SERVICES ENCOUNTER RECORD COUNT.	NUM	5	992	996	RECIPIENT'S TOTAL NUMBER OF OTHER SERVICES (EXCLUDING INPATIENT HOSPITAL, LONG TERM CARE AND PRESCRIPTION DRUG) ENCOUNTER RECORDS FOR THE CALENDAR YEAR. SOURCE: MSIS CLAIMS FILES
52.	RECIPIENT TOTAL MEDICAID PRESCRIPTION DRUG ENCOUNTER RECORD COUNT.	NUM	5	997	1001	RECIPIENT'S TOTAL NUMBER OF PRESCRIPTION DRUG ENCOUNTER RECORDS FOR THE CALENDAR YEAR. SOURCE: MSIS CLAIMS FILES
**	MONTHLY MAINTENANCE ASSISTANCE STATUS (MAS) GROUP	GROUP	12	1002	1013	THE ELIGIBLE'S MAINTENANCE ASSISTANCE STATUS (MAS) FROM JANUARY THROUGH DECEMBER. THE EXAMPLE IS FOR JANUARY.
53.	MAINTENANCE ASSISTANCE STATUS (MAS)	NUM	1	1002	1002	THE ELIGIBLE'S MAINTENANCE ASSISTANCE STATUS (MAS). *USER NOTE: THIS DATA ELEMENT IS INCLUDED IN THE FILE ONLY FOR INTERNAL DATA VALIDATION PURPOSES AND SHOULD NOT BE USED.*
**	MONTHLY BASIS OF ELIGIBILITY (BOE) GROUP	GROUP	12	1014	1025	THE ELIGIBLE'S BASIS OF ELIGIBILITY (BOE) FROM JANUARY THROUGH DECEMBER. THE EXAMPLE IS FOR JANUARY.
54.	BASIS OF ELIGIBILITY (BOE)	NUM	1	1014	1014	THE ELIGIBLE'S BASIS OF ELIGIBILITY (BOE). *USER NOTE: THIS DATA ELEMENT IS INCLUDED IN THE FILE ONLY FOR INTERNAL DATA VALIDATION PURPOSES AND SHOULD NOT BE USED.*