MEDS III Data Element Dictionary

Version 3.2

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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 9/20/2012 forward.
Version Number - Date: This version of the data dictionary is Version 3.2 – April 2012.
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 monthly 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. 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

Access Method	
	file is named properly. See MEVS Batch Authorization Manual 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. Contact CSC Provider Relations Staff at: MEDSSupport@csc.com

Submission

Plans are allowed to submit files on a daily basis. The list below indicates 2013 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. Pharmacy encounter data must be submitted on a weekly basis.**

2013 Data Extract Schedule:

January 24, 2013
February 21, 2013
March 21, 2013
April 25, 2013
May 23, 2013
June 20, 2013
July 25, 2013
August 22, 2013
September 26, 2013
October 24, 2013
November 21, 2013
December 26, 2013

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'
The carriage return (CR) is too short/long or misaligned	'Misaligned ASCII " ", "CR" in record " " column " " '

Tier One Error	Message Returned
	'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
Transaction Control Number (TCN)	16	26-41
Plan ID	08	42-49

Data Element	Width	Record Positions
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
19	Transportation
22	DME and Hearing Aids

Code	Value
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.state.ny.us.

Please contact us at:

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

Record Positions	Data Element - Common Detail	Format	Field Length	Submission Status	Description
97-107	Total Charged Amount	Numeric	11	Required	The total amount charged for each listed service.
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

Record Positions	Data Element - Common Detail	Format	Field Length	Submission Status	Description
					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.
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.
309-310 318-319	Neonate Birth Weight Value Code [up to 2]	Character	2	Required: COS 11	All newborn encounters will have a birth weight code of "54".
311-317 320-326	Neonate Birth Weight in Grams (Value Code Amount) [up to 2]	Numeric	7	Required: COS 11	The birth weight of the neonate in grams.
327-334 420-427 513-520 606-613 699-706 792-799 885-892 978-985 1071-1078 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.
335-338 428-431 521-524 614-617 707-710 800-803 893-896 986-989 1079-1082 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.
339-343 432-436 525-529	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
618-622 711-715 804-808 897-901 990-994 1083-1087 1176-1180					
344-345 437-438 530-531 623-624 716-717 809-810 902-903 995-996 1088-1089 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.
346-347 439-440 532-533 625-626 718-719 811-812 904-905 997-998 1090-1091 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.
348-349 441-442 534-535 627-628 720-721 813-814 906-907 999-1000	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 1185-1186					
350-351 443-444 536-537 629-630 722-723 815-816 908-909 1001-1002 1094-1095 1187-1188	Procedure Modifier Code 4 [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.
352-362 445-455 538-548 631-641 724-734 817-827 910-920 1003-1013 1096-1106 1189-1199	Quantity or Units Submitted [up to 10]	Numeric	11	Required: 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.
363-373 456-466 549-559 642-652 735-745 828-838 921-931 1014-1024 1107-1117 1200-1210	NDC (Formulary) Code [up to 10]	Character	11	Required: 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.
374-385 467-478 560-571	NDC (Formulary) Units [up to 10]	Numeric	12	Required: 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
653-664 746-757 839-850 932-943 1025-1036 1118-1129 1211-1222					
386-396 479-489 572-582 665-675 758-768 851-861 944-954 1037-1047 1130-1140 1223-1233	Charged Amount [up to 10]	Numeric	11	Required: 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.
397-407 490-500 583-593 676-686 769-779 862-872 955-965 1048-1058 1141-1151 1234-1244	Medicare Paid Amount [up to 10]	Numeric	11	Required: 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.
408-418 501-511 594-604 687-697 780-790 873-883 966-976 1059-1069	Paid Amount [up to 10]	Numeric	11	Required: 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 1245-1255					
419 512 605 698 791 884 977 1070 1163 1256	Non-Inpatient Claim/Encounter Indicator [up to 10]	Character	1	Required: 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: 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: 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 1272-1278 1279-1285 1286-1292 1293-1299 1300-1306 1307-1313 1314-1320	Other Diagnosis Codes [up to 8]	Character	7	Required: 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 1328-1334 1335-1341 1342-1348 1349-1355 1356-1362 1363-1369 1370-1376 1377-1383	Other Diagnosis Codes [9 to 24]	Character	7	Required: 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
1384-1390 1391-1397 1398-1404 1405-1411 1412-1418 1419-1425 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 1448 1449 1450 1451 1452 1453 1454 1455 1456 1457 1458 1459 1460 1461 1462 1463 1464 1465 1466 1467 1468 1469 1470	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
1471					
1472-1478	Principal Procedure Code	Character	7	Required: COS 11	The ICD-9-CM or ICD-10 procedure code identifying the principal procedure performed during an inpatient stay.
1487-1493 1502-1508 1517-1523 1532-1538 1547-1553	Other Procedure Codes [up to 5]	Character	7	Required: COS 11	ICD-9-CM or ICD-10 Procedure Codes identifying the procedures performed during an inpatient stay
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	Other Procedure Codes [6 to 24]	Character	7	Required: COS 11	ICD-9-CM or ICD-10 Procedure Codes identifying the procedures performed during an inpatient stay
1479-1486 1494-1501 1509-1516 1524-1531 1539-1546 1554-1561 1569-1576	Procedure Date [1 to 25]	Date CCYYMMDD	8	Required: 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
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					
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.
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.

Record Positions	Data Element - Institutional	Format	Field Length	Submission Status	Description
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	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.
308-310	Drug Days Supply Count	Numeric	3	Required: COS 14	Represents the number of days supply currently dispensed with this prescription service.
311-321 357-367	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

Record Positions	Data Element - Pharmacy	Format	Field Length	Submission Status	Description
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					HCPCS code) used to identify Durable Medical Equipment, Hearing Aids, OTC medications or other pharmacy products without an NDC code.
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	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
1012-1023 1058-1069 1104-1115 1150-1161 1196-1207 1242-1253 1288-1299 1334-1345 1380-1391 1426-1437					
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	Amount Charged [up to 25]	Numeric	11	Required: COS 14	The amount charged for the prescription or ingredient.
345-355 391-401 437-447	Amount Paid [up to 25]	Numeric	11	Required: COS 14	The amount paid for the prescription or ingredient.

Record Positions	Data Element - Pharmacy	Format	Field Length	Submission Status	Description
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					
356 402 448 494 540 586 632 678 724 770 816 862 908 954 1000 1046	Pharmacy Claim/Encounter Indicator [up to 25]	Character	1	Required: COS 14	“E” = Capitated encounter; “C” = Within plan claim; “A” = Administratively denied service

Record Positions	Data Element - Pharmacy	Format	Field Length	Submission Status	Description
1092 1138 1184 1230 1276 1322 1368 1414 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.
261-268 339-346 417-424 495-502 573-580 651-658 729-736 807-814 885-892 963-970	Service Start Date [up to 10]	Date CCYYMMDD	8	Required: COS 13	The date the service began.
269-276 347-354 425-432 503-510 581-588 659-666 737-744 815-822 893-900 971-978	Service End Date [up to 10]	Date CCYYMMDD	8	Required: COS 13	The date the service ended.
277-278	Place of Service/Place of Treatment	Character	2	Required:	Indicates where the dental service took place.

Record Positions	Data Element-Dental	Format	Field Length	Submission Status	Description
355-356 433-434 511-512 589-590 667-668 745-746 823-824 901-902 979-980	[up to 10]			COS 13	
279-283 357-361 435-439 513-517 591-595 669-673 747-751 825-829 903-907 981-985	Procedure Codes [up to 10]	Character	5	Required: COS 13	Procedure Codes identifying the procedures performed during the dental visit.
284-285 362-363 440-441 518-519 596-597 674-675 752-753 830-831 908-909 986-987	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	Required:	Procedure Modifier Codes are used in conjunction

Record Positions	Data Element-Dental	Format	Field Length	Submission Status	Description
364-365 442-443 520-521 598-599 676-677 754-755 832-833 910-911 988-989				COS 13	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.
288-289 366-367 444-445 522-523 600-601 678-679 756-757 834-835 912-913 990-991	Procedure Modifier Code 3 [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.
290-291 368-369 446-447 524-525 602-603 680-681 758-759 836-837 914-915 992-993	Procedure Modifier Code 4 [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.
292-293	Tooth Number or Letter [up to 10]	Character	2	Required:	The tooth that the service was performed on.

Record Positions	Data Element-Dental	Format	Field Length	Submission Status	Description
370-371 448-449 526-527 604-605 682-683 760-761 838-839 916-917 994-995				COS 13	
294-304 372-382 450-460 528-538 606-616 684-694 762-772 840-850 918-928 996-1006	Dental Number of Units/Visits [up to 10]	Numeric	11	Required: 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.
305-315 383-393 461-471 539-549 617-627 695-705 773-783 851-861 929-939 1007-1017	Charged Amount [up to 10]	Numeric	11	Required: COS 13	The Amount Charged for each listed service.
316-326	Medicare Paid Amount	Numeric	11	Required:	The amount Medicare paid for each listed service line

Record Positions	Data Element-Dental	Format	Field Length	Submission Status	Description
394-404 472-482 550-560 628-638 706-716 784-794 862-872 940-950 1018-1028				COS 13	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.
327-337 405-415 483-493 561-571 639-649 717-727 795-805 873-883 951-961 1029-1039	Paid Amount [up to 10]	Numeric	11	Required: COS 13	The amount paid by Medicaid for each listed service.
338 416 494 572 650 728 806 884 962 1040	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").
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.
262-268 269-275 276-282 283-289	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.
290-291 388-389 486-487 584-585 682-683 780-781 878-879 976-977 1074-1075 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.
292-299 390-397 488-495 586-593 684-691 782-789	Service Start Date [up to 10]	Date CCYYMMDD	8	Required: COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75	The date the service began.

880-887 978-985 1076-1083 1174-1181					
300-307 398-405 496-503 594-601 692-699 790-797 888-895 986-993 1084-1091 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.
308-312 406-410 504-508 602-606 700-704 798-802 896-900 994-998 1092-1096 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).
313-314 411-412 509-510 607-608 705-706 803-804 901-902	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.

999-1000 1097-1098 1195-1196					
315-316 413-414 511-512 609-610 707-708 805-806 903-904 1001-1002 1099-1100 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.
317-318 415-416 513-514 611-612 709-710 807-808 905-906 1003-1004 1101-1102 1199-1200	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.
319-320 417-418 515-516 613-614 711-712 809-810 907-908 1005-1006	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.

1103-1104 1201-1202					
321-331 419-429 517-527 615-625 713-723 811-821 909-919 1007-1017 1105-1115 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.
332-342 430-440 528-538 626-636 724-734 822-832 920-930 1018-1028 1116-1126 1214-1224	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.
343-353 441-451 539-549 637-647 735-745 833-843 931-941 1029-1039 1127-1137	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.

1225-1235					
354-364 452-462 550-560 648-658 746-756 844-854 942-952 1040-1050 1138-1148 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.
365-375 463-473 561-571 659-669 757-767 855-865 953-963 1051-1061 1149-1159 1247-1257	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.
376-386 474-484 572-582 670-680 768-778 866-876 964-974 1062-1072 1160-1170 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.

387 485 583 681 779 877 975 1073 1171 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)					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
Units																				
Charged Amount					R			R			R				R		R		R	R
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										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
Ordered Date																				
Date Filled										R										
Drug Days Supply Count										R										
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											

	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
Charged Amount									R											
Medicare Paid Amount									R											
Paid Amount									R											
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 NM1	08 09	66 67	MI	110
Dental	837D	2010CA	NM1	08 09	66 67	MI	137-138
Professional	837P	2010CA	NM1	08 09	66 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.state.ny.us 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 02	128 127	0B	83-84
Dental	837D	2010AA	REF	01 02	128 127	0B	84
Professional	837P	2010AA	REF	01 02	128 127	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 09	66 67	XX	77
Dental	837D	2010AA	NM1	08 09	66 67	XX	78
Professional	837P	2010AA	NM1	08 09	66 67	XX	86

Encounter Type	NCPDP Format
Pharmacy/DME	202-B2 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 a partial or complete U. S. zip 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: 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
MEDS III 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

Code	*Value*
OI	Other Insurance
SC	Sub-Capitated
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 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 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 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:

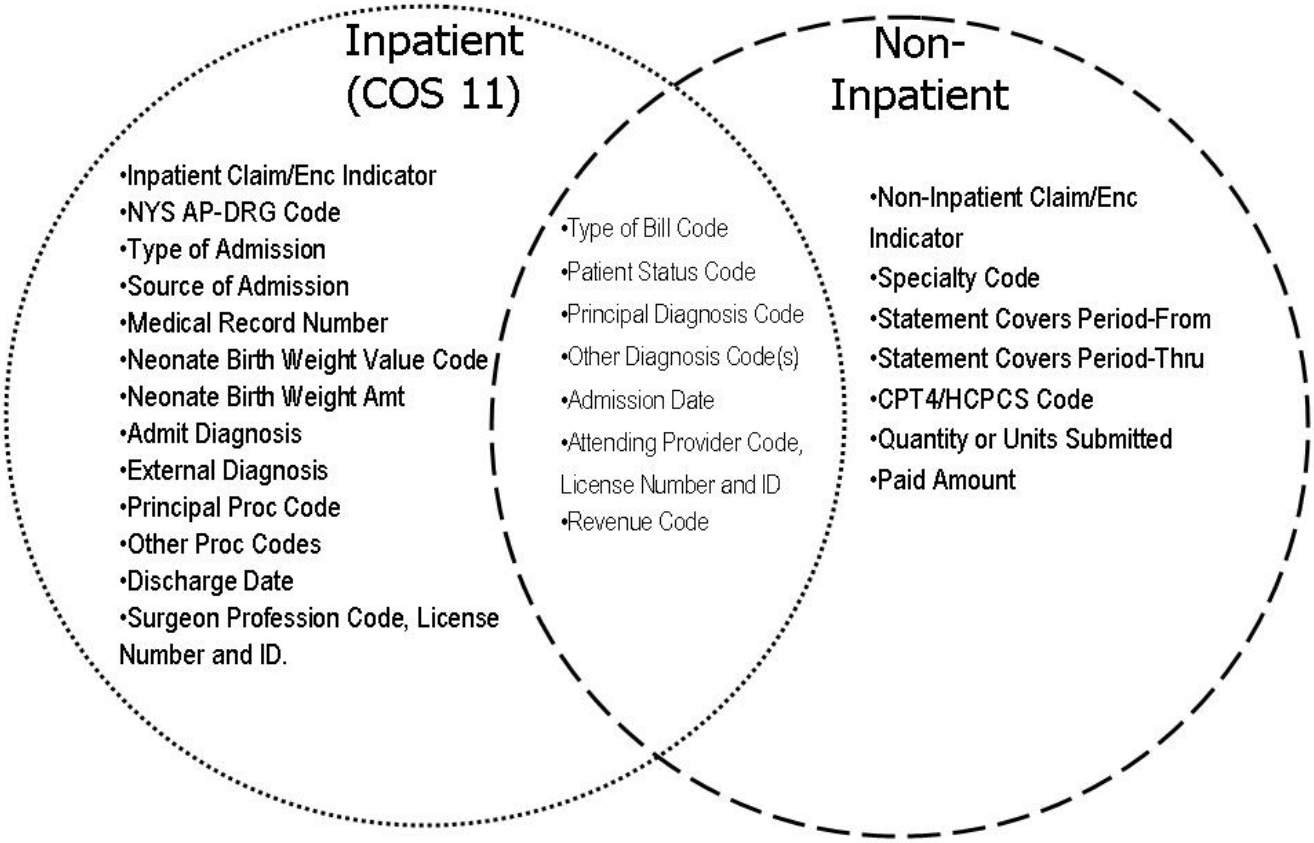
- Left-justified and space-filled

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 HI	01 01	1 2		230

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 C023-2	1331 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

Code	*Value*
27	SNF-SUBACUTE INP
28	SNF-SWING BEDS
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 02 03	374 1250 1251	434 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 02 03	374 1250 1251	434 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

Code	*Value*
42	EXPIRED - PLACE UNKNOWN
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 02	n/a	128 127	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 C0003-2	235 234	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 05		355 380	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
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 1000th (.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 C022-2	1270 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 C022-2	1270 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 C022-2	1270 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 C022-2	1270 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 C022-2	1270 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;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 C022-2	1270 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 C022-2	1270 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 C022-2	1270 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 02	128 127	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 02	128 127	0B	481 482

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 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 02 03	374 1250 1251	434 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

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 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 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 1000th (.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

MEDS III Transaction Segment: Pharmacy

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	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:

- 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

Code	*Value*
20	URGENT CARE FACILITY
21	INPATIENT HOSPITAL
22	OUTPATIENT HOSPITAL
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

Code	*Value*
74	CLINIC-ORF
75	CLINIC-CORF
76	CLINIC-COMM MH
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 02-2	235 234	HC	446 447
Dental	837D	2400	SV3	01-1 01-2	235 234		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 02	1270 1271	JP	271 272

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 05	355 380	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)	Elem-ent ID	Comp-osite	Code	Page No.
Professional	837P	2300	H1	01-04	1270 1271	C022-1 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

Code	*Value*
23	HOSPITAL EMERGENCY ROOM
24	AMBULATORY SURGICAL CENTER
25	BIRTHING CENTER
26	MILITARY TREATMENT FACILITY
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	1250	D8 & RD8	436
				03	1251		

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	1250	D8 & RD8	436
				03	1251		

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 01-2	235 234	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 04	355 380	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

Code	*Value*
058	Speech-Language Pathologist
059	Dentist, limited license (3 year)
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.

Specialty Code	Specialty Description
007	ALCH & SUB.ABUSE INPATIENT SERVICE (MC PNDS USE ONLY)
010	ALLERGY/IMMUN
011	GENERAL HOSPITAL – ART 28 (MC PNDS USE ONLY)
017	OMH PSYCH CTR – ART 31 STATE OPERATED & OASAS OPERATED ASA INPATIENT (MC PNDS USE ONLY)
018	PSYCH HOSPITAL AND PRIVATE ART 31 FOR-PROFIT NON-STATE ALCH & SUB.ABUSE (MC PNDS USE ONLY)
020	ANESTHESIOLOGY
030	COLON/RECTAL SURG
040	DERMATOLOGY
041	DERMATOPATHOLOGY
050	FAMILY PRACTICE
055	ADOL FAM MEDICINE
056	PED ADOL MEDICINE
057	PED DEVEL/BEHAV
058	PED INTERNAL MED
059	PED RHEUMATOLOGY
060	INTERNAL MED
061	PED INFECTIOUS DIS
062	CARDIOVASCULAR
063	ENDOCRIN/METAB
064	GASTROENTEROLOGY
065	HEMATOLOGY
066	INFECTIOUS DISEASE
067	NEPHROLOGY
068	PULMONARY DIS
069	RHEUMATOLOGY
070	NEURO SURG
071	SPINAL CORD INJ MED
072	PED NEUROSURGERY
073	PED DERMATOLOGY
074	MEDICAL TOXICOLOGY
075	UNDERSEA&HYPERBARIC
076	PED REHABILITATION
080	NUCLEAR MED
081	RADIOL MEDICAL NUCL
083	NEUROMUSCULAR MEDICINE (MC PNDS USE ONLY)
084	NEURORADIOLOGY (MC PNDS USE ONLY)
085	NEUROTOLOGY (MC PNDS USE ONLY)
089	OB AND GYN
092	MATERNAL AND FETAL
093	REPROD ENDOCRIN
095	DIABETES EDUCATOR
100	OPHTHALMOLOGY
101	PED OPHTHALMOLOGY
110	ORTHOPEDIC SURG
111	HAND SURG - ORTH
112	HAND SURG - PLASTIC
113	HAND SURGERY
114	HEAD/NECK SURG-PLAST
120	OTOLARYNGOLOGY
121	PED OTOLARYNGOLOGY
127	CLIA
128	CLIA
129	CLIA
130	CLIA
131	BLOOD BANKING
135	CLINICAL PATH
136	FORENSIC PATH
137	HEMATOLOGY PATH
138	CHEMICAL PATH
139	MED MICROBIOLOGY
140	MOLEC GENE SPEC PATH
141	NEUROPATHOLOGY
142	ANATOMIC PATH
143	DERMATOPATHOLOGY
144	TRANSPLANT HEPATOLOGY (MC PNDS USE ONLY)
145	PEDIATRIC TRANSPLANT

Specialty Code	Specialty Description
	HEPATOLOGY (MC PNDS USE ONLY)
146	ANATOM/CLINCL PATH
147	PEDIATRIC PATHOLOGY (MC PNDS USE ONLY)
148	RADIOISOTOPIC PATH
149	PED EMERGENCY MED
150	PEDIATRICS
151	PED CARDIOLOGY
152	PED HEMAT/ONCOL
153	PED SURGERY
154	PED NEPHROLOGY
155	NEO/PERINATAL MED
156	PED ENDOCRINOLOGY
157	PED PULMONOLOGY
160	PHYS MED/REHAB
161	PED CRITICAL CARE
162	OSTEO/CHIROPRACTIC
163	PED GASTROENTRLGY
164	CRIT CARE ANESTH
165	CRIT CARE INTERNAL
166	CRIT CARE OBSTET
167	CRIT CARE SURGERY
170	PLASTIC SURGERY
171	CLINICAL MOLECULAR GENETICS (MC PNDS USE ONLY)
180	CLINICAL BIOCHEMICAL GENETICS (MC PNDS USE ONLY)
182	PREVENTIVE MED
183	OCCUPATIONAL MED
184	PUBLIC HEALTH
186	TB DIR OBS THERAPY
187	PSY MED GENETICS
188	CLINICAL GENETICS
189	MOLECULAR GENETICS
190	PAIN MANAGEMENT-PSYC
191	CHILD PSYCHIATRY
192	PSYCHIATRY
193	CHILD NEUROLOGY
194	NEUROLOGY
195	PSYCH & NEUROLOGY
197	GERIATRIC PSYCH

Specialty Code	Specialty Description
198	ADDICTION PSYCH
199	NEURIDEV DISABILITY
200	RADIOLOGY
201	DX RADIOLOGY
202	DX NUCL RADIOLOGY
205	THERA RADIOLOGY
206	RADIOLOG PHYSICS
207	THERA RADIOLOGY
208	DX RADIOLOGY
210	GENERAL SURGERY
211	HOSPITALIST
220	THORACIC SURGERY
230	UROLOGY
231	PED UROLOGY
240	VASCULAR NEUROLOGY(MC PNDS USE ONLY)
241	MEDICAL ONCOLOGY
242	GYN ONCOLOGY
243	VASCULAR MEDICINE (MC PNDS USE ONLY)
244	RADIOLOG ONCOLOGY
245	PEDIATRIC RADIOLOGY
246	VASCUL&INTERV RADIOL
249	HIV PCP
250	EMERGENCY MED
254	SPECIALISTS PCMP
280	CHIROPRACTOR
281	CLINICAL SOCIAL WK
282	DRUG&ALC COUNSELOR
283	COUNSELOR
290	ACUPUNCTURIST
300	PHYSICAL THERAPY
301	OCCUPATIONAL THER
302	SPEECH THERAPY
303	AIDS/HIV SERVICES
304	MEDICAL REHAB
305	PED SPECIALIST
306	SCHOOL HTH PRG
307	DME SPECIALIST
308	HIV PRIMARY CARE
309	MED SUPR SUB ABUSE
310	MH ADULT CLINIC
311	MH CHILD CLINIC
312	MH CONT DAY TX

Specialty Code	Specialty Description
313	MH PARTIAL HOSP
314	MH INT PSYCH REHAB
315	MH ADULT CLINIC
316	MH CHILD CLINIC
317	MH CONT DAY TX
318	MH PARTIAL HOSP
319	MH INT PSYCH REHAB
321	COMP SPECIALTY CLN
324	PRE-SCHL SUPP HLTH
326	MH/CR ADULT
327	MH/CR CHILD
328	MH FAMILY BASED TX
329	MH/CR ADULT
330	MH/CR CHILD
331	MH TEACH FAM HOME
332	MRDD CR
350	ORAL SURGERY PPCP
351	DENTAL CLINIC PPCP
353	MH CLINIC PPCP
354	PSYCHIATRY PPCP
355	AIDS DAY HLTH/CNTR
358	TBI SERVICES
365	MENTAL HEALTH RESIDENTIAL (NON-INPAT) (MC PNDS USE ONLY)
371	CASE MGMT (MC PNDS USE ONLY)
375	MENTAL HEALTH OUTPATIENT -NON RES (MC PNDS USE ONLY)
376	MENTAL HEALTH COUNSELOR/PRACTITIONER (MC PNDS USE ONLY)
411	BACT GENERAL
412	BACT LIMITED
413	BACT AEROBES
414	BACT NEISSERIA GC
415	BACT GC SMEARS
416	BACT RESTRD DENT
419	MYCOBACT SMRS&CULT
420	MYCOBACT GENERAL
421	MYCOBACT LIMITED
422	MYCOBACT SMEARS
423	DX IMMUN COMP

Specialty Code	Specialty Description
427	DX IMMUN GENRL/LIM
430	HIV RESTRICTED A
431	HIV RESTRICTED B
432	HIV COMP
435	CELL IMMUN LIMTD 1
436	CELL IMMUN LIMTD 2
438	CELL IMMUN GENRL
439	CELL IMMUN LIMTD 3
440	VIRO GEN 1/GEN 2
441	VIRO LIMITED
442	VIRO RESTRICTED
450	MYCOLOGIST GENRL
451	MYCOLOGIST YEAST
460	PARASITOLOGY
470	URINE PREG TESTING
481	HEMA COMPREHENSIVE
482	HEMA GENERAL
483	HEMA COAG ONLY
484	HEMA LIMITED
485	HEMA OTHER
486	CYTOHEMA LIMTD/DX
491	BLOOD DX IMM HEMA
510	CHEMISTRY - GENERAL
511	CHEMISTRY - LIMITED
512	TOXI ERYTHRO FLURO
513	TOXI ERYTHRO EXTR
514	TOXI DRUG ANAL
515	TOXI BLOOD LEAD
516	ENDOCRINOLOGY
518	QUAL TOXI REHAB
521	BLOOD PH AND GASES
523	THERA SUBST MONITR
524	URINALYSIS
531	HISTOPATHOLOGY
540	CYTOPATHOLOGY
550	ONCOFETAL GENRL
551	ONCOFETAL LIMTD
552	ONCOFETAL SERA
553	ONCOFETAL AMNIO
560	GENETIC TESTING
571	CYTOGEN GENERAL
572	CYTOGEN LIMITED
573	CYTOGEN HEMA
599	ALL LABORATORIES

Specialty Code	Specialty Description
601	SPORTS FAMILY MED
602	SPORTS INTERNAL
603	PED SPORTS
604	SPORTS MED – ORTHOPEDIC (MC PNDS USE ONLY)
615	PERSONAL EMERGENCY RESPONSE SYSTEM – PERS (MC PNDS USE ONLY)
616	MENTAL HEALTH INPAT (MC PNDS USE ONLY)
620	GERIATRICS FAMILY
621	GERIATRICS INTERNAL
630	PAIN MANAGEMENT
640	AUDIOLOGIST
650	VASCULAR SURGERY
651	CARDIO THORAC SURG
652	INTERVEN CARDIOLOGY
653	CLINICAL CARDIAC ELECTROPHYSIOLOGY (MC PNDS USE ONLY)
660	INSTITUTIONAL LTC
661	SOCIAL & ENVIRON SPTS
662	SOCIAL DAY CARE
663	NUSING HOME CARE
664	ADULT DAY HLTH CARE
665	NON INSTIT LTC
666	ASSTD LIVNG PRGRM
667	HOME DELVRD MEALS
668	HOME CARE - HHA
669	HOSPICE CARE
670	AMBULANCE
671	OTH TRANSPORT
672	PERSONAL CARE – HOME HEALTH AID
673	PERSONAL CARE
674	RESPIRATORY THERAPY
675	CD Personal Asst. –Level 1
676	CD Personal Asst. –Level 2
680	NURSING
714	LOW VISION
715	OPTICIAN/CONTACT LENS PRIVELGE
716	OPTOMETRIST
730	INBORN META DIS

Specialty Code	Specialty Description
740	PERINAT TRANSPORT
741	TRANSPLANT SURGERY
749	ALCH & SUB.ABUSE GENERAL OUTPATIENT (MC PNDS USE ONLY)
750	MMTP PHYSICIAN
751	MMTP PREF PROV
754	ALCH & SUB.ABUSE MEDICALLY MONITORED WITHDRAWAL (MC PNDS USE ONLY)
760	PHARMACY
776	GENERAL PRACTICE
778	PODIATRISTS
779	NURSE PRACTIONER
780	PSYCHOLOGISTS
781	SOCIAL WORKERS
782	CERTIFIED MIDWIVE
790	RESPITE
798	LT HOME HLTH
800	GENERAL DENTIST
801	ORTHODONTURE
802	ENDODONTIST
803	ORAL PATHOLOGIST
804	PEDODONTIST
805	PROSTHODONTIST
806	PERIODONTIST
807	DENT PUBLIC HEALTH
808	ORAL SURGEON
809	DENTAL ANESTHES
810	PARENTERAL SEDATN
811	MAXILLOFACIAL SURG
815	ALL DENTISTS
851	OTHER VISION CARE
899	HOSPITAL INPATIENT
901	EMERGENCY ROOM
902	ENDOCRINE
903	DIABETES
904	OBSTETRICS
905	GYNECOLGY
906	FAMILY PLANNING
907	ABORTION
909	NUTRITION PROGRAM
910	ORAL SURGERY

Specialty Code	Specialty Description
911	GENERAL DENT CLN
912	ORTHODONTIC CLN
913	HEMODIALYSIS
914	GENERAL MED
915	ALLERGY
916	ARTHRITIS
917	RHEUMATOLOGY
918	PODIATRIST CENTER
919	EYE/VISION CNTR
920	PHYS THERAPY CLN
921	SPEECH THERAPY CLN
922	MMTP PROGRAM
923	OCCUP THERAPY CLN
924	REHAB MED CLINIC
925	HYPERTENSION
926	HEMATOLOGY CLINIC
927	CARDIOLOGY
928	CARDIOVASCULAR
929	PULMONARY
930	GASTROENTEROLOGY
931	NEUROLOGY CENTER
932	NEUROSURG CLINIC
933	CANCER DETECTION
934	ONCOLOGY - THERAPY
935	EAR NOSE THROAT
936	PED GENERAL MED
937	PED ALLERGY
938	PED NEUROLOGY
939	PED HEMATOLOGY
940	PED CARDIAC
941	PED RENAL
942	PED PULMONARY
943	PED ORTHOPEDIC
944	PED ENDOCRINE
945	PSYCHIATRY INDIVID
946	PSYCHIATRY GROUP
947	PSYCHIATRY 1/2 DAY
948	PSYCHIATRY DAY
949	ALC TX PROGRAM
950	ORTHOPEDIC
951	SURGICAL, MINOR
952	SURGICAL, GENERAL
953	UROLOGY
954	NEPHROLOGY

Specialty Code	Specialty Description
955	GENITO-URINARY
956	DERMATOLOGY CLINIC
958	OPTHALM CNTR/CLN
959	CHEM DEPEND YOUTH
960	PED DERMATOLOGY
961	PED DIABETES
962	PED SURGEON
963	CHILD PSYCHIATRY
964	PSYCHIATRY
965	TUBERCULOSIS
966	INFECTIOUS DISEASE
967	SPEECH AND HEARING
968	AMPUTEE CNTR
969	HOSP DME/ORTH/PROS
970	NH HOSPITAL DAYCARE
971	MH CLINIC TX
972	MH DAY TX
973	MH CONTINUING TX
974	MH CLINIC TX
975	MH DAY TX
976	MH CONTINUING TX
977	MR/DD CLINIC TX
979	MR/DD CLINIC TX
980	TB DIR OBS TX CLN
981	MR DIAG & RESEARCH
983	MR CLINIC
984	ALC CLINIC TX
985	ALC DAY REHAB
986	ALC CLINIC TX
987	ALC DAY REHAB
988	COMP ALC CARE
989	ALC DETOX
990	PHYS EXAM SCHOOL
991	ROUTINE VIS SCHOOL
992	COMP PSY EMERG PGM
993	AMBULATORY SURG
994	BLOOD PRODUCTS
995	GENETIC COUNSELING
996	HEARING SERVICES
997	CLINIC OPERATNG RM
998	RADIOLOGY
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
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

Code	*Value*
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
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)
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.
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.)

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.
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.
00400	Encounter Control Number Missing	If the Encounter Control Number is blank, the edit is failed.
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. **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
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.
00416	License Number Is Missing	If the Provider License Number is blank or equal to all zeros, the edit is failed.
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

Edit Number	Edit Description	Edit Logic
		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.
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.

Edit Number	Edit Description	Edit Logic
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.
00652	Discharge Date Prior To Admission Date	If Discharge Date is valid, but less than Admission Date, the edit is failed.
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	**For Professional (Not Dental, Not DME) -** If CIN, Provider Id, Date of Service, Procedure Code, Primary Diagnosis Code and Specialty Code are the same, the edit is failed. **For Dental encounters** - If CIN, Date of Service, Provider Id, Procedure Code and Tooth Number are the same, the edit is failed. **For DME encounters** - If CIN, Date of Service, Provider Id and Procedure Code are the same, the edit is failed. **For Institutional (Non-Inpatient) encounters** - If CIN, Date of Service, Provider Id, Procedure Code all Revenue Code are the same, the edit is failed. **For Inpatient encounters** - If CIN, Admit Date, and Provider Id are the same, the edit is failed. **For Pharmacy encounters** - If CIN, Date of Service, Provider Id, and NDC Code are the same, the edit is failed.
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.
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. The Encounter Type Indicator (ETI) must be equal to

Edit Number	Edit Description	Edit Logic
		"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.
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.
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.)
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.
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.

Edit Number	Edit Description	Edit Logic
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.
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.
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.
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.
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.
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. If the error is at the header level, the entire record will reject, and should be resubmitted as an original encounter. 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). 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	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	H	H	H	H	H	H	H	H
00021	Patient Status Code Invalid	N	N	N	H	H	H	N	H	N	N	N	N	N	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	S	S	S	S	S	S	S	S
00039	Primary Diagnosis Code Blank	H	H	H	H	S	S	S	S	N	N	N	N	N	N	N	N	N	N	N	N
00062	Provider Id Number Invalid	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	H	N
00070	Procedure Code Invalid	H	H	H	N	H	H	H	H	N	H	H	H	H	H	H	H	H	H	H	H
00071	Place of Service Code Invalid	N	N	N	N	N	N	N	N	N	H	H	H	H	H	H	H	H	H	S	H
00074	Recipient ID Number Invalid	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
00078	Referring Provider ID Number Invalid	H	H	H	H	H	H	H	H	H	N	N	N	N	N	N	N	N	N	N	N
00094	Number of Units Not Greater Than Zero	H	H	H	N	H	H	H	H	N	H	H	H	H	H	H	H	H	H	H	H
00103	Adjustment / Void Fields Incomplete	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H

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
00140	Recipient ID Not On File	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H
00146	Primary Diagnosis not on File	H	H	H	H	S	S	S	S	N	N	N	N	N	N	N	N	N	N	N	N
00170	Procedure Code Not On File	H	H	H	H	H	H	H	H	N	H	H	H	H	H	H	H	H	H	H	H
00175	Provider ID Not On File	N	N	N	N	N	N	N	N	N	H	H	H	H	H	H	H	H	H	H	H
00180	Units Greater than Maximum	S	S	S	N	N	N	S	N	N	S	S	S	S	S	S	S	S	N	N	S
00262	Medicare Paid, No Medicare on File	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
00400	Encounter Control Number Missing	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
00404	Provider Specialty Missing	H	H	H	N	H	H	H	H	N	H	H	H	H	H	H	H	H	H	H	H
00405	Principal Procedure Code Missing	N	N	N	S	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
00406	Diagnosis Code Missing	H	H	H	H	H	H	H	H	N	N	H	H	H	H	H	H	H	S	S	S
00408	Category of Service (COS) Missing	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F

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
00409	Inpatient MMIS Provider ID Is Not A Hospital	N	N	N	H	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
00410	DRG Code Missing	N	N	N	H	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
00412	Diagnosis Code Not On File	H	H	H	H	H	H	H	H	N	N	H	H	H	H	H	H	H	S	S	S
00413	Provider Specialty Not On File	H	H	H	N	H	H	H	H	N	H	H	H	H	H	H	H	H	H	H	H
00416	License Number Is Missing	N	N	N	N	N	N	N	N	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	F	F	F	F	F	F	F	F
00424	MMIS plan ID Not On File	F	F	F	F	F	F	F	F	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	H	H	H	H	H	H	H	H
00431	Neonate Birth Weight Code Invalid	N	N	N	H	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
00432	Attend Prov Id Not on File	H	H	H	H	H	H	H	H	N	N	N	N	N	N	N	N	N	N	N	N
00433	Oper Prov Id Not on File	N	N	N	H	N	N	N	N	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
00434	Birth Weight Not Reasonable	N	N	N	H	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
00435	Source of Admission Cd Invalid	N	N	N	H	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
00436	Type of Bill Digit 3 Invalid	H	H	H	H	H	H	H	H	N	N	N	N	N	N	N	N	N	N	N	N
00437	Claim/Encounter Ind Invalid	H	H	H	H	H	H	H	H	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	H	N	N	N	N	N	N	N	N	N	N	N
00526	M/I Prescription #	N	N	N	N	N	N	N	N	S	N	N	N	N	N	N	N	N	N	N	N
00528	M/I Quantity Dispensed	S	S	S	N	N	N	N	N	H	N	S	S	S	S	S	S	N	N	N	N
00534	Date Ordered Invalid	N	N	N	N	N	N	N	N	H	N	N	N	N	N	N	N	N	N	N	N
00540	No. of Days Supply Invalid	N	N	N	N	N	N	N	N	H	N	N	N	N	N	N	N	N	N	N	N
00544	NDC Code Non-Numeric	N	N	N	N	N	N	N	N	S	N	N	N	N	N	N	N	N	N	N	N
00548	Fill Date Prior Order Date	N	N	N	N	N	N	N	N	H	N	N	N	N	N	N	N	N	N	N	N
00530	New/Refill Code Invalid	N	N	N	N	N	N	N	N	S	N	N	N	N	N	N	N	N	N	N	N
00531	Authorized Refill Invalid	N	N	N	N	N	N	N	N	S	N	N	N	N	N	N	N	N	N	N	N
00561	Drug Code Not On File	S	H	S	N	N	N	N	N	S	N	H	S	S	S	S	S	N	N	N	H
00600	Admission Date Invalid	N	N	N	H	H	N	N	H	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
00603	Admit Type Code Invalid	N	N	N	H	S	S	N	S	N	N	N	N	N	N	N	N	N	N	N	N
00604	Admitting Diagnosis Code Missing	N	N	N	S	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
00613	Principal Proc Date Invalid	N	N	N	S	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
00625	Discharge Date Illogical	N	N	N	H	H	N	N	H	N	N	N	N	N	N	N	N	N	N	N	N
00652	Discharge Date Prior To Admit Date	N	N	N	H	H	N	N	H	N	N	N	N	N	N	N	N	N	N	N	N
00655	D/C Date Diff Than Thru Date	N	N	N	H	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
00664	Attending Physician Lic No. Missing	N	N	N	N	N	N	N	S	N	N	N	N	N	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	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	H	H	H	H	H	H	H	H
00694	Recipient Not Enrolled in Mngd Care on Date of Srvce	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H

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
00696	Recipient Enrolled in Another Mngd Care Plan on Date of Srvce	H	H	H	H	H	H	H	H	H	H	S	S	S	S	S	S	S	S	S	S
00705	Duplicate Claim In History	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H
00710	Procedure Exceeds Service Limits	S	S	S	N	N	N	N	N	S	S	S	S	S	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	H	H	H	H	H	H	H	H
00897	Prescriber Id Not on File	N	N	N	N	N	N	N	N	S	N	N	N	N	N	N	N	N	N	N	N
00901	Claim Type Unknown	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
00903	Provider Id Number Missing	H	H	H	H	H	H	H	H	H	N	N	N	N	N	N	N	N	N	N	N
00927	Modifier Invalid For Procedure Code	S	S	S	N	N	N	S	N	N	S	S	S	S	S	S	S	S	S	S	S
00931	Required Tooth For Procedure Invalid	N	N	N	N	N	N	N	N	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)

	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
01004	Thru Service Date Invalid	H	H	H	N	H	H	H	H	N	H	H	H	H	H	H	H	H	H	H	H
01006	Thru Service Prior to From Service Date	H	H	H	N	H	H	H	H	N	H	H	H	H	H	H	H	H	H	H	H
01292	Date of Service Two Years Prior to Date Received	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H
01608	Error Overflow	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H
01610	Missing or Invalid Alternate Product Code	N	N	N	N	N	N	N	N	S	N	N	N	N	N	N	N	N	N	N	N
01705	Revenue Code Not On File	H	H	H	H	H	H	H	H	N	N	N	N	N	N	N	N	N	N	N	N
01718	Type Of Bill Is Invalid	H	H	H	H	H	H	H	H	N	N	N	N	N	N	N	N	N	N	N	N
01737	Value Amount Invalid For Submitted Value Code	N	N	N	H	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
02002	Rx Serial No Missing	N	N	N	N	N	N	N	N	S	N	N	N	N	N	N	N	N	N	N	N
02022	Missing Referring NPI	S	S	S	S	S	S	S	S	S	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
02023	Missing Attending NPI	S	S	S	S	S	S	S	S	N	N	N	N	N	N	N	N	N	N	N	N
02024	Missing Operating NPI	N	N	N	S	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
02025	Missing Rendering NPI	N	N	N	N	N	N	N	N	N	S	S	S	S	S	S	S	S	S	S	S
02029	Missing Prescribing NPI	N	N	N	N	N	N	N	N	S	N	N	N	N	N	N	N	N	N	N	N
02032	Invalid Referring NPI	S	S	S	S	S	S	S	S	S	N	N	N	N	N	N	N	N	N	N	N
02033	Invalid Attending NPI	H	H	H	H	H	H	H	H	N	N	N	N	N	N	N	N	N	N	N	N
02034	Invalid Operating NPI	N	N	N	S	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
02035	Invalid Rendering NPI	N	N	N	N	N	N	N	N	N	S	S	S	S	S	S	S	S	S	S	S
02039	Invalid Prescribing NPI	N	N	N	N	N	N	N	N	S	N	N	N	N	N	N	N	N	N	N	N
02066	Drug Code Missing	S	H	S	N	N	N	N	N	N	N	H	S	S	S	S	S	N	N	N	H
02079	POA Code Mission or Invalid	N	N	N	H	N	N	N	N	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
02116	Missing Rx Origin Code	N	N	N	N	N	N	N	N	S	N	N	N	N	N	N	N	N	N	N	N
02117	Invalid Rx Origin Code	N	N	N	N	N	N	N	N	S	N	N	N	N	N	N	N	N	N	N	N
02171	NDC Occurs More than Once	N	N	N	N	N	N	N	N	S	N	N	N	N	N	N	N	N	N	N	N
02174	ICD Version Code Invalid	S	S	S	S	S	S	S	S	S	N	S	S	S	S	S	S	S	S	S	S
02210	ICD-9 Proc Date After Service Date	N	N	N	S	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
02211	ICD-9 Proc Without Date	N	N	N	S	N	N	N	N	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)

V. Response File Reconciliation

Plans will receive a transmission file confirming the acceptance or rejection of each encounte 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 f 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 fi the following day after a test file is processed. When submitting to the Production System th processing cycle pulls encounter files in daily and processes them in a weekly cycle. Therefor 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 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 fou 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 ECN of '00000000001' and a COS of '01'. The encounter passes all edits. The feedbac report will produce the following response:

000000000010000P EN0105220000015495201234567 8ABC

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.

```
000000000030000P    EN0105220000015495911234567 8ABC
000000000030000P    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.state.ny.us.

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