MEDS II
Data Element Dictionary

Version 3.1

January 2012

Prepared by:

Provider Network - MEDS Compliance Unit
Bureau of Outcomes Research
Division of Quality and Evaluation
Office of Health Insurance Programs
New York State Department of Health
Phone: 518-486-9012 Fax: 518-486-6098
Email: omcmeds@health.state.ny.us
HCS Homepage: https://commerce.health.state.ny.us/hcsportal/hcs_home.portal

MEDS II DATA ELEMENT DICTIONARY

Table of Contents

I. Introduction

This ***MEDS II 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 II). This document contains requirements by MEDS II 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 II Transaction Segment**:** The MEDS II Transaction Segment that the data element applies to: Common Detail, Institutional, Pharmacy, Dental or Professional.

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

Submission Status: Whether the data element is optional, situational upon other information (e.g., other payer data) or required for reporting. If required for reporting, the MEDS Categories of Service (COS) that the data element applies to are listed.
Encounter Record Position(s): The positions on the transaction layout where the data should be reported.
Format - Length: The format (Character, Numeric, Date) and length of the data element.
Effective Date: This version of the data dictionary is dated 2/1/2011 forward.
Version Number - Date: This version of the data dictionary is Version 3.1 – January 2012.
MEDS II 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

Under the new MEDS II reporting requirements, data submitted should be reflective of 2004 encounters that were lagged for submission and all encounters with dates of service as of January 1, 2005. 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 to less than 25,000 encounters.

Connectivity Options

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

Information requests for MEDS II data submissions should be directed to CSC Provider Relations staff at (518) 257- 4639.

In order to utilize the MEDS II 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	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

Access Method	
(TCP/IP)	the 'bin' command. Follow the FTP instructions to ensure that the 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 (518) 257-4639.

Submission

Plans are allowed to submit files on a daily basis. The list below indicates 2012 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 a minimum of a seven (7) day lag in processing.

2012 Data Extract Schedule:

January 26, 2012
February 23, 2012
March 22, 2012
April 26, 2012
May 17, 2012
June 21, 2012
July 26, 2012
August 23, 2012
September 20, 2012
October 25, 2012
November 22, 2012
December 27, 2012

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 1200 bytes	'Incomplete " ", Header Record' – will give the size and record that is not 1200 bytes
Required records missing (H1, D1, and a T1)	Required " " record missing' – will include the record type missing
Required records not in sequence (H1, D1, and a T1)	'Record " " is of unknown type or invalid sequence' – will include the record type in error
Test/Prod indicator is incorrect – must be PROD	'Specified mode " " does not match' 'Test/Prod Indicator'

Tier One Error	Message Returned
The carriage return (CR) is too short/long or misaligned	'Misaligned ASCII " ", "CR" in record " " column " " ' '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 #:'

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

Data Element	Width	Record Positions
COS Code	04	22-25
Transaction Control Number (TCN)	16	26-41
Plan ID	08	42-49
TSN	03	50-52
Filler	28	53-80

Encounter Control Number

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

Claim Line Number

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

Edit Status Code

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

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

Claim Edit Code

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

MEDS Category of Service Code

MEDS Category of Service Code categorizes provider services for the processing and reporting. The first two (2) digits will always be 'EN'. The second two-digits will be defined by the following codes and values (i.e., MEDS Category of Service Codes and Values).

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

Code	Value
14	Pharmacy
15	Home Health Care/Non-Institutional Long Term Care
16	Laboratories
19	Transportation
22	DME and Hearing Aids
28	Intermediate Care Facilities
41	NPs/Midwives
73	Hospice
75	Clinical Social Worker
85	Freestanding Clinic
87	Hospital OP/ER Room

Transaction Control Number

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

Reconciling the Response Report

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

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

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

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

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

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

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

Additional MEDS II Information and Reference Materials

MEDS Home Page on the HPN:
For up to date information on MEDS II reporting requirements and associated activities, please visit the MEDS Home Page on the Health Provider Network (HPN) intranet site at the following link: https://commerce.health.state.ny.us/hcsportal/hcs_home.portal.

CSC/eMedNY Contact Information:
Provider Services, Suite 270, 2nd Floor
phone: 1-518-257-4639 fax: 1-518-257-4637
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. An archive of discussion topics is available on the MEDS Home Page on the HPN.

Please contact us at:

Provider Network - MEDS Compliance Unit
Bureau of Outcomes Research
Division of Quality & Evaluation
Office Health Insurance Programs
New York State Department of Health
Corning Tower, Room 1938
Empire State Plaza
Albany, New York 12237

Phone: 518-486-9012
Fax: 518-486-6098
Email: omcmeds@health.state.ny.us

II. ENCOUNTER TYPE ASSIGNMENT BY CATEGORY OF SERVICE

For MEDS II 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***		
Code	***Value***	***Code***	***Value***	***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

* 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 II DATA ELEMENT REPORTING

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 “002”
Space-fill Record Positions 149 to 1200					

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.
86-87	Category of Service (COS) Code	Character	2	Required	Category of Service is a two-digit code that classifies the services in the encounter.
88-98	Medicare Total Paid Amount	Numeric	11	Required	The total amount Medicare paid for listed services that are received by dual eligible Medicaid/Medicare

Record Positions	Data Element-Common Detail	Format	Field Length	Submission Status	Description
					enrollees or beneficiaries. This is the Medicare Total Paid Amount on the Header Level.
99-109	Total Paid Amount	Numeric	11	Required	The total amount Medicaid paid for each listed service.
110-144	Other Payer Name	Character	35	Situational	Other Payer Name identifies the secondary payer on the encounter (if applicable).
145-155	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.
156-157	Other Insurance Type Code	Character	2	Situational	A code indicating insurance payers other than Medicaid (if applicable).

Institutional Segment

Record Positions	Data Element-Institutional	Format	Field Length	Submission Status	Description
158-160	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.
161	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").
162-165	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.
166-167	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.
168	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.
169-176	Statement Covers Period From	Date CCYYMMDD	8	Required: COS 06, 12, 15, 28, 73, 85, 87	The begin date of the encounter period.
177-184	Statement Covers Period Thru	Date	8	Required: COS	The end date of the encounter period.

Record Positions	Data Element-Institutional	Format	Field Length	Submission Status	Description
		CCYYMMDD		06, 12, 15, 28, 73, 85, 87	
185	Type of Admission	Character	1	Required: COS 11	One-digit alphanumeric code indicating priority of the admission.
186	Source of Admission	Character	1	Required: COS 11	One digit alphanumeric code indicating the source of the admission or outpatient registration.
187-188	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.
189-208	Medical Record Number	Character	20	Required: COS 11	The number assigned to the patient's medical/health record by the provider.
209-210 218-219	Neonate Birth Weight Value Code [up to 2]	Character	2	Required: COS 11	All newborn encounters will have a birth weight code of "54".
211-217 220-226	Neonate Birth Weight in Grams (Value Code Amount) [up to 2]	Numeric	7	Required: COS 11	The birth weight of the neonate in grams.
227-230 272-275 317-320 362-365 407-410 452-455 497-500 542-545 587-590 632-635	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.
231-235 276-280 321-325 366-370 411-415 456-460 501-505 546-550 591-595 636-640	CPT/HCPCS Code [up to 10]	Character	5	Required: COS 06, 12, 15, 28, 73, 85, 87	CPT/HCPCS code(s) describing non-inpatient procedure(s) performed.
236-237	Procedure Modifier Code	Character	2	Required: COS	Procedure Modifier Codes are used in

Record Positions	Data Element-Institutional	Format	Field Length	Submission Status	Description
281-282 326-327 371-372 416-417 461-462 506-507 551-552 596-597 641-642				06, 12, 15, 28, 73, 85, 87	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.
238-248 283-293 328-338 373-383 418-428 463-473 508-518 553-563 598-608 643-653	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.
249-259 294-304 339-349 384-394 429-439 474-484 519-529 564-574 609-619 654-664	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.
260-270 305-315 350-360 395-405 440-450 485-495 530-540 575-585	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
620-630 665-675					
271 316 361 406 451 496 541 586 631 676	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").
677-683	Principal/Primary Diagnosis Code	Character	7	Required: COS 06, 11, 12, 15, 28, 73, 85, 87	The ICD-9-CM diagnosis code that indicates the primary condition for an inpatient stay.
684-690 691-697 698-704 705-711 712-718 719-725 726-732 733-739	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 diagnosis codes, indicating additional significant condition(s) during the encounter.
740-746	Admit Diagnosis	Character	7	Required: COS 11	The diagnosis that describes the patient's condition upon admission to the hospital.
747-753	External Diagnosis Code (E Code)	Character	7	Required: COS 11	The ICD-9-CM code for the external cause of an injury, poisoning, or adverse effect.
754-760	Principal Procedure Code	Character	7	Required: COS 11	The ICD-9-CM procedure code identifying the principal procedure performed during an inpatient stay.
761-767 768-774 775-781 782-788 789-795	Other Procedure Codes [up to 5]	Character	7	Required: COS 11	ICD-9-CM Procedure Codes identifying the procedures performed during an inpatient stay
796-798	Attending Provider Profession Code	Character	3	Required: COS 06, 11, 12, 15,	The profession code issued by the state of the attending provider for inpatient encounters and

Record Positions	Data Element-Institutional	Format	Field Length	Submission Status	Description
				28, 73, 85, 87	the servicing provider for non-Inpatient encounters.
799-806	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.
807-816	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.
817-819	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.
820-827	Surgeon License Number	Character	8	Required: COS 11	The professional license number, issued by the State Department of Education that identifies the surgeon.
828-837	Surgeon Provider ID	Character	10	Required: COS 11	The NPI number of the surgeon.
838-845	Admission Date	Date CCYYMMDD	8	Required: COS 11, 12, 28	The admit date for the institutional stay.
846-853	Discharge Date	Date CCYYMMDD	8	Required: COS 11	The date of discharge from an inpatient stay at a hospital.
854-878	Present on Admission Code	Character	25	Required: COS 11	A one digit indicator for inpatient diagnoses that denotes whether or not the diagnosis was present at the time of admission.
879-885 886-892 893-899 900-906 907-913 914-920 921-927 928-934 935-941 942-948	Other Diagnosis Codes	Character	7	Required: COS 06, 11, 12, 15, 28, 73, 85, 87	Up to eight additional ICD-9-CM diagnosis codes, indicating additional significant condition(s) during the encounter.

Record Positions	Data Element-Institutional	Format	Field Length	Submission Status	Description
949-955 956-962 963-969 970-976 977-983 984-990					
991-997 998-1004 1005-1011 1012-1018 1019-1025 1026-1032 1033-1039 1040-1046 1047-1053 1054-1060 1061-1067 1068-1074 1075-1081 1082-1088 1089-1095 1096-1102 1103-1109 1110-1116 1117-1123	Other Procedure Codes	Character	7	Required: COS 11	ICD-9-CM Procedure Codes identifying the procedures performed during an inpatient stay
Space-fill Record Positions 1124 to 1200					

Pharmacy Segment

Record Positions	Data Element-Pharmacy	Format	Field Length	Submission Status	Description
158-160	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.
161-168	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.

Record Positions	Data Element-Pharmacy	Format	Field Length	Submission Status	Description
169-178	Prescribing Provider ID	Character	10	Required: COS 14	The NPI number of the prescribing provider.
179-186	Prescription Ordered Date	Date CCYYMMDD	8	Required: COS 14	The date the prescription was issued by the referring provider.
187-194	Date Filled	Date CCYYMMDD	8	Required: COS 14	The date the prescription was filled.
195-205	National Drug Code (NDC) or Product Code	Character	11	Required: COS 14	An 11-digit national drug identification number assigned by the Federal Drug Administration (or the HCPCS code) used to identify Durable Medical Equipment, Hearing Aids, OTC medications or other pharmacy products without an NDC code.
206-217	Quantity Dispensed	Numeric	12	Required: COS 14	The dispensing quantity based upon the unit of measure as defined by the National Drug Code.
218-220	Drug Days Supply Count	Numeric	3	Required: COS 14	Represents the number of days supply currently dispensed with this prescription service.
221	Pharmacy Claim/Encounter Indicator	Character	1	Required: COS 14	"E" = Capitated encounter; "C" = Within plan claim; "A" = Administratively denied service
Space-fill Record Positions 222 to 1200					

Dental Segment

Record Positions	Data Element-Dental	Format	Field Length	Submission Status	Description
158-160	Provider Specialty Code	Character	3	Required: COS 13	A provider's specialty code identifies a provider's medical, dental, clinic or program type specialty.
161 222 283 344 405 466 527 588 649 710	Dental Claim/Encounter Indicator [up to 10]	Character	1	Required: COS 13	Indicates whether the service provided was a capitated service within the health organization's contract ("E"); a within plan claim ("C") or an administratively denied service ("A").

Record Positions	Data Element-Dental	Format	Field Length	Submission Status	Description
162-163 223-224 284-285 345-346 406-407 467-468 528-529 589-590 650-651 711-712	Place of Service/Place of Treatment [up to 10]	Character	2	Required: COS 13	Indicates where the dental service took place.
164-168 225-229 286-290 347-351 408-412 469-473 530-534 591-595 652-656 713-717	Procedure Codes [up to 10]	Character	5	Required: COS 13	Procedure Codes identifying the procedures performed during the dental visit.
169-170 230-231 291-292 352-353 413-414 474-475 535-536 596-597 657-658 718-719	Procedure Code Modifier	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.
171-181 232-242 293-303 354-364 415-425 476-486 537-547	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.

Record Positions	Data Element-Dental	Format	Field Length	Submission Status	Description
598-608 659-669 720-730					
182-183 243-244 304-305 365-366 426-427 487-488 548-549 609-610 670-671 731-732	Tooth Number or Letter [up to 10]	Character	2	Required: COS 13	The tooth that the service was performed on.
184-194 245-255 306-316 367-377 428-438 489-499 550-560 611-621 672-682 733-743	Medicare Paid Amount	Numeric	11	Required: COS 13	The amount Medicare paid for each listed service line that is received by dual eligible Medicaid/Medicare enrollees or beneficiaries. A service line is identified through either CPT/HCPCS procedure codes or revenue codes. This is the Medicare Paid Amount on the service line.
195-205 256-266 317-327 378-388 439-449 500-510 561-571 622-632 683-693 744-754	Paid Amount [up to 10]	Numeric	11	Required: COS 13	The amount paid by Medicaid for each listed service.
206-213 267-274 328-335 389-396	Service Start Date [up to 10]	Date CCYYMMDD	8	Required: COS 13	The date the service began.

Record Positions	Data Element-Dental	Format	Field Length	Submission Status	Description
450-457 511-518 572-579 633-640 694-701 755-762					
214-221 275-282 336-343 397-404 458-465 519-526 580-587 641-648 702-709 763-770	Service End Date [up to 10]	Date CCYYMMDD	8	Required: COS 13	The date the service ended.
Space-fill Record Positions 771 to 1200					

Professional Segment

Record Positions	Data Element-Professional	Format	Field Length	Submission Status	Description
158-160	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.
161-167 168-174 175-181 182-188	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.
189 248 307 366 425 484	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").

Record Positions	Data Element-Professional	Format	Field Length	Submission Status	Description
543 602 661 720					
190-191 249-250 308-309 367-368 426-427 485-486 544-545 603-604 662-663 721-722	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.
192-196 251-255 310-314 369-373 428-432 487-491 546-550 605-609 664-668 723-727	Procedure Codes [up to 10]	Character	7	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).
197-198 256-257 315-316 374-375 433-434 492-493 551-552 610-611 669-670 728-729	Procedure Modifier Codes	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.
199-209 258-268 317-327	Professional Number of Units/Visits [up to 10]	Numeric	11	Required: COS 01, 03, 04, 05, 07,	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

Record Positions	Data Element-Professional	Format	Field Length	Submission Status	Description
376-386 435-445 494-504 553-563 612-622 671-681 730-740				16, 19, 22, 41, 75	rendered during an episode of care defined by Service Start and End Dates.
210-220 269-279 328-338 387-397 446-456 505-515 564-574 623-633 682-692 741-751	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.
221-231 280-290 339-349 398-408 457-467 516-526 575-585 634-644 693-703 752-762	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.
232-239 291-298 350-357 409-416 468-475 527-534 586-593 645-652 704-711 763-770	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.

Record Positions	Data Element-Professional	Format	Field Length	Submission Status	Description
240-247 299-306 358-365 417-424 476-483 535-542 594-601 653-660 712-719 771-778	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.
Space-fill Record Positions 779 to 1200					

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 1200					

IV. ENCOUNTER TYPE ASSIGNMENT BY COS: REQUIREMENTS BY MEDS II 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 Code							R	R							R		R			
Medical Record Number							R													
Neonate Birth Weight Value Code							R													
Neonate Birth Weight in Grams							R													
Revenue Code					R		R	R			R				R		R		R	R
HCPCS Code					R			R			R				R		R		R	R
Quantity or Units Submitted					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
Principal Diagnosis					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							R													
Principal							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
Procedure Code							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					
Present on Admission Code							R													
Pharmacy Transaction Segment (Encounter Type = "D")																				
Prescribing Provider Profession Code										R										
Prescribing Provider License Number										R										
Prescribing Provider ID										R										
Prescription Ordered Date										R										
Date Filled										R										
National Drug Code (NDC) or Product Code										R										
Quantity Dispensed										R										
Drug Days Supply Count										R										
Pharmacy Claim/Encounter Indicator										R										
Dental Transaction Segment (Encounter Type = "T")																				
Provider Specialty Code									R											
Dental Claim/Encounter Indicator									R											
Place of Service/Place of Treatment									R											
Procedure Codes									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
Tooth Number or Letter									R											
Paid Amount									R											
Service Start Date									R											
Service End Date									R											
Professional Transaction Segment (Encounter Type = "P")																				
Provider Specialty Code	R	R	R	R		R						R	R	R		R		R		
Diagnosis Codes	R	R	R	R		R						R		R		R		R		
Professional Claim/Encounter Indicator	R	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		
Procedure Codes	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		
Paid Amount	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		

V. HEADER RECORD

MEDS II 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 II 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 II 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 II 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 II 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 II 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 II 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 II 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 II 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 II 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 II 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 II 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 II 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 II 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 II 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 II 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 II 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 II 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 II 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 II 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 II 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 II 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 II 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 II 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 II 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 II 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 II 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 II 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 II 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 II 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 II 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 II 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 II 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 II DE# / DW#:	NA/NA

Definition: Version Number is “002”

Mapping: New York State Specific Data Element

Codes and Values: 002

Edit Applications: None

VI. COMMON DETAIL

MEDS II 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 II 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 II 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 II 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 II 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 II 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
- Can not 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 II Transaction Segment: Common Detail

Data Element Name: PREVIOUS TRANSACTION CONTROL NUMBER (TCN)

Submission Status:	Situational
Encounter Record Position(s):	15-30
Format - Length:	Character – 16
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II Transaction Segment:	**Common Detail**
Data Element Name:	**TRANSACTION STATUS CODE**
Submission Status:	Required: All COS
Encounter Record Position(s):	31
Format - Length:	Character – 1
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II 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 II 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 CIN format consists of 2 letters, followed by 5 numbers, and ending with 1 letter (e.g. XY12345Z)

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 II 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 II 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 II 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 II 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 HPN.
- Space-fill if not applicable.

Edit Applications:

- Must be a valid code

Important Note:

Plans are now receiving the profession code for every provider on their Provider Network Submission. Please contact the department's Provider Network 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 II 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 II 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 Health Provider Network Homepage on the HPN. 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 II 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 II 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)

MEDS II Transaction Segment:	**Common Detail**
Data Element Name:	**CATEGORY OF SERVICE**
Submission Status:	Required: All COS
Encounter Record Position(s):	86-87
Format - Length:	Character - 2
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II Transaction Segment:	**Common Detail**
Data Element Name:	**MEDICARE TOTAL PAID AMOUNT**
Submission Status:	Required: All COS
Encounter Record Position(s):	88-98
Format - Length:	Numeric - 11
Effective Date:	2/18/2010
Version Number - Date:	2.9 - April 2010
MEDS II 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 II Transaction Segment:	**Common Detail**
Data Element Name:	**TOTAL PAID AMOUNT**
Submission Status:	Required: All COS
Encounter Record Position(s):	99-109
Format - Length:	Numeric - 11
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II Transaction Segment:	**Common Detail**
Data Element Name:	**OTHER PAYER NAME**
Submission Status:	Situational
Encounter Record Position(s):	110-144
Format - Length:	Character - 35
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II Transaction Segment: Common Detail

Data Element Name: OTHER INSURANCE TOTAL PAID AMOUNT

Submission Status:	Situational
Encounter Record Position(s):	145-155
Format - Length:	Numeric - 11
Effective Date:	3/1/2005
Version Number – Date:	2.6 - July 2008
MEDS II 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 II Transaction Segment:	**Common Detail**
Data Element Name:	**OTHER INSURANCE TYPE CODE**
Submission Status:	Situational
Encounter Record Position(s):	156-157
Format - Length:	Character - 2
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 Admininistration Plan
WC	Workers Compensation Health Plan
ZZ	Mutually Defined

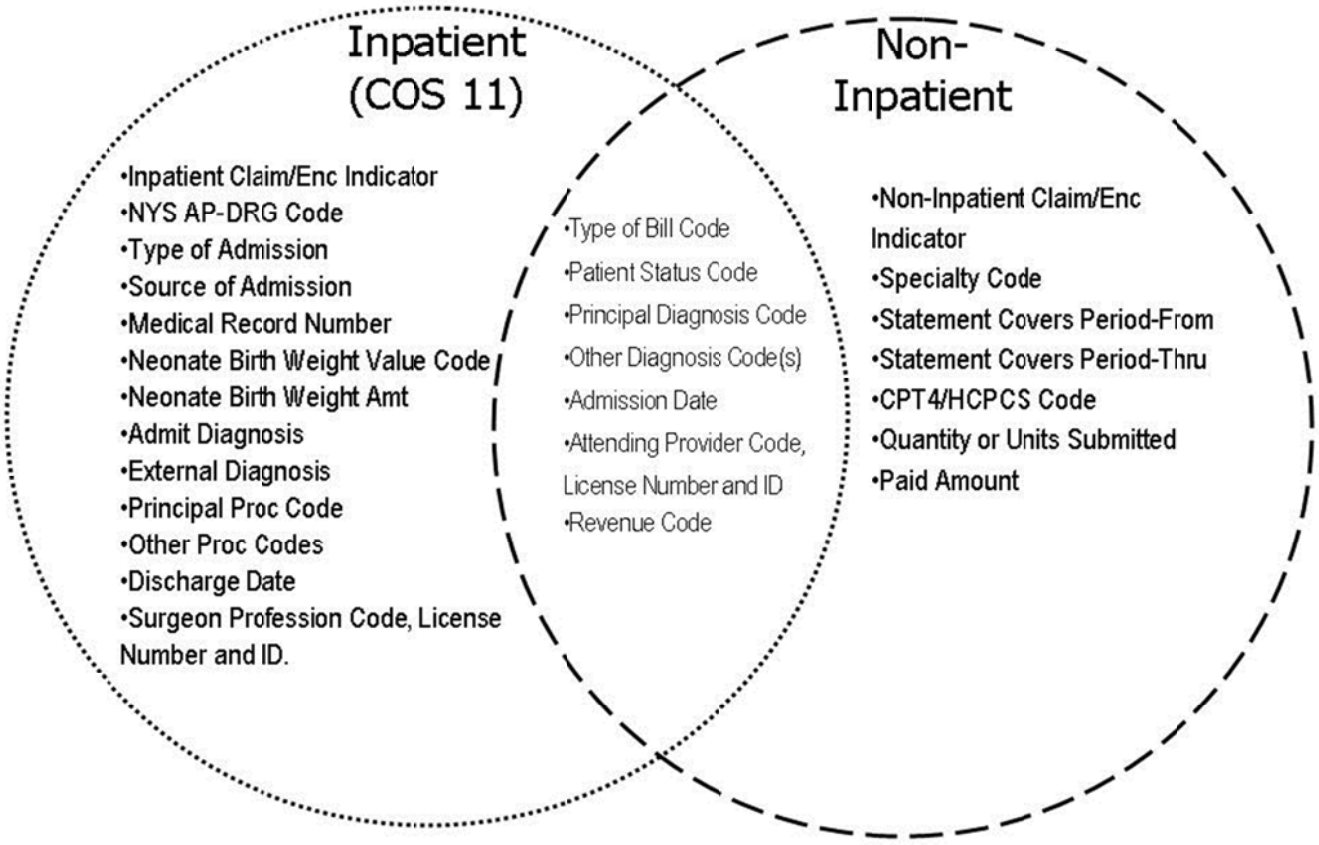
- Space-fill if not applicable.

Edit Applications:

- Must be a valid code

VII. INSTITUTIONAL

Inpatient and Non-Inpatient Reporting Requirements
By Data Element



There are two components to the Institutional segment of MEDS II 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 II 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):	158-160
Format - Length:	Character - 3
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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. These codes and values are available for download on the MEDS Home Page on the HPN.
- 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 II Transaction Segment: **Institutional**
Data Element Name: **HOSPITAL INPATIENT CLAIM/ENCOUNTER INDICATOR**

Submission Status: Required for COS 11
Encounter Record Position(s): 161
Format - Length: Character - 1
Effective Date: 3/1/2005
Version Number - Date: 2.6 - July 2008
MEDS II 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 II Transaction Segment:	**Institutional**
Data Element Name:	**NYS DIAGNOSIS RELATED GROUP CODE**
Submission Status:	Required for COS 11
Encounter Record Position(s):	162-165
Format - Length:	Character – 4
Effective Date:	12/01/2009
Version Number - Date:	2.6 - July 2008
MEDS II 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 II 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):	166-167
Format - Length:	Character - 2
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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
27	SNF-SUBACUTE INP

Code	*Value*
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

For more information refer to the Code Structure described on the UB-92 for Element #4 or in the 837I on pg. 159.

Edit Applications:

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

MEDS II 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):	168
Format - Length:	Character – 1
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II Transaction Segment:	**Institutional**
Data Element Name:	**STATEMENT COVERS PERIOD FROM**
Submission Status:	Required for COS 06, 11, 12, 15, 28, 73, 85, 87
Encounter Record Position(s):	169-176
Format - Length:	Date – CCYYMMDD
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II Transaction Segment:	**Institutional**
Data Element Name:	**STATEMENT COVERS PERIOD THRU**
Submission Status:	Required for COS 06, 11, 12, 15, 28, 73, 85, 87
Encounter Record Position(s):	177-184
Format - Length:	Date - CCYYMMDD
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II Transaction Segment:	**Institutional**
Data Element Name:	**TYPE OF ADMISSION**
Submission Status:	Required for COS 11
Encounter Record Position(s):	185
Format - Length:	Character - 1
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II Transaction Segment:	**Institutional**
Data Element Name:	**SOURCE OF ADMISSION**
Submission Status:	Required for COS 11
Encounter Record Position(s):	186
Format - Length:	Character - 1
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II Transaction Segment:	**Institutional**
Data Element Name:	**PATIENT STATUS OR DISPOSITION CODE**
Submission Status:	Required for COS 11, 12, 28, 73
Encounter Record Position(s):	187-188
Format - Length:	Character - 2
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II Transaction Segment:	**Institutional**
Data Element Name:	**MEDICAL RECORD NUMBER**
Submission Status:	Required for COS 11
Encounter Record Position(s):	189-208
Format - Length:	Character – 20
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II Transaction Segment:	**Institutional**
Data Element Name:	**NEONATE BIRTH WEIGHT CODE [up to 2]**
Submission Status:	Required for COS 11
Encounter Record Position(s):	209-210; 218-219
Format - Length:	Character – 2
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II DE# / DW#:	1093/3321

Definition: The MEDS II layout allows for up to two Value Codes and up to two Value Code Amounts. At this time, only neonatal birthweight 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 II Transaction Segment: Institutional

Data Element Name: NEONATE BIRTH WEIGHT IN GRAMS [up to 2]

Submission Status:	Required for COS 11
Encounter Record Position(s):	211-217; 220-226
Format - Length:	Numeric – 7
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II 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):	227-230; 272-275; 317-320; 362-365; 407-410; 452-455; 497-500; 542-545; 587-590; 632-635
Format - Length:	Character - 4
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II 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):	231-235; 276-280; 321-325; 366-370; 411-415; 456-460; 501-505; 546-550; 591-595; 636-640
Format - Length:	Character - 5
Effective Date:	1/1/2009
Version Number - Date:	2.8 - January 2009
MEDS II 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 II Transaction Segment:	**Institutional**
Data Element Name:	**PROCEDURE MODIFIER CODE [UP TO 10]**
Submission Status:	Required for COS 06, 12, 15, 28, 73, 85, 87
Encounter Record Position(s):	236-237; 281-282; 326-327; 371-372; 416-417; 461-462; 506-507; 551-552; 596-597; 641-642
Format - Length:	Character - 2
Effective Date:	1/1/2009
Version Number - Date:	2.8 - January 2009
MEDS II 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	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).
- Not applicable for inpatient encounters.

Edit Applications:

- 00927 Modifier Invalid For Procedure Code

MEDS II 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):	238-248; 283-293; 328-338; 373-383; 418-428; 463-473; 508-518; 553-563; 598-608; 643-653
Format - Length:	Numeric – 11
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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. (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 II 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):	249-259; 294-304; 339-349; 384-394; 429-439; 474-484; 519-529; 564-574; 609-619; 654-664
Format - Length:	Numeric - 11
Effective Date:	2/18/2010
Version Number - Date:	2.9 – April 2010
MEDS II 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 II Transaction Segment:	**Institutional**
Data Element Name:	**PAID AMOUNT**
Submission Status:	Required for COS 06, 12, 15, 28, 73, 85, 87
Encounter Record Position(s):	260-270; 305-315; 350-360; 395-405; 440-450; 485-495; 530-540; 575-585; 620-630; 665-675
Format - Length:	Numeric - 11
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II 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):	271; 316; 361; 406; 451; 496; 541; 586; 631; 676
Format - Length:	Character - 1
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II 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):	677-683
Format - Length:	Character - 7
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II DE# / DW#:	4183/3006

Definition: The ICD-9-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 code is unique.
- Record the appropriate ICD-9-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 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 II Transaction Segment:	**Institutional**
Data Element Name:	**OTHER DIAGNOSIS CODES [UP TO 24]**
Submission Status:	Required for COS 06, 11, 12, 15, 28, 73, 85, 87
Encounter Record Position(s):	684-690; 691-697; 698-704; 705-711; 712-718; 719-725; 726-732; 733-739; 879-885; 886-892; 893-899; 900-906; 907-913; 914-920; 921-927; 928-934; 935-941; 942-948; 949-955; 956-962; 963-969; 970-976; 977-983; 984-990
Format - Length:	Character - 7
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 coding reference, excluding the decimal point, and Space-filled. The decimal point is implied because each ICD-9-CM code is unique.
- Record the appropriate ICD-9-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 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 II Transaction Segment:	**Institutional**
Data Element Name:	**ADMIT DIAGNOSIS**
Submission Status:	Required for COS 11
Encounter Record Position(s):	740-746
Format - Length:	Character - 7
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 coding reference, excluding the decimal point, and Space-filled.
- Must have been a valid ICD-9-CM code excluding the decimal point. To be valid, ICD-9-CM codes must have been entered at the most specific level to which they are classified in the ICD-9-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 II Transaction Segment:	**Institutional**
Data Element Name:	**EXTERNAL DIAGNOSIS CODE (E Code)**
Submission Status:	Required for COS 11
Encounter Record Position(s):	747-753
Format - Length:	Character - 7
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 "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 II Transaction Segment: **Institutional**

Data Element Name:	**PRINCIPAL PROCEDURE CODE**
Submission Status:	Required for COS 11
Encounter Record Position(s):	754-760
Format - Length:	Character - 7
Effective Date:	3/1/2005
Version Number - Date:	1.2 - May 96
MEDS II DE# / DW#:	0606/5055

Definition: The ICD-9-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 II Transaction Segment:	**Institutional**
Data Element Name:	**OTHER PROCEDURE CODES [UP TO 24]**
Submission Status:	Required for COS 11
Encounter Record Position(s):	761-767; 768-774; 775-781; 782-788; 789-795 991-997; 998-1004; 1005-1011; 1012-1018; 1019-1025; 1026-1032; 1033-1039; 1040-1046; 1047-1053 1054-1060;1061-1067; 1068-1074; 1075-1081; 1082-1088;1089-1095; 1096-1102; 1103-1109; 1110-1116;1117-1123
Format - Length:	Character - 7
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 coding reference, excluding decimal points.
- If this field is not applicable it must be Space-filled.

Edit Applications:

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

MEDS II 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):	796-798
Format - Length:	Character - 3
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II 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):	799-806
Format - Length:	Character – 8
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II 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):	807-816
Format - Length:	Character – 10
Effective Date:	9/1/2008
Version Number - Date:	2.7 - August 2008
MEDS II DE# / DW#:	1563/W039

Definition: The National Provider Identification 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 II Transaction Segment:	**Institutional**
Data Element Name:	**SURGEON PROFESSION CODE**
Submission Status:	Required for COS 11
Encounter Record Position(s):	817-819
Format - Length:	Character - 3
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II Transaction Segment: **Institutional**
Data Element Name: **SURGEON LICENSE NUMBER**
Submission Status: Required for COS 11
Encounter Record Position(s): 820-827
Format - Length: Character - 8
Effective Date: 3/1/2005
Version Number - Date: 2.6 - July 2008
MEDS II 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 II Transaction Segment:	**Institutional**
Data Element Name:	**SURGEON IDENTIFICATION NUMBER**
Submission Status:	Required for COS 11
Encounter Record Position(s):	828-837
Format - Length:	Character - 10
Effective Date:	9/1/2008
Version Number - Date:	2.7 - August 2008
MEDS II DE# / DW#:	1563/W042

Definition: The National Provider Identification 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 II Transaction Segment:	**Institutional**
Data Element Name:	**ADMISSION DATE**
Submission Status:	Required for COS 11, 12, 28
Encounter Record Position(s):	838-845
Format - Length:	Date – CCYYMMDD
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II Transaction Segment:	**Institutional**
Data Element Name:	**DISCHARGE DATE**
Submission Status:	Required for COS 11, 12, 28
Encounter Record Position(s):	846-853
Format - Length:	Date - CCYYMMDD
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II Transaction Segment:	**Institutional**
Data Element Name:	**PRESENT ON ADMISSION (POA)**
Submission Status:	Required for COS 11
Encounter Record Position(s):	854-878
Format - Length:	Char- 25
Effective Date:	7/17/2008
Version Number - Date:	2.6 - July 2008
MEDS II 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

VIII. PHARMACY SEGMENT

MEDS II Transaction Segment: Pharmacy

Data Element Name: PRESCRIBING PROVIDER PROFESSION CODE

Submission Status:	Required for COS 14
Encounter Record Position(s):	158-160
Format - Length:	Character - 3
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II Transaction Segment: **Pharmacy**

Data Element Name: **PRESCRIBING PROVIDER LICENSE NUMBER**

Submission Status:	Required for COS 14
Encounter Record Position(s):	161-168
Format - Length:	Character - 8
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II Transaction Segment: Pharmacy
Data Element Name: PRESCRIBING PROVIDER IDENTIFICATION NUMBER

Submission Status:	Required for COS 14
Encounter Record Position(s):	169-178
Format - Length:	Character - 10
Effective Date:	9/1/2008
Version Number - Date:	2.7 - August 2008
MEDS II 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 II Transaction Segment:	**Pharmacy**
Data Element Name:	**PRESCRIPTION ORDERED DATE**
Submission Status:	Required for COS 14
Encounter Record Position(s):	179-186
Format - Length:	Date – CCYYMMDD
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II Transaction Segment:	**Pharmacy**
Data Element Name:	**DATE FILLED**
Submission Status:	Required for COS 14
Encounter Record Position(s):	187-194
Format - Length:	Date – CCYYMMDD
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II Transaction Segment: Pharmacy

Data Element Name: NATIONAL DRUG CODE (NDC) / PRODUCT CODE

Submission Status:	Required for COS 14
Encounter Record Position(s):	195-205
Format - Length:	Character - 11
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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

MEDS II Transaction Segment:	**Pharmacy**
Data Element Name:	**QUANTITY DISPENSED**
Submission Status:	Required for COS 14
Encounter Record Position(s):	206-217
Format - Length:	Numeric – 12
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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
- The actual metric decimal quantity administered based on the NDC unit of measurement
- Must be a positive numeric value

Edit Applications:

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

Examples:
2.755 units = 000000002755
4.5 units = 000000004500
30 units = 000000030000
750 units = 000000750000

MEDS II Transaction Segment:	**Pharmacy**
Data Element Name:	**DRUG DAYS SUPPLY COUNT**
Submission Status:	Required for COS 14
Encounter Record Position(s):	218-220
Format - Length:	Numeric - 3
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II Transaction Segment: Pharmacy

Data Element Name: PHARMACY CLAIM/ENCOUNTER INDICATOR

Submission Status:	Required for COS 14
Encounter Record Position(s):	221
Format - Length:	Character - 1
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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

IX. DENTAL SEGMENT

MEDS II Transaction Segment:	**Dental**
Data Element Name:	**PROVIDER SPECIALTY CODE**
Submission Status:	Required for COS 13
Encounter Record Position(s):	158-160
Format - Length:	Character - 3
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II Transaction Segment:	**Dental**
Data Element Name:	**DENTAL CLAIM/ENCOUNTER INDICATOR**
Submission Status:	Required for COS 13
Encounter Record Position(s):	161; 222; 283; 344; 405; 466; 527; 588; 649; 710
Format - Length:	Character - 1
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II Transaction Segment: Dental

Data Element Name: PLACE OF SERVICE/PLACE OF TREATMENT

Submission Status:	Required for COS 13
Encounter Record Position(s):	162-163; 223-224; 284-285; 345-346; 406-407; 467-468; 528-529; 589-590; 650-651; 711-712
Format - Length:	Character - 2
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II DE# / DW#:	4178/3016

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

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Dental	ADA	#38

- **Electronic**:

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

Codes and Values:

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

Code	*Value*
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
74	CLINIC-ORF
75	CLINIC-CORF

Code	*Value*
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 II Transaction Segment:	**Dental**
Data Element Name:	**PROCEDURE CODE [UP TO 10]**
Submission Status:	Required for COS 13
Encounter Record Position(s):	164-168; 225-229; 286-290; 347-351; 408-412; 469-473; 530-534; 591-595; 652-656; 713-717
Format - Length:	Character - 5
Effective Date:	1/1/2009
Version Number - Date:	2.8 - January 2009
MEDS II 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 II Transaction Segment:	**Dental**
Data Element Name:	**PROCEDURE MODIFIER CODE [UP TO 10]**
Submission Status:	Required for COS 13,
Encounter Record Position(s):	169-170; 230-231; 291-292; 352-353; 413-414; 474-475; 535-536; 596-597; 657-658; 718-719
Format - Length:	Character - 2
Effective Date:	1/1/2009
Version Number - Date:	2.8 - January 2009
MEDS II 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:

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 II Transaction Segment:	**Dental**
Data Element Name:	**DENTAL NUMBER OF UNITS/VISITS**
Submission Status:	Required for COS 13
Encounter Record Position(s):	171-181; 232-242; 293-303; 354-364; 415-425; 476-486; 537-547; 598-608; 659-669; 720-730
Format - Length:	Numeric – 11
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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. (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 II Transaction Segment:	**Dental**
Data Element Name:	**TOOTH NUMBER OR LETTER**
Submission Status:	Required for COS 13
Encounter Record Position(s):	182-183; 243-244; 304-305; 365-366; 426-427; 487-488; 548-549; 609-610; 670-671; 731-732
Format - Length:	Character - 2
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II Transaction Segment: Dental

Data Element Name:	**MEDICARE PAID AMOUNT**
Submission Status:	Required for COS 13
Encounter Record Position(s):	184-194; 245-255; 306-316; 367-377; 428-438; 489-499; 550-560; 611-621; 672-682; 733-743
Format - Length:	Numeric - 11
Effective Date:	2/18/2010
Version Number - Date:	2.9 – April 2010
MEDS II 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 II Transaction Segment:	**Dental**
Data Element Name:	**PAID AMOUNT**
Submission Status:	Required for COS 13
Encounter Record Position(s):	195-205; 256-266; 317-327; 378-388; 439-449; 500-510; 561-571; 622-632; 683-693; 744-754
Format - Length:	Numeric - 11
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II Transaction Segment:	**Dental**
Data Element Name:	**SERVICE START DATE**
Submission Status:	Required for COS 13
Encounter Record Position(s):	206-213; 267-274; 328-335; 389-396; 450-457; 511-518; 572-579; 633-640; 694-701; 755-762
Format - Length:	Date - CCYYMMDD
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II Transaction Segment:	**Dental**
Data Element Name:	**SERVICE END DATE**
Submission on Status:	Required for COS 13
Encounter Record Position(s):	214-221; 275-282; 336-343; 397-404; 458-465; 519-526; 580-587; 641-648; 702-709; 763-770
Format - Length:	Date - CCYYMMDD
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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

X. PROFESSIONAL SEGMENT

MEDS II 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):	158-160
Format - Length:	Character - 3
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II 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):	161-167; 168-174; 175-181; 182-188
Format - Length:	Character - 7
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 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 coding format.
- 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 after third digit because each ICD-9-CM code 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 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 II 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):	189; 248; 307; 366; 425; 484; 543; 602; 661; 720
Format - Length:	Character - 1
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II 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):	190-191; 249-250; 308-309; 367-368; 426-427; 485-486; 544-545; 603-604; 662-663; 721-722
Format - Length:	Character - 2
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II DE# / DW#:	4178/3016

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

Mapping:

- **Paper Form**:

Encounter Type	Form	Element
Professional	CMS-1500	#24B

- **Electronic**:

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

Codes and Values:

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

Code	*Value*
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 II 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):	192-196; 251-255; 310-314; 369-373; 428-432; 487-491; 546-550; 605-609; 664-668; 723-727
Format - Length:	Character - 5
Effective Date:	1/1/2009
Version Number - Date:	2.8 - January 2009
MEDS II 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 II Transaction Segment:	**Professional**
Data Element Name:	**PROCEDURE MODIFIER CODE [UP TO 10]**
Submission Status:	Required for COS 01, 03, 04, 05, 07, 16, 19, 22, 41, 75
Encounter Record Position(s):	197-198; 256-257; 315-316; 374-375; 433-434; 492-493; 551-552; 610-611; 669-670; 728-729
Format - Length:	Character - 2
Effective Date:	1/1/2009
Version Number - Date:	2.8 - January 2009
MEDS II 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	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).
- Not applicable for inpatient encounters

Edit Applications:

- 00927 Modifier Invalid For Procedure Code

MEDS II 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):	199-209; 258-268; 317-327; 376-386; 435-445; 494-504; 553-563; 612-622; 671-681; 730-740
Format - Length:	Numeric - 11
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II 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):	210-220; 269-279; 328-338; 387-397; 446-456 505-515; 564-574; 623-633; 682-692; 741-751
Format - Length:	Numeric - 11
Effective Date:	2/18/2010
Version Number - Date:	2.9 – April 2010
MEDS II 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 II 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):	221-231; 280-290; 339-349; 398-408; 457-467; 516-526; 575-585; 634-644; 693-703; 752-762
Format - Length:	Numeric - 11
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II 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):	232-239; 291-298; 350-357; 409-416; 468-475; 527-534; 586-593; 645-652; 704-711; 763-770
Format - Length:	Date - CCYYMMDD
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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 II 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):	240-247; 299-306; 358-365; 417-424; 476-483; 535-542; 594-601; 653-660; 712-719; 771-778
Format - Length:	Date - CCYYMMDD
Effective Date:	3/1/2005
Version Number - Date:	2.6 - July 2008
MEDS II 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

APPENDIX A – Provider Profession Codes

This list is available for download on the MEDS Home Page on the HPN under the heading MEDS II.

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 II reporting are available for download on the MEDS Home Page on the HPN under the heading MEDS II.

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

Specialty Code	Specialty Description
197	GERIATRIC PSYCH
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

Specialty Code	Specialty Description
311	MH CHILD CLINIC
312	MH CONT DAY TX
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

Specialty Code	Specialty Description
421	MYCOBACT LIMITED
422	MYCOBACT SMEARS
423	DX IMMUN COMP
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

Specialty Code	Specialty Description
571	CYTOGEN GENERAL
572	CYTOGEN LIMITED
573	CYTOGEN HEMA
599	ALL LABORATORIES
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
680	NURSING
714	LOW VISION
715	OPTICIAN/CONTACT LENS

Specialty Code	Specialty Description
	PRIVILEGE
716	OPTOMETRIST
730	INBORN META DIS
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

Specialty Code	Specialty Description
906	FAMILY PLANNING
907	ABORTION
909	NUTRITION PROGRAM
910	ORAL SURGERY
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

Specialty Code	Specialty Description
950	ORTHOPEDIC
951	SURGICAL, MINOR
952	SURGICAL, GENERAL
953	UROLOGY
954	NEPHROLOGY
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

Specialty Code	Specialty Description
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

Code	*Value*
73	SUPERNUMARY 23
74	SUPERNUMARY 24
75	SUPERNUMARY 25
76	SUPERNUMARY 26
77	SUPERNUMARY 27
78	SUPERNUMARY 28
79	SUPERNUMARY 29
80	SUPERNUMARY 30
81	SUPERNUMARY 31
82	SUPERNUMARY 32
A	PRIMARY SECOND MOLAR-UPPER RIGHT
AL	LOWER ARCH
AS	TOOTH CODES AS
AU	UPPER ARCH UPPER ARCH
B	PRIMARY FIRST MOLAR-UPPER RIGHT
BS	TOOTH CODES BS
C	PRIMARY CANINE-UPPER RIGHT
CS	TOOTH CODES CS
D	PRIMARY LATERAL INCISOR-UPPER RIGHT
DE	ALL DECIDUOUS
DS	TOOTH CODES DS
E	PRIMARY CENTRAL INCISOR-UPPER RIGHT
ES	TOOTH CODES ES
F	PRIMARY CENTRAL INCISOR-UPPER LRFT
FS	TOOTH CODES FS
G	PRIMARY LATERAL INCISOR-UPPER LEFT
GS	TOOTH CODES GS
H	PRIMARY CANINE-UPPER LEFT
HS	TOOTH CODES HS
I	PRIMARY FIRST MOLAR-UPPER LEFT
IS	TOOTH CODES IS
J	PRIMARY SECOND MOLAR-UPPER LEFT
JS	TOOTH CODES JS
K	PRIMARY SECOND MOLAR-LOWER LEFT
KS	TOOTH CODES KS
L	PRIMARY FIRST MOLAR-LOWER LEFT
LL	LOWER LEFT QUADRANT
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 II (MEDS II) Supplemental Manual On Applicable Edits

I. MEDS II 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

Prepared by:
Provider Network – MEDS Compliance Unit
Division of Quality and Evaluation
New York State Department of Health
Phone: (518) 486-9012
Fax: (518) 486-6098
Email: omcmeds@health.state.ny.us

April 2010

I. MEDS II 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 HPN. https://commerce.health.state.ny.us/hcsportal/hcs_home.portal

CSC Contact Information:
CSC Provider Relations Staff (518)257-4639.
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 1200 bytes	'Incomplete " ", Header Record' – will give the size and record that is not 1200 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 #:'

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 II 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.
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.)
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.).

Edit Number	Edit Description	Edit Logic
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.
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 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.

Edit Number	Edit Description	Edit Logic
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.
00528	Missing Or Invalid Quantity Dispensed	If the Quantity Dispensed is blank or equal to zero, the edit is failed.
00534	Date Ordered Invalid	If the Date Ordered is not a valid date (CCYYMMDD), the edit is failed.
00540	Number of Days Supply Invalid	If the Days Supply is blank or equal to zero, the edit is failed.
00544	NDC Code Non-Numeric	If the NDC Code is non-numeric or blank, the edit is failed.
00548	Fill Date Precedes Order Date	If the Fill Date is less than the Ordered Date, the edit is failed.
00561	Drug Code Not On File	If the NDC Code is not on the eMedNY Reference Drug Table, the edit is failed.
00600	Admission Date Invalid	If the Admission Date is not a valid date (CCYYMMDD), the edit is failed.
00603	Admission Type Code Invalid	If the Admission Type Code is not: 1-5, the edit is failed.
00604	Admitting Diagnosis Code Missing	If Admit Diagnosis Code is blank, the edit is failed.
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.

Edit Number	Edit Description	Edit Logic
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 and 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 II COS combination), the edit is failed. The Encounter Type Indicator (ETI) must be equal to "I", "T", "D" or "P", and in the correct MEDS II Category of Service. Correct submission standards are detailed in the MEDS II 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

Edit Number	Edit Description	Edit Logic
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 II 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.
02022	Missing Referring NPI	If Referring NPI is blank, and the Referring Group MMIS ID or License Number field is not equal to spaces, this edit is failed.
02023	Missing Attending NPI	If Attending NPI is blank, and the Attending MMIS ID or License Number field is not equal to spaces, this edit is failed.
02024	Missing Operating NPI	If Operating NPI is blank, and the Operating MMIS ID or License Number field is not equal to spaces, this edit is failed.
02025	Missing Rendering NPI	If Rendering NPI is blank, and the Rendering MMIS ID or License Number field is not equal to spaces, this edit is failed.
02029	Missing Prescribing NPI	If Prescribing NPI is blank, and the Prescribing MMIS ID or License Number field is not equal to spaces this edit is failed.
02032	Invalid Referring NPI	If Referring NPI check digit is invalid, this edit is failed.
02033	Invalid Attending NPI	If Attending NPI check digit is invalid, this edit is failed.

Edit Number	Edit Description	Edit Logic
02034	Invalid Operating NPI	If Operating NPI check digit is invalid, this edit is failed.
02035	Invalid Rendering NPI	If Rendering NPI check digit is invalid, this edit is failed.
02039	Invalid Prescribing NPI	If Prescribing NPI check digit is 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.

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
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
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 License No. Missing	N	N	N	N	N	N	N	N	H	N	N	N	N	N	N	N	N	N	N	N
00528	Missing Or Invalid Quantity Dispensed	N	N	N	N	N	N	N	N	H	N	N	N	N	N	N	N	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	Number 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 Precedes Order Date	N	N	N	N	N	N	N	N	H	N	N	N	N	N	N	N	N	N	N	N
00561	Drug Code Not On File	N	N	N	N	N	N	N	N	S	N	N	N	N	N	N	N	N	N	N	N
00600	Admission Date Invalid	N	N	N	H	H	H	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
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	Discharge Date Different 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 License Number 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	N	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
02022	Missing Referring NPI	S	S	S	S	S	S	S	S	S	N	N	N	N	N	N	N	N	N	N	N

	ETI:	I=Institutional					D	T	P=Professional				
	Claim Type:	Clinic	IP	Nursing Home	HH	ICF	Rx	Dental	Practitioner	Eye	Lab	Trans	DME

Legend: F=Fatal; H=Hard Edit (Deny); S=Soft Edit (Accept); N=Non-Edit (Ignore)

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
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)

V. Response File Reconciliation

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

The response file provides valuable feedback to the plan on the quality of the encounter data submitted. The plan will receive information on whether the record was accepted or rejected as well as up to 24 edits.

Data Element	Width	Record Positions
Encounter Control Number	11	1-11
Claim Line Number	04	12-15
Edit Status Code	01	16
Claim Edit Code	05	17-21
COS Code ("EN" precedes code)	04	22-25
TCN	16	26-41
Plan ID	08	42-49
TSN	03	50-52
Filler	28	53-80

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

Since the Response File reports errors on the service line level, plans should be aware of four general rules about feedback reports:

Rule # 1:

If the encounter record passes through without hitting any edits, the plan will receive one record line back with an edit status code of 'P' at line number '0000'. The plan should store the associated TCN and the Accepted status in their data system. Any changes to these records should be handled as an adjustment.

Example:

Plan ID '12345678' with a TSN of 'ABC' submits a professional service encounter with an ECN of '00000000001' and a COS of '01'. The encounter passes all edits. The feedback report will produce the following response:

000000000010000P 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 II 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 Office of Managed Care 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 II system.

The listserv is closed, restricted to health plans and associated parties that are involved with the submission of Medicaid encounter data.

An archive of MEDS-L questions and answers can be found on the MEDS Home Page on the HPN at the following direct link:
https://commerce.health.state.ny.us/hcsportal/hcs_home.portal
If you wish to be added to the MEDS-L listserv please contact the MEDS Unit at omcmeds@health.state.ny.us.

The MEDS II transaction file will be a fixed width file of 1200 characters.
Filler should be added at the end of each record type so that the file width equals 1200.

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
Category of Service (COS) Code	2	86	87
Medicare Total Paid Amount	11	88	98
Total Paid Amount	11	99	109
Other Payer Name	35	110	144
Other Insurance Total Paid Amount	11	145	155
Other Insurance Type Code	2	156	157
Institutional Segment			
Provider Specialty Code	3	158	160
Hospital Inpatient Claim/Encounter Indicator	1	161	161
NYS DRG Code	4	162	165
Type of Bill Digits 1& 2 Code	2	166	167
Type of Bill Digit 3 Code	1	168	168
Statement Covers Period From	8	169	176
Statement Covers Period Thru	8	177	184
Type of Admission	1	185	185
Source of Admission	1	186	186

MEDS Data Element Name	Length	Start	End
Patient Status or Disposition Code	2	187	188
Medical Record Number	20	189	208
Neonate Birth Weight Value Code [1]	2	209	210
Neonate Birth Weight in Grams [1]	7	211	217
Neonate Birth Weight Value Code [2]	2	218	219
Neonate Birth Weight in Grams [2]	7	220	226
Revenue Code [1]	4	227	230
CPT/HCPCS Code [1]	5	231	235
Procedure Modifier Code [1]	2	236	237
Quantity or Units Submitted [1]	11	238	248
Medicare Paid Amount [1]	11	249	259
Paid Amount [1]	11	260	270
Non-Inpatient Claim/Encounter Indicator [1]	1	271	271
Revenue Code [2]	4	272	275
CPT/HCPCS Code [2]	5	276	280
Procedure Modifier Code [2]	2	281	282
Quantity or Units Submitted [2]	11	283	293
Medicare Paid Amount [2]	11	294	304
Paid Amount [2]	11	305	315
Non-Inpatient Claim/Encounter Indicator [2]	1	316	316
Revenue Code [3]	4	317	320
CPT/HCPCS Code [3]	5	321	325
Procedure Modifier Code [3]	2	326	327
Quantity or Units Submitted [3]	11	328	338
Medicare Paid Amount [3]	11	339	349
Paid Amount [3]	11	350	360
Non-Inpatient Claim/Encounter Indicator [3]	1	361	361
Revenue Code [4]	4	362	365
CPT/HCPCS Code [4]	5	366	370
Procedure Modifier Code [4]	2	371	372
Quantity or Units Submitted [4]	11	373	383
Medicare Paid Amount [4]	11	384	394
Paid Amount [4]	11	395	405
Non-Inpatient Claim/Encounter Indicator [4]	1	406	406
Revenue Code [5]	4	407	410
CPT/HCPCS Code [5]	5	411	415
Procedure Modifier Code [5]	2	416	417
Quantity or Units Submitted [5]	11	418	428
Medicare Paid Amount [5]	11	429	439
Paid Amount [5]	11	440	450
Non-Inpatient Claim/Encounter Indicator [5]	1	451	451
Revenue Code [6]	4	452	455
CPT/HCPCS Code [6]	5	456	460
Procedure Modifier Code [6]	2	461	462
Quantity or Units Submitted [6]	11	463	473
Medicare Paid Amount [6]	11	474	484
Paid Amount [6]	11	485	495
Non-Inpatient Claim/Encounter Indicator [6]	1	496	496
Revenue Code [7]	4	497	500
CPT/HCPCS Code [7]	5	501	505

MEDS Data Element Name	Length	Start	End
Procedure Modifier Code [7]	2	506	507
Quantity or Units Submitted [7]	11	508	518
Medicare Paid Amount [7]	11	519	529
Paid Amount [7]	11	530	540
Non-Inpatient Claim/Encounter Indicator [7]	1	541	541
Revenue Code [8]	4	542	545
CPT/HCPCS Code [8]	5	546	550
Procedure Modifier Code [8]	2	551	552
Quantity or Units Submitted [8]	11	553	563
Medicare Paid Amount [8]	11	564	574
Paid Amount [8]	11	575	585
Non-Inpatient Claim/Encounter Indicator [8]	1	586	586
Revenue Code [9]	4	587	590
CPT/HCPCS Code [9]	5	591	595
Procedure Modifier Code [9]	2	596	597
Quantity or Units Submitted [9]	11	598	608
Medicare Paid Amount [9]	11	609	619
Paid Amount [9]	11	620	630
Non-Inpatient Claim/Encounter Indicator [9]	1	631	631
Revenue Code [10]	4	632	635
CPT/HCPCS Code [10]	5	636	640
Procedure Modifier Code [10]	2	641	642
Quantity or Units Submitted [10]	11	643	653
Medicare Paid Amount [10]	11	654	664
Paid Amount [10]	11	665	675
Non-Inpatient Claim/Encounter Indicator [10]	1	676	676
Principal/Primary Diagnosis Code	7	677	683
Other Diagnosis Codes [1]	7	684	690
Other Diagnosis Codes [2]	7	691	697
Other Diagnosis Codes [3]	7	698	704
Other Diagnosis Codes [4]	7	705	711
Other Diagnosis Codes [5]	7	712	718
Other Diagnosis Codes [6]	7	719	725
Other Diagnosis Codes [7]	7	726	732
Other Diagnosis Codes [8]	7	733	739
Admit Diagnosis	7	740	746
External Diagnosis Code (E Code)	7	747	753
Principal Procedure Code	7	754	760
Other Procedure Codes [1]	7	761	767
Other Procedure Codes [2]	7	768	774
Other Procedure Codes [3]	7	775	781
Other Procedure Codes [4]	7	782	788
Other Procedure Codes [5]	7	789	795
Attending Provider Profession Code	3	796	798
Attending Provider License Number	8	799	806
Attending Provider ID	10	807	816
Surgeon Profession Code	3	817	819
Surgeon License Number	8	820	827
Surgeon Provider ID	10	828	837
Admission Date	8	838	845

MEDS Data Element Name	Length	Start	End
Discharge Date	8	846	853
Present on Admission Code	25	854	878
Other Diagnosis Codes [9]	7	879	885
Other Diagnosis Codes [10]	7	886	892
Other Diagnosis Codes [11]	7	893	899
Other Diagnosis Codes [12]	7	900	906
Other Diagnosis Codes [13]	7	907	913
Other Diagnosis Codes [14]	7	914	920
Other Diagnosis Codes [15]	7	921	927
Other Diagnosis Codes [16]	7	928	934
Other Diagnosis Codes [17]	7	935	941
Other Diagnosis Codes [18]	7	942	948
Other Diagnosis Codes [19]	7	949	955
Other Diagnosis Codes [20]	7	956	962
Other Diagnosis Codes [21]	7	963	969
Other Diagnosis Codes [22]	7	970	976
Other Diagnosis Codes [23]	7	977	983
Other Diagnosis Codes [24]	7	984	990
Other Procedure Codes [6]	7	991	997
Other Procedure Codes [7]	7	998	1004
Other Procedure Codes [8]	7	1005	1011
Other Procedure Codes [9]	7	1012	1018
Other Procedure Codes [10]	7	1019	1025
Other Procedure Codes [11]	7	1026	1032
Other Procedure Codes [12]	7	1033	1039
Other Procedure Codes [13]	7	1040	1046
Other Procedure Codes [14]	7	1047	1053
Other Procedure Codes [15]	7	1054	1060
Other Procedure Codes [16]	7	1061	1067
Other Procedure Codes [17]	7	1068	1074
Other Procedure Codes [18]	7	1075	1081
Other Procedure Codes [19]	7	1082	1088
Other Procedure Codes [20]	7	1089	1095
Other Procedure Codes [21]	7	1096	1102
Other Procedure Codes [22]	7	1103	1109
Other Procedure Codes [23]	7	1110	1116
Other Procedure Codes [24]	7	1117	1123
Pharmacy Segment			
Prescribing Provider Profession Code	3	158	160
Prescribing Provider License Code	8	161	168
Prescribing Provider ID	10	169	178
Prescription Ordered Date	8	179	186
Date Filled	8	187	194
National Drug Code (NDC) or Product Code	11	195	205
Quantity Dispensed	12	206	217
Drug Days Supply Count	3	218	220
Pharmacy Claim/Encounter Indicator	1	221	221
Dental Segment			
Provider Specialty Code	3	158	160
Dental Dental Claim/Encounter Indicator [1]	1	161	161

MEDS Data Element Name	Length	Start	End
Place of Service/Place of Treatment [1]	2	162	163
Procedure Codes [1]	5	164	168
Procedure Modifier Code [1]	2	169	170
Dental Dental Number of Units/Visits [1]	11	171	181
Tooth Number or Letter [1]	2	182	183
Medicare Paid Amount [1]	11	184	194
Paid Amount [1]	11	195	205
Service Start Date [1]	8	206	213
Service End Date [1]	8	214	221
Dental Claim/Encounter Indicator [2]	1	222	222
Place of Service/Place of Treatment [2]	2	223	224
Procedure Codes [2]	5	225	229
Procedure Modifier Code [2]	2	230	231
Dental Dental Number of Units/Visits [2]	11	232	242
Tooth Number or Letter [2]	2	243	244
Medicare Paid Amount [2]	11	245	255
Paid Amount [2]	11	256	266
Service Start Date [2]	8	267	274
Service End Date [2]	8	275	282
Dental Claim/Encounter Indicator [3]	1	283	283
Place of Service/Place of Treatment [3]	2	284	285
Procedure Codes [3]	5	286	290
Procedure Modifier Code [3]	2	291	292
Dental Number of Units/Visits [3]	11	293	303
Tooth Number or Letter [3]	2	304	305
Medicare Paid Amount [3]	11	306	316
Paid Amount [3]	11	317	327
Service Start Date [3]	8	328	335
Service End Date [3]	8	336	343
Dental Claim/Encounter Indicator [4]	1	344	344
Place of Service/Place of Treatment [4]	2	345	346
Procedure Codes [4]	5	347	352
Procedure Modifier Code [4]	2	352	353
Dental Number of Units/Visits [4]	11	354	364
Tooth Number or Letter [4]	2	365	366
Medicare Paid Amount [4]	11	367	377
Paid Amount [4]	11	378	388
Service Start Date [4]	8	389	396
Service End Date [4]	8	397	404
Dental Claim/Encounter Indicator [5]	1	405	405
Place of Service/Place of Treatment [5]	2	406	407
Procedure Codes [5]	5	408	412
Procedure Modifier Code [5]	2	413	414
Dental Number of Units/Visits [5]	11	415	425
Tooth Number or Letter [5]	2	426	427
Medicare Paid Amount [5]	11	428	438
Paid Amount [5]	11	439	449
Service Start Date [5]	8	450	457
Service End Date [5]	8	458	465
Dental Claim/Encounter Indicator [6]	1	466	466

MEDS Data Element Name	Length	Start	End
Place of Service/Place of Treatment [6]	2	467	468
Procedure Codes [6]	5	469	473
Procedure Modifier Code [6]	2	474	475
Dental Number of Units/Visits [6]	11	476	486
Tooth Number or Letter [6]	2	487	488
Medicare Paid Amount [6]	11	489	499
Paid Amount [6]	11	500	510
Service Start Date [6]	8	511	518
Service End Date [6]	8	519	526
Dental Claim/Encounter Indicator [7]	1	527	527
Place of Service/Place of Treatment [7]	2	528	529
Procedure Codes [7]	5	530	534
Procedure Modifier Code [7]	2	535	536
Dental Number of Units/Visits [7]	11	537	547
Tooth Number or Letter [7]	2	548	549
Medicare Paid Amount [7]	11	550	560
Paid Amount [7]	11	561	571
Service Start Date [7]	8	572	579
Service End Date [7]	8	580	587
Dental Claim/Encounter Indicator [8]	1	588	588
Place of Service/Place of Treatment [8]	2	589	590
Procedure Codes [8]	5	591	595
Procedure Modifier Code [8]	2	596	597
Dental Number of Units/Visits [8]	11	598	608
Tooth Number or Letter [8]	2	609	610
Medicare Paid Amount [8]	11	611	621
Paid Amount [8]	11	622	632
Service Start Date [8]	8	633	640
Service End Date [8]	8	641	648
Dental Claim/Encounter Indicator [9]	1	649	649
Place of Service/Place of Treatment [9]	2	650	651
Procedure Codes [9]	5	652	656
Procedure Modifier Code [9]	2	657	658
Dental Number of Units/Visits [9]	11	659	669
Tooth Number or Letter [9]	2	670	671
Medicare Paid Amount [9]	11	672	682
Paid Amount [9]	11	683	693
Service Start Date [9]	8	694	701
Service End Date [9]	8	702	709
Dental Claim/Encounter Indicator [10]	1	710	710
Place of Service/Place of Treatment [10]	2	711	712
Procedure Codes [10]	5	713	717
Procedure Modifier Code [10]	2	718	719
Dental Number of Units/Visits [10]	11	720	730
Tooth Number or Letter [10]	2	731	732
Medicare Paid Amount [10]	11	733	743
Paid Amount [10]	11	744	754
Service Start Date [10]	8	755	762
Service End Date [10]	8	763	770
Professional Segment			

MEDS Data Element Name	Length	Start	End
Provider Specialty Code	3	158	160
Diagnosis Codes [1]	7	161	167
Diagnosis Codes [2]	7	168	174
Diagnosis Codes [3]	7	175	181
Diagnosis Codes [4]	7	182	188
Professional Claim/Encounter Indicator [1]	1	189	189
Place of Service/Place of Treatment [1]	2	190	191
Procedure Codes [1]	5	192	196
Procedure Modifier Code [1]	2	197	198
Professional Number of Units/Visits [1]	11	199	209
Medicare Paid Amount [1]	11	210	220
Paid Amount [1]	11	221	231
Service Start Date [1]	8	232	239
Service End Date [1]	8	240	247
Professional Claim/Encounter Indicator [2]	1	248	248
Place of Service/Place of Treatment [2]	2	249	250
Procedure Codes [2]	5	251	255
Procedure Modifier Code [2]	2	256	257
Professional Number of Units/Visits [2]	11	258	268
Medicare Paid Amount [2]	11	269	279
Paid Amount [2]	11	280	290
Service Start Date [2]	8	291	298
Service End Date [2]	8	299	306
Professional Claim/Encounter Indicator [3]	1	307	307
Place of Service/Place of Treatment [3]	2	308	309
Procedure Codes [3]	5	310	314
Procedure Modifier Code [3]	2	315	316
Professional Number of Units/Visits [3]	11	317	327
Medicare Paid Amount [3]	11	328	338
Paid Amount [3]	11	339	349
Service Start Date [3]	8	350	357
Service End Date [3]	8	358	365
Professional Claim/Encounter Indicator [4]	1	366	366
Place of Service/Place of Treatment [4]	2	367	368
Procedure Codes [4]	5	369	373
Procedure Modifier Code [4]	2	374	375
Professional Number of Units/Visits [4]	11	376	386
Medicare Paid Amount [4]	11	387	397
Paid Amount [4]	11	398	408
Service Start Date [4]	8	409	416
Service End Date [4]	8	417	424
Professional Claim/Encounter Indicator [5]	1	425	425
Place of Service/Place of Treatment [5]	2	426	427
Procedure Codes [5]	5	428	432
Procedure Modifier Code [5]	2	433	434
Professional Number of Units/Visits [5]	11	435	445
Medicare Paid Amount [5]	11	446	456
Paid Amount [5]	11	457	467
Service Start Date [5]	8	468	475
Service End Date [5]	8	476	483

MEDS Data Element Name	Length	Start	End
Professional Claim/Encounter Indicator [6]	1	484	484
Place of Service/Place of Treatment [6]	2	485	486
Procedure Codes [6]	5	487	491
Procedure Modifier Code [6]	2	492	493
Professional Number of Units/Visits [6]	11	494	504
Medicare Paid Amount [6]	11	505	515
Paid Amount [6]	11	516	526
Service Start Date [6]	8	527	534
Service End Date [6]	8	535	542
Professional Claim/Encounter Indicator [7]	1	543	543
Place of Service/Place of Treatment [7]	2	544	545
Procedure Codes [7]	5	546	550
Procedure Modifier Code [7]	2	551	552
Professional Number of Units/Visits [7]	11	553	563
Medicare Paid Amount [7]	11	564	574
Paid Amount [7]	11	575	585
Service Start Date [7]	8	586	593
Service End Date [7]	8	594	601
Professional Claim/Encounter Indicator [8]	1	602	602
Place of Service/Place of Treatment [8]	2	603	604
Procedure Codes [8]	5	605	609
Procedure Modifier Code [8]	2	610	611
Professional Number of Units/Visits [8]	11	612	622
Medicare Paid Amount [8]	11	623	633
Paid Amount [8]	11	634	644
Service Start Date [8]	8	645	652
Service End Date [8]	8	653	660
Professional Claim/Encounter Indicator [9]	1	661	661
Place of Service/Place of Treatment [9]	2	662	663
Procedure Codes [9]	5	664	668
Procedure Modifier Code [9]	2	669	670
Professional Number of Units/Visits [9]	11	671	681
Medicare Paid Amount [9]	11	682	692
Paid Amount [9]	11	693	703
Service Start Date [9]	8	704	711
Service End Date [9]	8	712	719
Professional Claim/Encounter Indicator [10]	1	720	720
Place of Service/Place of Treatment [10]	2	721	722
Procedure Codes [10]	5	723	727
Procedure Modifier Code [10]	2	728	729
Professional Number of Units/Visits [10]	11	730	740
Medicare Paid Amount [10]	11	741	751
Paid Amount [10]	11	752	762
Service Start Date [10]	8	763	770
Service End Date [10]	8	771	778
Trailer			
Record Type	2	1	2
Submission Record Count	9	3	11