11375 DATA REQUIREMENTS

The minimum data element file requirements for systems approval derive from State plan requirements and Federal reporting requirements. Data elements related to services not covered in the State plan need not be included.

Claim format and content varies depending upon the type of provider that submits a claim and individual State plan requirements.

NOTE: Subtitle F of Public Law 104-191 mandates that the Secretary of the Department of Health and Human Services adopt a wide range of national standards for the electronic exchange of health information. Standards are to be adopted for: 1) electronic transactions and data elements, 2) code sets, 3) unique health identifiers for individuals, providers, health plans, and employers, 4) security of health information, and 5) electronic signatures. The recommended standards for various types of standards mandated under Public Law 104-191 will be made available for public comment via Notices of Proposed Rulemaking in the Federal Register. Once standards are published as Final Rules in the Federal Register, States and all health related providers must implement standards within 2 years from the Federal Register publication date. The final standards will supersede any/all standards currently in place for electronic transactions and data elements.

The Uniform Hospital Discharge Data Set (UHDDS), developed through the National Committee on Vital and Health Statistics (NCVHS) and required by HHS departmental policy, effective January 1, 1975, and which meets current PRO requirements of §11205, contains, for hospital service only, discharge data as a file requirement and is identified in this section as:

* UHDDS as well as MMIS requirement
** UHDDS requirement only

The following data elements contained in the systems files are minimal and not exclusive requirements for source and use within the MMIS.

1. Recipient Identification Number:
A number that uniquely identifies an individual eligible for Medicaid benefits.

*2. Recipient Social Security Number (SSN):
The number used by SSA throughout a wage earner's lifetime to identify earnings under the Social Security program.

For newborns and children not having a SSN but covered under Medicaid use No. 1 above to identify these eligibles.

3. Recipient Social Security Claim Number:
The number assigned to an individual by the SSA under which monthly cash benefits (and Medicare benefits) are paid or eligibility is established.

4. Recipient's Name:
The name of the recipient.

*5. Recipient's Address:
The address of the recipient.

*6. Recipient's Date of Birth:
The date of birth of the recipient.

7. Recipient's Race Code:
a. The racial origin of the recipient
** b. Race/Ethnic
White, Black, Hispanic, Asian/Pacific Islander, American/Indian/Alaska Native, and other

*8. Recipient's Sex Code:
The sex of the recipient.

9. Recipient's Aid Category:
The statutory category of public assistance, SSI or State supplementary payment under which a recipient is eligible for Medicaid benefits.

10. Gross Family Income:
The monthly gross income for the family of which this recipient is a member.

11. Family Size:
The number of persons in the family of which this recipient is a member.

12. Eligibility Beginning Date:
A date that begins a period in which a recipient was certified as eligible to receive Medicaid benefits.

13. Eligibility Ending Date:
A date concluding a period in which a recipient is eligible to receive Medicaid benefits.

14. Third Party Liability Code:
a. A code indicating availability to a recipient of potential third party resources.
** b. Expected Principal Source of Payment
(1) Self-pay
(2) Workmen's Compensation
(3) Medicare
(4) Medicaid
(5) Maternal and Child Health
(6) Other Government Payments
(7) Blue Cross
(8) Insurance Companies
(9) No charge (free, charity, special research, or teaching)
(10) Other

15. Buy-In Status Code:
    The code indicating a recipient's status with respect to the Medicare Buy- In Program.

16. Recipient Exception Indicator:
    A code indicating that all claims for a given recipient are to be manually reviewed prior to payment.

17. Money Payment Code:
    A code indicating whether or not the recipient is currently receiving cash assistance.

18. Medicare Type Code:
    A code indicating whether the recipient is covered by Medicare, and, if so, whether he/she has Hospital Insurance Benefits (Part A) and/or Supplementary Medical Insurance Benefits (Part B).

19. Buy-In Eligibility Date:
    The date from which the recipient is eligible for the Medicare Buy-In Program.

20. Buy-In Premium Date:
    The date associated with a Buy-In premium amount.

21. Buy-In Premium Amount:
    The amount of money the State pays to HCFA each month per recipient for Buy-In coverage.

22. SSA-Information Exchange Code:
    A code scheme consisting of various numerical codes which describe situations that can occur at SSA or at the State level.

23. Recipient's Eligibility Certification Date:
    Date recipient was certified as eligible for public assistance, supplemental security income or State supplemental benefits.

24. Recipient's Location Code:
    The geographic or geopolitical subdivision of a State in which the recipient resides.

25. Medicaid Premium Amount:
    A recurring premium paid by medically needy individuals before they can receive Medicaid services. The amount of the fee is based upon the number of persons in the family and the gross family income.

26. Medicaid Enrollment Fee Amount:
    A one-time enrollment fee paid by medically needy individuals before they can receive Medicaid services. The amount of the fee is based on the number of persons in the family and the gross family income.

27. Medicaid Deductible Amount:
    The annual (or other period) amount which the recipient must pay toward the cost of medical services before Medicaid will begin to pay.

28. Date of Death:
The date of a recipient's death as indicated in the Social Services or SSI file after an official notice of death has been received.

29. Provider Number (State):
A unique number assigned by the State to each participating provider of services.

30. Provider Name:
The name of the provider of Medicaid services as used on official State records.

31. Provider Address:
The mailing address of the provider.

32. Provider Pay to Address:
The address to which Medicaid payments to a provider are sent.

33. Provider Type:
A code indicating the classification of the provider rendering health and medical services as approved under the State Medicaid plan.

34. Provider Beginning Date of Service:
A date beginning a period in which the provider was authorized to receive Medicaid payments.

35. Provider Ending Date of Service:
A date concluding a period in which the provider is authorized Medicaid payments for services rendered.

36. Provider Group Number:
The number assigned to the group practice of which an individual provider is a member.

37. Provider Type of Practice Organization:
A code identifying the organizational structure of a provider's practice.

38. Provider Employer Identification Number:
The number assigned to an employer by the Internal Revenue Service for tax reporting purposes.

39. Provider Social Security Number:
The number assigned to an individual by SSA.

*40. Medicare Provider Number:
The identification number assigned to a Medicare provider by HCFA (provider means any individual or entity furnishing Medicaid services under a provider agreement with the Medicaid agency (Reference 42 CFR 430.l).

41. Provider Year End Date:
The calendar date on which the provider's fiscal year ends.

42. Provider Specialty Code:
    A code used to indicate the medical specialty of a physician.

43. Provider Exception Indicator:
    A code indicating that all claims from a given provider are to be manually reviewed prior to payment.

44. Provider Credit Balance Amount:
    The amount of money the Medicaid program owes a provider.

45. Provider Credit Balance Date:
    The processing date on which the last amount was entered in the Provider Credit Balance amount.

46. Out-of-State Provider Code:
    A code indicating that the provider is located out of State.

47. Per Diem Rate:
    The payment amount for each day of care in an institution reimbursed on a per diem basis.

48. Percent-of-Charges Factor:
    The percent of a provider's charges that constitutes payment for certain categories of service.

49. Rate Effective Date:
    The effective date of the accompanying per diem rate or percent-of-charges factor.

50. Provider Location Code:
    The geographic or geopolitical subdivision in which the provider's place of business is located.

51. Provider Enrollment Status Code:
    A code indicating a provider's certification status with respect to the Medicaid program.

52. Provider Enrollment Status Date:
    The effective date of the accompanying provider enrollment status code.

53. Provider Group Name and Address:
    The name and mailing address of the provider group.

54. Transaction Control Number:
    A unique number identifying each claim transaction received.

55. Category of Service:
    A code defining the category of service rendered (e.g., general inpatient, pharmacy, physician, home health).

56. Laboratory, Medicare Certified Indicator:
    A code indicating that a laboratory is approved as meeting the requirements for participation in Medicare.

57. Laboratory Service Authorized Code:
A code indicating the services/procedures that a laboratory which meets the requirements for participation in Medicare is authorized to perform.

*58. Physician Identification:
   a. Attending Physician Number
   The provider number of the physician attending an inpatient in a hospital, nursing home, or other institution.

   This is the physician primarily responsible for the care of the patient from the beginning of this institutional episode.

   **b. Operating Physician
   This is the physician who performed the principal procedure. See Data Element No. 87 below, for definition of principal procedure.

59. Referring Physician Number:
The provider number of the physician referring a recipient to another practitioner or provider.

60. Prescribing Physician Number:
The provider number of the physician issuing a prescription.

*61. Principal Diagnosis Code:
   a. The diagnosis code for the principal condition requiring medical attention.

   **b. The condition established after study to be chiefly responsible for causing the patient's admission to the hospital for care for the current hospital stay. (HCFA requires the acceptance of ICD-9-CM coding.)

62. Other Diagnosis Code:
   a. The diagnosis code of any condition other than the principal condition which requires supplementary medical treatment.

   **b. Conditions (up to four) other than the principal condition that coexisted at the time of admission, or developed subsequently, which affected the treatment received and/or the length of stay. Exclude diagnoses that relate to an earlier episode which have no bearing on this hospital stay. (HCFA requires the acceptance of ICD-9-CM coding.)

*63. Admission Date:
The date a recipient was admitted to a medical institution.

64. Beginning Date of Service:
The date upon which the first service covered by a claim was rendered. If a claim is for one service only (e.g., a prescription), this is the only service date.

65. Ending Date of Service:
The date upon which the last service covered by a claim was rendered.

*66. Discharge Date:
The formal release of an inpatient from a hospital.

67. Place of Service:
A code indicating where a service was rendered by a provider.

*68. Patient Number:
Any number assigned by a provider to a recipient or claim for reference purposes, such as a medical record number.

69. Patient Status:
A code indicating the patient's status on the last date of service covered by an institutional claim.

70. Total Claim Charge:
The sum of all charges associated with an individual claim.

71. Units of Service:
A quantitative measure of the services rendered to, or for, a recipient (e.g., days, visits, miles, injections).

72. Third Party Payment Amount:
The amount of payment applied toward a claim by third party sources.

73. Medicare Cash Deductible Amount:
The unmet Medicare deductible subject to payment by Medicaid.

74. Medicare Blood Deductible Amount:
The unmet Medicare deductible for blood subject to payment by Medicaid.

75. Medicare Coinsurance Charge:
The Medicare coinsurance amount subject to payment by Medicaid.

76. Medicare Reasonable Charge:
Payment amount recognized as the reasonable charge for Medicare.

77. Medicaid Co-Payment Amount:
The portion of the claim charge which the recipient must pay, called coinsurance when expressed as a percentage of the payment amount.

78. Prior Authorization Control Number:
A number that uniquely identifies a particular instance of prior authorization.

79. Payment Amount:
The computed amount of payment due a provider for a claim transaction.

80. Date of Adjudication:
    The date a claim is approved (or partially approved) or disallowed.

81. Error Code:
    A code indicating the nature of an error condition associated with that claim transaction.

82. Date Entered Suspense:
    The date a claim transaction was initially suspended.

83. Payment Date:
    The date a payment instrument was generated for a claim transaction.

84. Allowable Procedure Payment:
    The maximum allowed amount payable for a particular medical procedure, treatment, or service item.

85. Professional Fee:
    The amount allowed to a dispenser of drugs as compensation for his professional services.

86. Prescription Number:
    The number assigned by a pharmacist to a prescription at the time it is filled.

87. Procedure Codes:
    Codes identifying medical procedures (i.e. accept and use exclusively the HCPCS in a physician or outpatient setting). (For an inpatient setting, ICD-9-CM Volume 3 is recommended).

    **a. Principal Significant Procedures:
    When more than one procedure is reported, designate the principal procedure. In determining which of several procedures is the principal, apply the following criteria:

    (1) The principal procedure is the one which was performed for definitive treatment rather than performed for diagnostic or exploratory purposes, or was necessary to take care of a complication.

    (2) The principal procedure is that procedure most closely related to the principal diagnosis.

    **b. Other Significant Procedures:

    (1) One which carries an operative or anesthetic risk, requires highly trained personnel, or requires special facilities or equipment.

    (2) Up to four significant procedures can be reported.

    (HCFA requires the acceptance of ICD-9-CM coding.)

88. Drug Code:
    Codes identifying particular drugs; e.g., National Drug Code, drug tables.

89. Diagnosis Code:
    A table of codes identifying medical conditions; i.e., ICD-9-CM.

90. Drug Name:
    The generally accepted nomenclature for a particular drug.

91. Drug Classification:
    The therapeutic group in to which a drug is categorized.

92. Minimum Days Supply of Drugs:
    The minimum units of a drug prescription eligible for payment.

93. Maximum Days Supply of Drug:
    The maximum units of a drug prescription eligible for a particular drug.

94. Procedures Names:
    The generally accepted nomenclature for medical, surgical, dental, etc., procedure.

95. Diagnosis Name:
    The generally accepted nomenclature for a diagnosis. Name is required only if not encoded by provider. (See Data Element No. 6l.)

96. Unit of Measure:
    The unit in which a drug is dispensed (e.g., cc, capsule, tablet).

97. Drug Cancellation Date:
    The date after which a particular drug is no longer covered under the State Medicaid program.

98. Medicaid Reasonable Charge:
    Payment amount recognized as the reasonable charge for Medicaid.

*99. Discharged Patient's Destination:
    A code indicating a recipient's destination upon discharge from a medical institution.

    a. Discharged to home (routine discharge).
    b. Left against medical advice.
    c. Discharged to another short term hospital.
    d. Discharged to a long term care institution.
    e. Died.
    f. Other.

100. Billing Date:
    The date a provider indicates a claim was prepared.

101. Procedure Charge:
    The charge for an individual procedure, treatment, or service item as submitted by the provider.

102. Drug Charge:
    The charge submitted by a provider for a given drug prescription.

103. Adjustment Amount:
    The amount (plus or minus) by which a provider's account is to be changed.

104. Date Claim Received:
    The date on which a claim transaction is received by the claims processing agency.

105. Date of Surgery:
    The date on which a surgical procedure(s) was performed on an inpatient.

106. Drug Wholesale Cost:
    The generally accepted wholesale cost of a drug.

107. Maximum Allowed Price:
    The maximum amount that will be paid for a procedure, treatment, or service item.

108. Valid Sex Indicator:
    A code which indicates when a procedure or diagnosis is limited to one sex only.

109. Age Range Indicator:
    A code which specifies an age range when a procedure or diagnosis is limited to a particular age group.

110. Budgeted Amount:
    The planned expenditures for various Medicaid services over a given period of time.

111. Screening Results Code:
    A code indicating the outcome of the various screening tests rendered.

112. Screening Referral Code:
    A code indicating the nature of any referrals made as a result of screening.

113. Screening Related Treatment:
    A code identifying procedures or services received as a result of screening.

114. Family Planning Code:
    A code indicating whether any diagnosis, treatment, drugs, supplies, and devices, counseling service, or other billed services or materials are for the purposes of family planning.

115. Certification Review Indicator:
    Indicator showing that review was made of certification of a recipient who has been admitted to institutional care including approval status.

116. Certification/Recertification Date:
The date of certification/recertification of a recipient who has been admitted to institutional care.

117. Certification Status:
An indication of initial certification status of a patient in an institution.

118. Number of Requests for Extension:
The number of times an extension of certification of stay was requested for a patient in an institution.

119. Days Certified Initially:
The number of days stay certified initially for a patient in an institution.

120. Total Days Certified:
The total number of days stay certified for a patient in an institution.

121. Date of Application:
The date that a recipient applied for eligibility status in the Medicaid program.

122. SSN of an Absent Parent:
See 42 CFR 433.138 for the conditions under which this piece of information must be captured.