Buy-in Code Descriptions
Chapter 4

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(Rev. 4, 08-21-20)

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4.0 - Introduction

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

This chapter contains descriptions of codes used in the buy-in file exchange between states and CMS. The buy-in file layouts are set forth in chapter 3.

4.1 - State Buy-in Eligibility Codes (BIECs) - Position 71 on State Agency Input File and CMS Response Files

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Buy-in Eligibility Codes (BIECs) provide states with a method for identifying specific Medicaid categories included in the state's Medicare buy-in accounts. States and CMS can populate the BIEC data field, but the ***states are responsible for maintaining its accuracy****.*

States can change the BIEC or add a new one for an individual record by using the ***code 99*** *transaction. These* ***code 99*** *changes only apply prospectively, meaning they take effect in a subsequent billing period (e.g., if the state submits a* ***code 99*** *for a record in March, the updated BIEC will first appear in the state's May billing file from CMS).*

NOTE: *States can submit a record with a blank BIEC field, but once a BIEC field is populated, it cannot be changed back to a blank field. States cannot use a* ***code 99*** *to delete a BIEC. A* ***code 99*** *record with a blank will not eliminate an existing BIEC on the Enrollment Database (EDB). If the state decides to use a BIEC of its own design, it must be an alphabetic character.*

4.1.1 - Table of Buy-in Eligibility Codes

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Buy-in Eligibility Code	***Description***	***Notes (as applicable)***
Mandatory Codes		
P	*Qualified Medicare Beneficiary (QMB)*	*All states must cover QMBs. States must identify and maintain identification of members of this coverage group for CMS to update the EDB.*
L	*Specified Low-Income Medicare Beneficiary (SLMB)*	*All states must cover SLMBs. States must identify and maintain identification of members of this coverage group within the EDB.*

Buy-in Eligibility Code	***Description***	***Notes (as applicable)***
U	*Qualifying Individual (QI)*	*All states must cover QIs. States must identify and maintain identification of members of this coverage group for CMS to update the EDB.*
M	*Full-benefit dual eligible individuals who do not receive (or are not deemed to receive) cash assistance (also known as Medical Assistance Only (MAO))*	*All states that include full-benefit dual eligible individuals without cash assistance in their state buy-in agreement must identify and maintain identification of members of this coverage group for CMS to update the EDB. See chapter 1, section 1.6.3 for a description of "all other Medicaid categories."*
Optional		
Z	*Deemed Categorically Needy*	
CMS-Generated Codes (These codes are based on Supplemental Security Income (SSI) records.)		
A	*Aged recipient of Federal SSI payments*	
B	*Blind recipient of Federal SSI payments*	
D	*Disabled recipient of Federal SSI payments*	
E	*Aged recipient of supplemental payment administered by SSA*	
F	*Blind recipient of supplemental payment administered by SSA*	
G	*Disabled recipient of supplemental payment administered by SSA*	
H	*Aged, blind, or disabled recipient of a one-time payment*	

4.2 - Agency Codes for State Buy-in (Positions 73-75)

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

CMS assigns agency codes to all Third Party Premium Payers, including states and U.S. territories. All states have two assigned agency codes – one for Part A transactions and one for Part B transactions. The first position in state agency codes for Part A buy-in transactions is "S" and the first position for Part B buy-in transactions is a number from 0 through 6. Each third party billing action must include an agency code to identify the state and type of transaction.

4.2.1 - Table of State Agency Codes

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

PART A AGENCY CODE	***PART B AGENCY CODE***	***STATE***
S01	*010*	*Alabama*
S02	*020*	*Alaska*
S03	*030*	*Arizona*
S04	*040*	*Arkansas*
S05	*050*	*California*
S06	*060*	*Colorado*
S07	*070*	*Connecticut*
S08	*080*	*Delaware*
S09	*090*	*District of Columbia*
S10	*100*	*Florida*
S11	*110*	*Georgia*
S12	*120*	*Hawaii*
S13	*130*	*Idaho*
S14	*140*	*Illinois*
S15	*150*	*Indiana*

PART A AGENCY CODE	PART B AGENCY CODE	STATE
S16	160	Iowa
S17	170	Kansas
S18	180	Kentucky
S19	190	Louisiana
S20	200	Maine
S21	210	Maryland
S22	220	Massachusetts
S23	230	Michigan
S24	240	Minnesota
S25	250	Mississippi
S26	260	Missouri
S27	270	Montana
S28	280	Nebraska
S29	290	Nevada
S30	300	New Hampshire
S31	310	New Jersey
S32	320	New Mexico
S33	330	New York
S34	340	North Carolina
S35	350	North Dakota
S36	360	Ohio
S37	370	Oklahoma

PART A AGENCY CODE	PART B AGENCY CODE	STATE
S38	380	Oregon
S39	390	Pennsylvania
S40*	400	Puerto Rico
S41	410	Rhode Island
S42	420	South Carolina
S43	430	South Dakota
S44	440	Tennessee
S45	450	Texas
S46	460	Utah
S47	470	Vermont
S48**	480	Virgin Islands
S49	490	Virginia
S50	500	Washington
S51	510	West Virginia
S52	520	Wisconsin
S53	530	Wyoming
S64**	640	Commonwealth of the Northern Mariana Islands
S65**	650	Guam

** Puerto Rico does not have a state buy-in agreement.*

*** The Virgin Islands, Commonwealth of the Northern Mariana Islands, and Guam have elected not to cover QMBs.*

4.3 - Health Insurance Claim Numbers (HICNs)

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

The Third Party System (TPS) continues to classify buy-in records by the HICN, but can recognize and accept the Medicare Beneficiary Indicator (MBI) on the state input file. TPS will only provide the HICN on the response file to the state.

It is important to distinguish the beneficiary's Social Security Number (SSN) from the beneficiary's HICN. The Social Security Administration (SSA) assigns each individual a SSN to record and track earnings and work credits for Social Security benefits.

The HICN is the number identifying Medicare entitlement for an individual. It includes the nine-digit SSN combined with a one- or two-position alpha-numeric suffix known as the beneficiary identification code (BIC). The BIC designates the type of benefits the individual is receiving, such as wage earner's, spouse's, or child's benefits. The nine-digit SSN is divided into three parts and is usually separated by hyphens (-). From left to right, the three parts are referred to as area, group, and serial.

*Prior to June 25, 2011, the area number was derived from the ZIP Code in the mailing address the individual provided on their initial application for an SSN card. On June 25, 2011, SSA began randomizing the assignment of SSNs, thereby making available all numbers from **001-899** (with the exception of 666) for area assignment nationwide, regardless of the mailing address of the applicant. Numbers **900-999** were reserved for IRS Individual Taxpayer Identification Numbers (ITINs) and are, therefore, not available for the area series.*
*Group numbers range from **01-99**.*

*Serial numbers range from **0001- 9999** within each group.*
The first position of the BIC must always be an alphabetic character (e.g., 000-00-0000A). The second position of the BIC may be alphabetic or numeric (e.g., 000-00-0000J1). If the second position of the BIC is numeric, it is referred to as a subscript. Section 4.3.1 provides a table of BICs for Social Security beneficiaries.
Effective January 1983, newly retired federal employees became entitled to Medicare benefits. These Medicare-qualified federal employees (MQFE) receive a BIC unique to this group. Section 4.3.2 includes the table of BICs for MQGEs.

4.3.1 - Table of Beneficiary Identification Codes (BICs)

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

	1st Claimant	*2nd Claimant*	*3rd Claimant*	*4th Claimant*	*5th Claimant*
Primary Claimant	*A*	---	---	---	---

	1st Claimant	2nd Claimant	3rd Claimant	4th Claimant	5th Claimant
Wife age 62 or older	B	B3	B8	BA	BD
Wife under age 62	B2	B5	B7	BK	BL
Divorced Wife age 62 or older	B6	B9	BN	BP	BQ
Young Husband	BY	BW	---	---	---
Child	C (Oldest child will have highest subscript; subscripts disabled or will descend to C1 for youngest child. If there are (student child) more than nine children, there will be an alphabetic subscript beginning with CA for the 10th child.)				
Widow age 60 or older	D	D2	D8	DD	DG
Widow Remarried after age 60	D4	D9	DA	DL	DN
Surviving Divorced Wife aged 60 or older	D6	D7	DV	DW	DY
Surviving Divorced Husband	DC	DM	DS	DX	DZ
Mother	E	E2	E7	E8	EA
Surviving Divorced Mother	E1	E3	EB	EC	ED
Husband age 62 or	B1	B4	BG	BH	BJ

	1st Claimant	2nd Claimant	3rd Claimant	4th Claimant	5th Claimant
older					
Divorced Husband	BR	BT	---	---	---
Widower age 60 or older	D1	D3	DH	DJ	DK
Widower Remarried	D5	DP	DQ	DR	DT
Widowed Father	E4	E6	EF	EG	EH
Surviving Divorced Father	E5	E9	EJ	EK	EM
Father	F1	F7	---	---	---
Mother	F2	F8	---	---	---
Stepfather	F3	---	---	---	---
Stepmother	F4	---	---	---	---
Adopting Father	F5	---	---	---	---
Adopting Mother	F6	---	---	---	---
Entitled to HIB* (less than 30 QCs)**	J1	---	---	---	---
Entitled to HIB* (30 QCs or more)**	J2	---	---	---	---
Not Entitled to HIB*	J3	---	---	---	---

	1st Claimant	2nd Claimant	3rd Claimant	4th Claimant	5th Claimant
(less than 30 QCs)**					
Not Entitled to HIB* (30 QCs or more)**	J4	---	---	---	---
Wife Entitled to HIB* (less than 30 QCs)**	K1	K5	K9	KD	KH
Wife Entitled to HIB* (30 QCs or more)**	K2	K6	KA	KE	KJ
Wife not Entitled to HIB* (less than 30 QCs)**	K3	K7	KB	KF	KL
Wife not Entitled to HIB* (30 QCs or more)**	K4	K8	KC	KG	KM
Black Lung Miner	LM	---	---	---	---
Black Lung Miner's Widow	LW	---	---	---	---
Uninsured (not entitled to HIB,*	M	---	---	---	---

	1st Claimant	2nd Claimant	3rd Claimant	4th Claimant	5th Claimant
qualified for SMIB)***					
Insured (qualified for HIB,* but requested only SMIB)***	M1	---	---	---	---
Uninsured (entitled to HIB* under deemed insured provision)	T	---	---	---	---
Disabled Widow	W	W2	W4	W9	WF
Disabled Widower	W1	W3	W5	WB	WG
Disabled Surviving Divorced Wife	W6	W7	W8	WC	WJ
Disabled Surviving Divorced Husband	WR	WT	---	---	---

* HIB – Hospital Insurance Benefits (Medicare Part A)

**QC – quarters of coverage for Title II

***SMIB – Supplementary Medical Insurance Benefits (Medicare Part B)

4.3.2 - Table of Beneficiary Identification Codes (BICs) for Medicare Qualified Government Employees (MQGEs)

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

	1ST Claimant	*2nd Claimant*	*3rd Claimant*	*4th Claimant*	*5th Claimant*
Number Holder (Primary)	*TA*	---	---	---	---
ESRD Wife*	*TB*	*TG*	*TH*	*TJ*	*TK*
ESRD Husband*	*TB*	*TG*	---	---	---
Aged Wife	*TB*	*TG*	*TH*	*TJ*	*TK*
Aged Husband	*TB*	*TG*	*TH*	*TJ*	*TK*
Divorced Wife	*TB*	*TG*	*TH*	*TJ*	*TK*
Divorced Husband	*TB*	*TG*	---	---	---
ESRD Widow*	*TE*	*TR*	*TS*	*TT*	*TU*
ESRD Widower*	*TE*	*TR*	*TS*	*TT*	*TU*
Surviving Divorced ESRD Wife*	*TE*	*TR*	*TS*	*TT*	*TU*
Surviving Divorced ESRD Husband*	*TE*	*TR*	*TS*	*TT*	*TU*
Aged Widow	*TD*	*TL*	*TM*	*TN*	*TP*
Aged Widower	*TD*	*TL*	*TM*	*TN*	*TP*
Remarried Widow	*TD*	*TL*	*TM*	*TN*	*TP*
Remarried Widower	*TD*	*TL*	*TM*	*TN*	*TP*
Surviving Divorced Aged Wife	*TD*	*TL*	*TM*	*TN*	*TP*

	1ST Claimant	2nd Claimant	3rd Claimant	4th Claimant	5th Claimant
Surviving Divorced Aged Husband	TD	TL	TM	TN	TP
Father	TF	TF	---	---	---
Mother	TQ	TQ	---	---	---
Stepfather	TF	---	---	---	---
Stepmother	TQ	---	---	---	---
Adopting Father	TF	---	---	---	---
Adopting Mother	TQ	---	---	---	---
Child (Disabled/ESRD)*	TC (Additional children T2 – T9)				
Disabled Widow	TW	TX	TY	TZ	TV
Disabled Widower	TW	TX	TY	TZ	TV
Disabled Surviving Divorced Wife	TW	TX	TY	TZ	TV
Disabled Surviving Divorced Husband	TW	TX	---	---	---

**End-stage renal disease claimant under age 65.*

4.4 - Railroad Retirement Board (RRB) Claim Numbers

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

An individual who primarily worked in the U.S. railroad will receive retirement benefits based on a RRB claim number rather than on a social security claim number. A RRB claim number is either a six- or nine-digit number with an alphabetic prefix. Although the RRB ended the assignment of six-digit numbers for most beneficiaries in 1964, there remains a small number of survivors who have the six-digit claim number. The RRB does continue to issue six-digit claim numbers to Canadian beneficiaries who do not have a SSN.

The dependents of an individual who primarily worked in the railroad may receive benefits from the RRB. The dependents will have an alphabetic prefix before the six- or nine-digit number, as well. See Table 4.5.

The RRB Medicare claim number, also known as RRB HICN, is always the same number as the RRB claim number for the railroad employee. For a dependent, however, the RRB HICN is not always the same number as the RRB claim number. Since the RRB HICN has been replaced on the Medicare card with the MBI, dependent RRB beneficiaries may not know their RRB HICN. In these instances, states may submit buy-in transactions using the MBI, instead.
CMS prefers that states submit an accretion record for a RRB beneficiary with the pseudo HICN since the EDB stores the data in this format. If a state submits the RRB claim number, CMS will convert it to a pseudo HICN and send a claim number change record to the state.

***NOTE:** States must submit deletion records for RRB beneficiaries using the pseudo HICN.*
Convert an RRB claim number to a pseudo HICN in the following manner:

1. *Convert the RRB claim number prefix to the appropriate two-digit SSA BIC according to the format contained in the Table of RRB Prefixes and Equivalent SSA BICs (see section 4.5).*
2. *Place the two-digit SSA BIC at the end of the RRB claim number and drop the alphabetic RRB prefix.*
3. *If the numeric portion of the original RRB claim number consists of a six-digit number, three zeroes (000) must be added as a prefix to the six-digit RRB claim number, thereby creating a nine-digit pseudo HICN.* ***NOTE: The first zero in this type of conversion must always be zoned as a signed field. The hexadecimal representation for a positive-zoned zero is "C0."***
   ***Example:** RRB Claim Number WA123456*
   Pseudo HICN 00012345616 (First zero must be zoned plus.)

4. *If the numeric portion of the original RRB claim number consists of nine digits, convert the first digit to an alphabetic character according to the table below. At the present time, there are no claim numbers which begin with 8 or 9.*

4.4.1 - Conversion Table for Nine-Digit Numeric Portion of RRB Claim Number

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Numeric	*Alphabetic or Numeric*	*Numeric*	*Alphabetic*
0	*0 (Zoned Plus)*	*4*	*D*
1	*A*	*5*	*E*

Numeric	Alphabetic or Numeric	Numeric	Alphabetic
2	B	6	F
3	C	7	G

Example: *RRB Claim Number A321549876*
Pseudo HICN C2154987610

4.5 - Table of RRB Prefixes and Equivalent SSA BICs
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

RRB Claim Prefix	SSA BIC	RRB Beneficiary Type
A	10	Retirement – employee or annuitant
H	80	RR pensioner (age or disability)
MA	14	Spouse of RR employee or annuitant (husband or wife)
MH	84	Spouse of RR pensioner
WCD*	43	Child of RR employee
WCA*	13	Child of RR annuitant
CA	17	Disabled adult child of RR annuitant
WD	46	Widow or widower of an RR employee
WA	16	Widow or widower of an RR annuitant
WH	86	Widow or widower of an RR pensioner
WCD*	43	Widow of employee with a child in her care

RRB Claim Prefix	*SSA BIC*	*RRB Beneficiary Type*
*WCA**	*13*	*Widow of annuitant with a child in her care*
WCH	*83*	*Widow of pensioner with a child in her care*
PD	*45d*	*Parent of RR employee*
PA	*15*	*Parent of RR annuitant*
PH	*85*	*Parent of RR pensioner*
JA	*11*	*Survivor joint annuitant – an annuitant who has taken a reduced amount to guarantee payments to a surviving spouse*

**WCD and WCA have two designations each.*

4.6 - CMS-Initiated Alpha-numeric Character Changes to the HICN/MBI

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

CMS notifies the state in the regular monthly billing file of any changes in the beneficiary's Medicare number and/or BIC. CMS may process a Medicare number and/or BIC change for an ongoing buy-in record or to a state-initiated transaction.

A Medicare number and BIC change can occur when an individual becomes entitled to benefits on another social security record. For example, a woman may first be entitled to Medicare under her own number as an uninsured individual. She may then become entitled as a wife or widow on a spouse's Medicare number.

A BIC change will occur, for example, when a beneficiary's status on his/her account changes from uninsured, BIC M or BIC T, to insured BIC A. Another common example occurs when a woman's status changes from wife, BIC B, to widow, BIC D.

*CMS will send a transaction **code 23bb** Medicare number/BIC or BIC-only change record to the state when the Third Party System (TPS) receives notification from internal systems of the BIC or Medicare number change. The **code 23bb** transaction also indicates that the change applies to an existing open master record **(code 41)**, contained in the billing file in proper sequence under the new Medicare number.*

***NOTE:** In rare instances, SSA may have erroneously created two different Medicare claim numbers (HICN or MBI) for the same beneficiary causing the EDB to create two master records for the beneficiary. Once CMS learns of the error, CMS will deactivate one of the HICNs/MBIs and consolidate the records.*

*If the state detects this error in the billing file, it should not initiate any action as CMS will automatically institute corrective action to consolidate the duplicate master records in the next billing month. If CMS must take manual action, however, the correction may take an additional month. The state will receive a transaction **code 42** credit item refunding premiums for any overlapping periods of buy-in coverage. If the state does not receive the **code 42** credit action within two billing months from the billing month in which the duplicate items appeared, send the record to CMS (see chapter 6) describing the situation. States have no time limit to obtain an adjustment for duplicate billing.*

*States may receive Medicare number/BIC or BIC-only change records on any state-initiated action (accretions, deletions, **code 99s**).*

- *For state accretion or deletion requests that require either type of change, the state can receive the following reply codes from CMS:*
  - *2361*
  - *2363*
  - *2375*
  - *2384*
  - *2350*
  - *2351*
  - *2353*
- *In addition to the transaction **code 23XX** record (XX represents state input code), CMS will send a reply record for the requested action to the state under the new Medicare number.*
- *The **code 99** request (state change record) can also require a Medicare number change action by CMS, which would trigger a reply **code 2399**.*

*Section 4.7 contains the record format for all transaction **code 23** replies.*

4.7 - CMS Buy-in Transaction Codes - Positions 77-81

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

CMS buy-in transaction codes consist of not less than two and no more than four numerals which appear in positions 77 through 80 of the record. When CMS transmits a two-position transaction code, positions 79 through 80 are blank. Certain CMS disposition codes are enhanced by an alphabetic sub-code. If a sub-code applies, it appears in position 81 of the record. An explanation of the sub-code appears with the explanation of the transaction code.

Many CMS transaction codes convey information only to the state, but some codes aim to prompt state action as described in the table below.

***NOTE:** The table below represents the last two positions in a code series as "XX." For example, for the 11XX series– the XX indicate that the **code 11** is a prefix code and XX are placeholders. For **code 23bb** – the bb indicates that two blank spaces may follow the CMS transaction code. Any code displayed in this section followed by the bb is a valid*

two-position transaction code.

4.7.1 - Table of CMS Buy-in Transaction Codes
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Transaction Code	***Definition/State Action***
11XX	*CMS uses the **code 11** series to inform the state of new state buy-in accretions. A two-digit numeric code following the **code 11**identifies the source of the transaction or the reason that TPS took an action prior to accreting the item to TPS. The accretion establishes state liability for the individual's Medicare Part A and/or B premiums, resulting in a CMS debit action for the state. In subsequent months (as long as the individual remains enrolled in buy-in), the item will appear on the state's monthly billing file as a **code 41** (ongoing item).*
1125	*The **code 1125** informs the state that TPS adjusted the accretion effective date in the state input record because the EDB shows a closed period of coverage for the same state that ended after the state-submitted accretion date. TPS has adjusted the accretion start date to the first month after the deletion date on the record for the closed period. The following month the item will appear on the state's billing file as a **code 41** (ongoing item) unless the item is deleted.*
1161 *1163*	*The **code 1161 or 1163** informs the state that CMS accepted the accretion in the state input record and added it to the EDB. The EDB accretion date is the same as the state input record unless a **code 30** action applies. The item will appear on the state's billing file as a **code 41** (ongoing item) the next month unless the item is deleted.*

Transaction Code	***Definition/State Action***
1165	*The **code 1165** informs the state that CMS initiated a Part A or B buy-in accretion on the state's behalf because (1) the state requested manual action by CMS to address a system limitation that prevented CMS from accepting the state accretion; or (2) SSA submitted a Form CMS-1957 requesting a Part A accretion, because the beneficiary qualifies as a QMB or Qualified Disabled Working Individual (QDWI). The following month, the item will appear on the state's monthly billing file as a **code 41** (ongoing item) unless the item is deleted.* ***State Action** - States should confirm the accuracy of the buy-in transaction. If state records don't support the accretion, states should submit a **code 50** deletion, or "wipe-out" action, within two months of the receipt of the **code 1165** to annul the accretion or establish a closed period of buy-in coverage.* *If the accretion date is incorrect, annul the transaction within the two-month window and re-accrete the record with the correct effective date.* *If the state submits the **code 50** after the two-month window, TPS will delete the **code 1165** open period and send a deletion reply **code 1750.** TPS will effectuate Part A deletions in the current month and Part B deletions as described in chapter 2, section 2.6.1.*

Transaction Code	***Definition/State Action***
1167 (Part B only)	*The **code 1167** informs the state that TPS processed a Part B accretion first initiated by an SSA Field Office (FO) through the Public Welfare (PW) process.* ***State Action** - States should confirm the accuracy of the buy-in transaction. If state records don't support the accretion, states should submit a **code 50** deletion, or "wipe-out" action, within two months of the receipt of the **code 1167** to annul the accretion or establish a closed period of buy-in coverage.* *If the accretion date is incorrect, states should annul the record within the two-month limitation and re-accrete the record with the correct effective date.* *If the state submits the **code 50** after the two-month window, TPS will delete the **code 1167** open period and send a deletion reply **code 1750** with a modified effective end date as required by the Commissioner's Decision. See chapter 2, section 2.6.1.*

Transaction Code	***Definition/State Action***
1180 (Part B only)	*The **code 1180** informs an auto-accrete state that CMS has initiated a Part B accretion (auto-accretion) for a SSI recipient who also qualifies for Medicare. The effective date of the auto-accretion is generally the first continuous period of buy-in eligibility based upon the most recent period of SSI or federally-administered state supplement (SSPs).[1] The following month the item will appear on the state's billing file as a **code 41** (ongoing item) unless the item is deleted.* ***Sub-code A*** *- If the SSI record received by CMS in the data exchange with SSA reflects past SSI/SSPs entitlement while the individual was a resident of the state, CMS will follow up the **code 1180** with the sub-code A to alert the state that CMS will also send the state a RIC-A record with the complete SSI data. The state will review the SSI record, and if it determines that the beneficiary was eligible for buy-in coverage during a prior period of SSI/SSPs entitlement, the state should submit a simultaneous accretion/deletion record **(code 75)** to add a closed period of buy-in coverage for that period.* ***State Action** - TPS establishes the effective date of the accretion beginning with the first month of the most recent period of continuous SSI or a federally-administered state supplement payment status of C01 on the Social Security record. However, it is imperative for the state to review SSA data to confirm the appropriate buy-in coverage period(s), particularly if CMS sent the state a RIC-A record to reflect prior SSI entitlement for the individual.*
1184 (Part B Only)	*The **code 1184** informs the state that a Part B accretion has been added to the EDB, either by an alert state in response to a **code 86** accretion alert from CMS, or by an auto-accrete state based on an examination of SSA data. The effective date is the same as reported on the state input record except when a **code 30** action is present. The following month, the item will appear on the state's billing file as a **code 41** (ongoing item) unless the item is deleted.*

1 Pursuant to the court decision in NY State v. Sebelius (N.D. NY, June 22, 2009), CMS has in effect a policy under which states are granted equitable relief from the imposition of retroactive Part B premiums in instances involving lengthy delays in Medicare eligibility determinations to the extent that such delays would result in retroactive auto-accretions that would cover periods for which it is too late to obtain the benefits of Medicare coverage.

Transaction Code	***Definition/State Action***
14bb	*This code informs the state that CMS has deleted the Part A or Part B record as the result of an internal systems adjustment. These occurrences are rare. This code is also used to delete the Part A record because the beneficiary has obtained entitlement to Premium-free Part A.*
15bb	*This code informs the state that the individual was deleted from the state's buy-in account because the SSA record indicates that the individual does not currently meet all the requirements for Medicare (such as age, citizenship or residency, or continuation of disability or end-stage renal disease).* ***State Action*** *- If the state has reason to believe that the individual does meet the requirements for Medicare, refer the individual to the SSA Field Office (FO) to re-establish Medicare entitlement. If Medicare entitlement is re-established, re-accrete the record.*
16bb	*This code informs the state that according to SSA/CMS records, the beneficiary is deceased. CMS has deleted the beneficiary from the state's buy-in account.* ***State Action*** *- If the state believes that the individual is alive, obtain corroboration from the SSA. The state may then re-accrete the individual to state buy-in through the automated data exchange process. If the SSA records have not been corrected, the state's re-accretion will reject with a* ***code 29XX****. If the state agrees with the fact of death, but disagrees with the date of death, obtain corroboration from the SSA before sending a memorandum to CMS requesting an adjustment to the deletion date.*
17XX	*CMS uses the* ***code 17*** *series to inform the state of new record* ***deletions*** *from the state's buy-in account. The* ***code 17*** *is followed by a two-digit numeric code that identifies the reason for the deletion. The deletion may trigger a credit action to the state. The state's liability for the individual's Medicare Part A and/or B premium(s) ends with the month in which the buy-in deletion is effective. If the record is annulled, the state will not have any premium liability for the period.*

Transaction Code	***Definition/State Action***
1728	*This code informs the state that a beneficiary was deleted from the state's buy-in account because another state submitted an accretion that was accepted by TPS or because the SSI record shows that the beneficiary's state of residence changed.* ***State Action*** *- The state should examine the Medicaid eligibility record for any beneficiary for whom it receives a* ***code 1728*** *to ensure that the state's Medicaid eligibility record has been closed. This will prevent a cycle of accretion and deletion actions between states. If the state that received the* ***code 1728*** *believes it should retain jurisdiction of the case, it must contact the state that submitted the new accretion in order to resolve jurisdictional issues (i.e., to determine in which state the individual currently resides). States receiving the* ***code 1728*** *deletion will find the Agency Code for the state accreting the beneficiary in position(s) 124-126 of the RIC-B billing record. In addition, daily states receiving a RIC-D will find the state accreting the beneficiary in position(s) 94-96 of the reply record.*
1750	*This code informs the state that CMS has processed a* ***code 50*** *to annul or establish a closed period of Part A or Part B buy-in coverage for a* ***code 1165*** *transaction or, for Part B only, a* ***code 1167*** *transaction. If the* ***code 50*** *was submitted within two months of the month in which the state received the* ***code 1165 or 1167****, the* ***code 1750*** *will credit the state for premiums billed past the accepted transaction effective date as supplied in the* ***code 50*** *transaction submitted by the state. If the* ***code 50*** *was not submitted within two billing months, TPS will send a deletion reply* ***code 1750*** *with a modified effective end date as required by the Commissioner's Decision. The state will be credited for Part A premiums billed as a current month deletion and for Part B premiums billed past the derived transaction effective date. See chapter 2, section 2.6.1.* ***NOTE:*** *For all TPS credit transaction replies, the transaction effective date can be derived from TPS reply record as the billing period start date minus one month.*

Transaction Code	***Definition/State Action***
1751	*This code informs the state that the beneficiary was deleted from the state's buy-in account based on a deletion record submitted by the state. The retroactivity on a **code 1751** is limited to the current month for Part A and by the Commissioner's Decision for Part B.* *If Part B coverage is closed by **code 1751** and Part A coverage is open, CMS will automatically close Part A with **code 1751**, as well. In rare instances where one state has Part A buy-in on record and a second state has Part B buy-in on record, if the second state closes Part B coverage, CMS automatically closes the Part A coverage in the first state. In this case, both states will receive **code 1751**.*
1753	*This code informs the state that the beneficiary was deleted from the state's buy-in account based on a death deletion record submitted by the state.*
1759	*This code informs the state that the beneficiary was deleted from the state's buy-in account by a clerical action by CMS based on a state request or SSA submission of Form CMS-1957 reporting a problem case. Occasionally, the **code 1759** may reflect a deletion date that exceeds the deletion rules for a Part A buy-in deletion action or the limitations of the Commissioner's Decision for a Part B buy-in deletion action.*
20XX *2050* *2051* *2053*	*This code series informs the state that CMS rejected a deletion request because it has no record of buy-in coverage in the state for the identified HICN/MBI.* ***State Action -** Examine the HICN/MBI in the deletion record to rule out any input keying errors. The HICN/MBI in the deletion record must match a corresponding record on TPS <u>exactly</u> in order for the transaction to be applied. If the HICN/MBI was keyed correctly, review the case to ensure that the state did not previously delete the record or that the state did not fail to process a prior **code 23** HICN/MBI change. If the HICN/MBI is correct, examine previous TPS reply files to determine if a **code 1728** was received transferring jurisdiction to another state.*

21XX *2161* *2163* *2175* *2184 (Part B Only)*	*This code series informs the state that the accretion or simultaneous accretion/deletion records it submitted cannot be matched to a record on the EDB, or other criteria present in the request cannot be processed. The **code 21** is followed by the two-digit numeric accretion code submitted by the state. Each **code 21** contains an alphabetic sub-code in position 81 that further defines the reject.* ***Sub-code A*** *There is no record of the HICN/MBI on the EDB. The HICN/MBI may be absent from the EDB, it may contain blanks, alphabetic characters, or special non-numeric characters in positions that should be numeric, or it does not include an alphabetic BIC.* ***State Action** - Look up the correct HICN/MBI in CMS or SSA data systems made available to the state. Resubmit the record with the correct HICN/MBI.* ***Sub-code B*** *The HICN/MBI on the accretion matches a HICN/MBI on the EDB record, however, required matching personal characteristics differ.* ***NOTE:** CMS data may differ from SSA data since CMS sometimes shortens the beneficiary's first name to the first initial.* ***State Action** - Research in the EDB and resubmit the record with data that matches what is in the EDB using the following guide:* *Name* • *Surname (last name) mismatches: CMS requires an exact match on the first six characters. If the name as recorded in the EDB is incorrect, the state or the beneficiary should contact SSA to correct. SSA will then automatically update CMS' systems. This should be a rare occurrence.* • *Given (first) name mismatches: CMS requires an exact match on the first three characters. If this fails, however, and CMS has only the first initial of the given name in its system, CMS will accept an exact match on the first character alone.* • *Suffix mismatches: If JR or SR is part of the surname, include the JR or SR in the surname field of the accretion*

	record. Failure to include the JR or SR may cause the record to reject. • *Special instructions that apply to all name fields**:** (1) Retain blank spaces that are part of a compound name; (2) Insert a single blank space between the name and suffixes, such as JR, SR, or III; (3) Names may not include a period, although other punctuation marks (e.g., an apostrophe or hyphen) are allowed; and (4) All alphabetic characters must be capitalized or matching criteria will fail.* *Date of Birth* *Month and year of birth mismatch: CMS requires an exact match on the four-position year and two-position month. Review the state's record to ensure that DOB in the accretion record matches the corresponding data in CMS and SSA systems. If there is a discrepancy, correct and resubmit the record.* ***Sub-code C*** *Part A* *1. The beneficiary may be entitled to Premium-free Part A.* ***State Action -** Check SSA systems to determine if the beneficiary is entitled to Premium-free Part A. If so, the beneficiary is not eligible for Part A buy-in. Do not resubmit this record. If the beneficiary is not entitled to Premium-free Part A, see state action under #2 below.* *2. CMS records do not show Premium-Part A entitlement or conditional Part A enrollment **(code Z99)**, causing CMS to reject the buy-in enrollment.* ***State Action -*** *Part A buy-in states: states can accrete beneficiaries to Part A buy-in without sending the individual to SSA to file for conditional Part A if the beneficiary is already enrolled in Part B. If CMS rejects this request, submit it to the DMSEI resource mailbox at statebuy-in@cms.hhs.gov for manual processing.* *Part A group payer states: if a **code Z99** does not appear in SSA systems, refer the individual to SSA to file for conditional Part A during the General Enrollment Period (January through March with coverage effective July 1). Once the individual is enrolled in conditional Part A, the state can resubmit the Part A buy-in record.*

	Part B *CMS rejected the record because it contains a BIEC for an MSP group (i.e., "P" for QMB, "L" for SLMB, or "U" for QI) in position 71 of the input record. The CMS system may not process records with these three BIECs (if no Part A entitlement on record). In this case, states should use the workaround described below.* ***State Action** - Resubmit the Part B accretion record, leaving the BIEC blank. If your state system requires a BIEC value, use another code besides "P," "L," or "U" to avoid triggering a rejection.* *Use the **code 99** procedures to update the BIEC after 5-7 business days. If the **code 99** rejects, wait three business days and resubmit the request.* ***Sub-code D*** *Part A - For a QMB-eligible individual, CMS has no record of Part B buy-in, which is a prerequisite for Part A buy-in.* ***State Action** –If the state has not yet submitted a Part B accretion record for the beneficiary, submit the Part B buy-in record and then resubmit the Part A buy-in accretion.* *If CMS rejected a state Part B buy-in accretion record, correct the Part B buy-in error. Once you verify that Part B buy-in is present in CMS systems, resubmit the Part A buy-in accretion.* *Part B - CMS data indicate this individual may be eligible for QDWI (i.e., CMS data show they have a disability but lost Premium-free Part A and Social Security disability benefits because they returned to work). States may pay the Part A premium for QDWIs, but may not pay the Part B premium.* ***State Action** - Do not resubmit the Part B Buy-in record if the state agrees the individual is a QDWI.* *If the state believes the individual is not a QDWI, submit the accretion request to the DMSEI resource mailbox at statebuy-in@cms.hhs.gov for assistance.* ***Sub-code E***

Transaction Code	***Definition/State Action***
	Part A - For a QMB-eligible individual, CMS does not yet have Part A or Part B entitlement history or the CMS system shows a closed period (i.e., both start and termination dates appear) of Medicare Part A entitlement. CMS systems may reject such requests in some instances. ***State Action -*** *Submit the accretion request to the DMSEI resource mailbox at statebuy-in@cms.hhs.gov for manual processing.* *Part B - CMS does not yet have Part B entitlement history or the CMS system shows a closed period (i.e., both start and termination dates appear) of Medicare Part B entitlement. CMS systems may reject such requests in some instances.* ***State Action -*** *Submit the accretion request to the DMSEI resource mailbox at statebuy-in@cms.hhs.gov for manual processing.*
23XX	*The **code 23** series inform the state that the HICN/MBI and/or BIC have been changed. A **code 23** may be applied to an accretion, deletion, state change record, or to an ongoing **code 41** billing record.* ***State Action*** *- Change the HICN/MBI in the state's records and report all future actions under the correct HICN/MBI.*
23bb	*This code informs the state that a HICN/MBI change was processed to an ongoing buy-in record.*
2350 *2351* *2353*	*These **codes (2350-2353)** inform the state that a HICN/MBI change was processed to a deletion record.*
2361 *2363* *2375* *2384 (Part B only)*	*These **codes (2361-2384)** inform the state that a HICN/MBI change was processed to an accretion or to a simultaneous accretion/deletion record.*

Transaction Code	***Definition/State Action***
2399	*This code informs the state that a HICN/MBI change was processed to a state-submitted change record.*
24XX	*The **code 24** series informs the state that the accretion or deletion action it submitted was rejected because the effective date was blank, incomplete, or otherwise in error.* *An accretion action will be rejected if the effective date is equal to or later than the billing month. A deletion action, other than a death deletion, will be rejected if the effective date is equal to or greater than the billing month.* *A death deletion **(code 53)** will be rejected if the effective date (i.e., date of death) is later than the update month.*
2450 *2451* *2453*	*These **codes (2450-2453)** inform the state that the deletion record it submitted was rejected.*
2461 *2463* *2475* *2484 (Part B only)*	*These **codes (2461-2484)** inform the state that the accretion record or simultaneous accretion/deletion record it submitted was rejected.*
25XX	*This code series informs the state that the accretion or simultaneous accretion/deletion it submitted was rejected because it duplicates a transaction previously processed by TPS. In all instances, it duplicates a transaction previously submitted by the same state.*
2561 *2563* *2575* *2584 (Part B only)*	*These codes inform the state that the accretion or simultaneous accretion/deletion record it submitted duplicates an existing accretion.*

Transaction Code	***Definition/State Action***
27XX	*This code series informs the state that its intended action was rejected because the transaction contained an invalid transaction code. The input code may be blank, may contain alphabetic characters, or may contain a combination of numerals that do not correspond to established state input codes. If a transaction code is used improperly (e.g., if a **code 50** is submitted to delete a code other than a **code 1165 or 1167**, the transaction will reject as a **code 2750)**. The reject displays the erroneous input code immediately following the **code 27**.*
29XX *2961* *2963* *2975* *2984*	*This code series informs the state that the accretion or simultaneous accretion/deletion action it submitted was rejected because there is a death deletion on the EDB which is at least one month earlier than the accretion effective date. The **code 29** may apply to a new accretion or to a re-accretion. The month and year of death will appear in positions 97 through 102 of the reject record.* ***State Action -** If investigation establishes that the beneficiary died later than the date of death on SSA/CMS records, the state must contact SSA to correct the date of death on the MBR. If the beneficiary is alive, the beneficiary must contact the SSA FO to remove the date of death on the MBR. When the date is corrected in or removed from the MBR, the updated information will be reflected on the EDB. After the MBR is updated/corrected, resubmit the buy-in accretion through the automated data exchange process.*
30XX *3061* *3063* *3075* *3084 (Part B only)*	*This **code series (3061-3084)** informs the state that the effective date in the state's accretion record required adjustment to a later effective date to conform to the Medicare entitlement date or to conform to an already established closed period of coverage for the same state. As a result of this adjustment action, TPS will create two records from the state accretion record: the first record is a **code 30XX** that contains the effective date as submitted by the state; and the second record contains the adjusted effective date that corresponds to the individual's Medicare entitlement date, or the earliest eligible start date in relation to an existing closed coverage period for the same state.*

Transaction Code	***Definition/State Action***
41bb	*This code informs the state of the ongoing buy-in enrollment of a beneficiary. The state is responsible for paying the beneficiary's Part A or B premium and has deletion responsibility if the beneficiary is no longer eligible for buy-in. The **code 41** also means that there has not been a change in the beneficiary's buy-in status since the last billing record.*
42XX	*This code series informs the state of a credit adjustment to the state's premium liability. Credit actions result from an adjustment to either the buy-in accretion date or the deletion date on TPS. The adjustment may be applied to an open or a closed record. Adjustments are made for a variety of reasons, such as a notification from SSA of a correction to Medicare entitlement or termination dates, a correction in the date of death, or the identification of duplicate billing records on TPS for the beneficiary.*
42bb	*This code informs the state of a credit adjustment issued in response to duplicate billing records in TPS for one or more months of buy-in coverage. The duplicate premiums are refunded to the state as a credit adjustment. CMS may also generate a **code 42bb** credit as the result of a TPS recovery action to correct a program error or to adjust a billing record that requires a corrective action that cannot be defined with one of the sub-codes. The transaction start date and stop date fields will be populated to indicate the period of coverage for which a credit adjustment is warranted.* ***NOTE:** For all CMS credit transaction replies, the transaction effective date can be derived from TPS reply record as the billing period start date minus one month.*
4211	*This code informs the state that the buy-in accretion date on an ongoing record was adjusted to a later date. The adjustment was necessary because TPS was notified of a change to the beneficiary's Medicare entitlement date. The buy-in effective date on TPS was earlier than the corrected Medicare entitlement date.*
4214	*This code informs the state that the deletion date on an established record was adjusted to an earlier date.*

Transaction Code	***Definition/State Action***
4215	*This code informs the state that the deletion date on an established record was adjusted to an earlier date because the individual did not meet all the requirements for Medicare and should have been terminated prior to the deletion date previously recorded.*
4216	*This code informs the state that the date of death in an established record was incorrect and has been adjusted to an earlier date.*
4268	*This code informs the state that CMS used a clerical action to adjust an accretion to a later date, resulting in a credit to the state.*
4269	*This code informs the state that CMS used a clerical action to adjust the record to an earlier date, resulting in a credit to the state.*
43XX	*This code series informs the state of a debit action. Debit actions can result from a request to establish a retroactive accretion for an ongoing record or to insert a past period of closed coverage. Most adjustments stem from state requests to expand coverage. Other adjustments to ongoing buy-in records are related to SSI changes or a TPS recovery action to correct a program error.*
43bb	*This code informs the state of a debit adjustment generated to correct billing errors related to a TPS recovery action to correct a program error or to adjust a record that requires a corrective action that cannot be defined with one of the sub-codes. The transaction start date and stop date fields will be populated to indicate the period of coverage for which a debit adjustment is warranted. The transaction effective date can be derived as being equal to TPS reply record billing period start date.*

Transaction Code	***Definition/State Action***
4325	*Part A* *This code informs the state that a period of third party coverage, accreted with an adjusted start date, involved periods with different premium rates. This transaction code will be accompanied by a **code 1125**. The part(s) billed at a different rate will be billed as a **code 43** closed period of coverage.* *Part B* *The **code 4325** informs the state that an earlier period of buy-in coverage, brought about by a retroactive state accretion, has been established for the state; however, the effective date of the accretion submitted by the state was adjusted by TPS to a later date.* *In other words, a defined period of state buy-in coverage (specific coverage start and end dates) has been inserted into an existing beneficiary coverage history. A **code 4325** does not indicate the establishment of new open coverage. However, if the beneficiary record already shows open ongoing buy-in coverage, CMS will continue to send **code 41** ongoing billing records each month so long as ongoing coverage continues.*
4361 *4363* *4384 (Part B only)*	*These **codes (4361-4384)** inform the state that an earlier period of buy-in coverage resulting from a retroactive state accretion, has been established for the state. A state may receive one or more **code 4361, 4363 or 4384** records from a single input record. These codes always refer to earlier coverage. If ongoing coverage is established, the state will also receive a **code 1161, 1163** or, for Part B, **1184.***
4365	*This code informs the state that a period of CMS-accreted coverage previously billed at one rate was billed for another rate for a different period or a new period being accreted spanned periods with different premium rates. Usually a reduced rate (as set forth under the provisions of section 1854(f)(1) of the Social Security Act) is involved. If new coverage is being established, a **code 1165** will accompany the **code 4365**. The part(s) billed at a different rate will be billed as a **code 4365** closed period of coverage.*

Transaction Code	***Definition/State Action***
4367 (Part B only)	*This code informs the state that a period of PW coverage previously billed at one rate was billed for another rate for a different period or a new period being accreted spanned periods with different premium rates. Usually a reduced rate (as set forth under the provisions of section 1854(f)(1) of the Social Security Act) is involved. If new coverage is being established, a **code 1167** will accompany the **code 4367**. The part(s) billed at a different rate will be billed as a **code 4367** closed period of coverage.*
4368	*This code informs the state that the accretion date on a TPS record was adjusted to an earlier date resulting in a debit to the state. The adjustment is the result of a CMS clerical action.*
4369	*This code informs the state that the deletion date on a TPS record was adjusted to a later date resulting in a debit to the state. The adjustment is the result of a CMS clerical action.*
4375	*This code informs the state that a simultaneous accretion/deletion (closed period of buy-in coverage) has been added to TPS.*
4380 (Part B only)	*This code informs the state that an earlier period of buy-in coverage, brought about by a retroactive SSI accretion, has been established. A state may receive one or more **code 4380** records. The **code 4380** always refers to earlier coverage. If ongoing coverage is established, the state will receive a **code 1180**.*

Transaction Code	***Definition/State Action***
44	*<u>Part A</u>* *This code informs the state that the Part A premium rate was decreased resulting in a credit to the state. A reduced Part A premium will apply if the beneficiary earned at least 30 work credits under Social Security (P.L. 103-66) but does not have enough work credits to be eligible for Premium-free Part A. In the Part A Group Payer states, the premium will revert to the base rate (or to the reduced Premium-Part A premium rate) once the 10% premium surcharge, if applicable, expires.* *<u>Part B</u>* *This code informs the state that the monthly Part B premium was reduced resulting in a credit to the state. The beneficiary is or was a member of a group health plan that offered a reduction in the Part B premium in accordance with the provisions of section 1854(f)(1) of the Social Security Act.*
45	*<u>Part A</u>* *This code informs the state that the Part A premium rate was increased resulting in a debit to the state. The Part A premium will increase if the initial Part A premium for the beneficiary was erroneously established at the reduced Part A premium rate and the premium was subsequently increased to the base rate. The premium rate increase will also occur if the initial Part A premium, for a beneficiary who resides in a Part A Group Payer state, failed to include a premium surcharge and the surcharge was subsequently added to the record.* *<u>Part B</u>* *This code informs the state of an increase in the monthly Part B premium rate resulting in a debit to the state. The beneficiary is or was a member of a group health plan that offered a reduction in the Part B premium. The group health plan subsequently decreased or eliminated the premium reduction.*

Transaction Code	***Definition/State Action***
4999	*This code informs the state that a request to correct the buy-in eligibility code or welfare identification number on a TPS record was rejected because the HICN/MBI or state agency code in the **code 99** did not match a record on TPS.* *This reject code is also used if the state submits a **code 99** record with a Part B buy-in eligibility code of "P," "L," or "U" (all of which require Medicare Part A entitlement) and the EDB does not currently reflect Medicare Part A.*
50	*States use this deletion code to delete or annul a **code 1165** or, for Part B, **code 1167** accretion posted to the state's buy-in account by CMS either as the result of a clerical action **(code 1165)** or a PW accretion **(code 1167)** initiated by the SSA FO. The **code 50** may be used either to annul buy-in coverage or to enter a termination date that will establish a closed period of coverage. The **code 50** must be sent to CMS no later than the second month following the month in which the state receives the **code 1165** or **code 1167** accretion. For example, if the accretion is processed in the April update, the state will receive the transaction in May. If the state determines that it should submit a **code 50**, the state must submit the **code 50** no later than the July update. If the state submits the **code 50** after more than two updates have elapsed, the **code 50** will be processed as if it was a **code 51** current month deletion for Part A and in accordance with the limitation imposed by the Commissioner's Decision for Part B with a deletion reply **code 1750**. The **code 50** will be rejected only if the state attempts to apply the **code 50** against any codes other than the **code 1165** or **code 1167**.* *If the state is annulling coverage, the effective date of the **code 50** deletion must be one month prior to the accretion date contained in the **code 1165** or **code 1167**. If the state is establishing a closed period of coverage, the effective date of the **code 50** deletion must be the last month in which the individual was a member of the state's coverage group.*

Transaction Code	***Definition/State Action***
51	*<u>Part A</u>* ***States*** *use this code to* ***delete*** *a beneficiary who is no longer a QMB. Do not use this code for death deletions. The retroactivity of a* ***code 51*** *deletion is limited to the update month or the update month plus one month. For example, a* ***code 51*** *deletion processed in the December 2018 update may terminate an individual's coverage in December 2018 or January 2019. If the state submits a retroactive deletion date, TPS adjusts the deletion date so that it conforms to the update month.* *<u>Part B</u>* *States use this code to delete a beneficiary from the state's buy-in account because the beneficiary is no longer a member of the state's coverage group. Do not use this code for death deletions. The retroactivity of a* ***code 51*** *deletion is limited in accordance with CMS processing of* ***code 51*** *deletions. See chapter 2, section 2.6.1.*
53	*The state uses this code to* ***delete*** *an individual who is deceased. The effective date of the deletion must be the month and year of death.*
61	*States uses this code to* ***accrete*** *a beneficiary to the state's buy-in account. TPS will accept Part B buy-in retroactive to the individual's initial eligibility for buy-in, except for QMBs. TPS will not accept retroactive accretions for Part A or Part B buy-in for QMBs (or Part A accretions for QDWIs). To ensure the appropriate buy-in accretion effective dates for QMBs and QDWIs, states should follow procedures in chapter 2, section 2.5.*
63	*States use this code to identify accretion records for subsequent state analysis. The* ***code 63*** *is processed in exactly the same manner as the* ***code 61****. The state is responsible for the accuracy of the accretion. When the accretion is accepted by TPS, the accretion date cannot be adjusted to a later date even if the state later determines that the accretion date it submitted is incorrect.*

Transaction Code	***Definition/State Action***
75	*States use this code to designate a request for a **simultaneous accretion/deletion** action to establish a closed period of buy-in coverage for a beneficiary. The state is responsible for the accuracy of the dates in the simultaneous accretion/deletion record. When the simultaneous accretion/deletion is accepted by TPS, the accretion date cannot be adjusted to a later date and the deletion date cannot be adjusted to an earlier date even if the state later determines that the date it submitted is incorrect.* *The **code 75** is restricted to Part A buy-in states. The **code 75** should be used infrequently.*
84 (Part B only)	*This code is used by an alert state to accrete a beneficiary to the buy-in account in response to a **code 86** accretion alert record or by an auto-accrete state to accrete a beneficiary based on an examination of SSA data. The state is responsible for the accuracy of the accretion. When the accretion is accepted by TPS, the accretion date cannot be adjusted to a later date even if the state later determines that the accretion date it submitted is incorrect.*
86bb (Part B only)	*CMS uses this code to inform the SSI alert state that a beneficiary in its jurisdiction is entitled to SSI benefits and may be eligible for buy-in. It may also be sent to an auto-accrete state for informational purposes if a beneficiary already accreted to the buy-in rolls subsequently becomes eligible for SSI benefits. TPS will not delete and re-accrete the buy-in record in such cases.* *The beneficiary's SSI and Medicare entitlement dates are contained in the record.* *An auto-accrete state may receive a **code 86** record in conjunction with a **code 1180** record.* ***State Action** - If the state determines that the beneficiary is eligible for buy-in, the state should accrete with a **code 84**. The state may use the **code 61 or code 63** in lieu of the **code 84**. The auto-accrete state should use the **code 75**, simultaneous accretion/deletion action, to establish additional buy-in coverage.*

Transaction Code	*Definition/State Action*
87bb (Part B only)	*CMS uses this code to inform both the alert state and the auto-accrete state that SSI entitlement has terminated for the beneficiary.* ***State Action** - Determine the individual's continuing eligibility for buy-in. If the individual remains eligible, no action is necessary. If the individual is no longer eligible for buy-in, submit a deletion record.*
99	*This code is used by the state to correct the BIEC or the welfare identification number on an existing buy-in record on TPS.*

4.8 - Supplemental Security Income (SSI) Status Codes
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

CMS includes the individual's SSI status in each SSI accretion, SSI accretion alert, SSI deletion or SSI deletion alert record that the states receive from TPS. See chapter 1, section 1.4 for information on requirements for redetermining Medicaid eligibility when there is a change in circumstance, including SSI status as indicated below.

4.8.1 - SSI Status Codes - Accretion
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

The status codes for SSI accretion or SSI accretion alert records are:

- *"C" – conditionally eligible for SSI.*[2]
- *"E" – eligible for SSI and may or may not be receiving a federally-administered state supplementary payment.*
- *"M" – special SSI payment for individuals engaged in substantial gainful activity.*
- *"S" – eligible for SSI and is receiving a federally-administered state supplementary payment only.*

4.8.2 - SSI Status Codes - Deletion
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

These status codes for SSI deletion or SSI deletion alert records should prompt states to follow the special procedures in chapter 2, section 2.6.1.2 regarding Medicaid eligibility

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2 For information about conditional SSI benefits, see SSA POMS SI 01150.200 at https://secure.ssa.gov/poms.nsf/lnx/0501150200.

redetermination after loss of SSI:

- *"B" – SSI terminated due to cost of living increase in Social Security benefits-Medicaid eligibility is retained.*
- *"G" – SSI terminated because individual is engaging in substantial gainful activity – Medicaid eligibility is retained.*
- *"T" – SSI terminated for a reason other than the codes described in this section. The SSA data exchanges for states (SVES/SOLQ, SDX, BENDEX) will provide the precise reason for termination.*
- *"U" – SSI terminated because the individual is reported to have died but the date of death has not been verified.*
- *"W" – State withdrawal of agreement for federally-administered state supplemental payments.*
- *"Y" – SSI terminated because the individual has excess income*
- *"Z" – SSI terminated because the individual has excess resources*

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R4SPMP	08/21/2020	New State Payment of Medicare Premiums, (SPMP)	09/08/2020	N/A
R1SBI5	10/01/2003	Initial Release of Chapter	N/A	N/A