MAX 1999-2004 State Claims Anomalies

State	File Type	Record Type	Crossover	Measure	Issue
_ALL	All	All		Eligibility	There are separate yearly eligibility anomaly reports. Some of the information in those reports is useful in understanding distributions in the claims files.
				MSIS ID	In states where a MSIS ID cross reference file is used, the 'master' MSIS ID replaces the MSIS ID and the claims and eligibility records. If there are duplicate eligibility records with the same 'master' MSIS ID, the most recent record is chosen. It is possibly that some months of eligibility may be lost.
				SMRF 98	Many of the differences in the SMRF 98 and MAX 99 values are because code values were added and changed in MAX 99 and in general the MAX 99 files are more complete. There was a big change in the Type of Service Categories, Managed Care enrollment, type of Dual Eligibility as well as other variables. PHP & PHP + PCCM enrollees were excluded in the validation tables for 1996-98, but included in 1999. Also, in 1996-98 the capitation claims are included in the fee-for-service (FFS) sections of the validation tables but excluded in 1999. This impacts the percentages by Type of Service and span bills since most capitation claims are span bills. Finally, there are more people enrolled in managed care in 1999 than there were in previous years, making the comparisons of distributions on claims measures more difficult. About one third of the states did not submit MSIS files prior to 1999, so the validation tables do not have a comparison with 1998 data for those states.
				Validation Tables	Some measures in the MAX validation tables are changed or added between years. This results in some measures being shown as missing and some changes in the values reported. It is important to note the changes in definition when doing cross year comparisons.

State	File Type	Record Type	Crossover	Measure	Issue
_ALL	All	All	Crossover	Dual Elig/ Crossover Clms	There is a difference between the definition of dual eigibles and crossover claims (claims paid in part by Medicare). The PSF has had the EDB verification of dual status added to the file and EDB verification is used for the definition of a dual eligible in the PSF verification tables. However, in the claims file, crossover claims are identified based on the values in the Medicare Coinsurance/Deductible fields. Dual eligibles can have non-crossover claims.
			Crossovers	Definition	The definition of non-EDB Duals changed in the 2002 MAX PS validation tables. Previously the definition included people with either reported MSIS Dual eligibility and/or at least 1 crossover claim and not found in the Medicare EDB files. In 2002, only claims with reported MSIS dual edibility that don't link with the EDB file are counted as non-EDB duals.
	Claims			Adjustments	There are generally more adjusted claims in the 1999 MAX files because of the more intensive review of the 1999 MSIS files to make sure the states were properly submitting adjustments. The MAX Adjustment Indicator was not always properly set and should be ignored. Some claims can not be properly adjusted as the source MSIS files do not include ICN that helps link the original claim with it's adjustments. The ICN will be included in MSIS starting with October 2008.
				Encounter Claims	The encounter claims from the source MSIS files have not been evaluated for completeness or data quality. Most (perhaps all) states do not submit encounter claims for all services and often they do not submit any, even if they have people enrolled in managed care. The few states that submit a large number of encounter claims can not be relied upon to be complete or accurate without an independent evaluation. Encounter claims should not be used for any purpose at this time.

State	File Type	Record Type	Crossover	Measure	Issue
_ALL	Claims	All		HIPAA	There were many state system changes to accommodate the implementation of HIPAA particularly during late 2002 and 2003. In some states, these have a noticeable impact on the MAX files (and source MSIS files). One of the biggest changes is the switch to using national service codes for most claims instead of a mix of national and state defined codes. It does impact the reporting of MAX Type of Service in some cases, as the national codes are not always as specific as the local codes.
				Managed Care	Changes within states in the level and type of managed care has an impact on the distribution and number of FFS claims. These changes are often most noticable in the Type of Service distributions. States with a high percentage of their enrollees in comprehensive managed care often show an unusual distribution of services as the non-managed care enrollees often have quite different charactoristics.
				Medicaid Amount Paid	From 1999-2004 claims with $0 Medicaid Amount Paid were not included in the MAX files. Starting in 2005, claims with $0 Medicaid Amount Paid but with positive Medicare Coinsurance, Medicare Deductables, TPL or Patient Liability are not excluded from the files. From 1999-2003 the Medicaid Amount Paid was changed to the sum of the Medicare Coinsurance and Deductibles if the Amount Paid had been $0. In 2004, there were more claims with $0 Medicaid Paid for this reason, so more claims were deleted from the MAX file. This means that for some types of service there were fewer users, but the same expenditures, resulting in the average Medicaid Pd being more.
				Medicare Coinsurance	During Valids processing, the value "99998" in the Medicare Coinsurance field is not reset to 0. This is corrected in the MAX processing.
				Missing Eligibility	Some records in the MAX 1999-2004 IP/LT/OT/RX files for people with missing eligibility have erroneous eligibility and demographic information and should not be used. This does not occur in the PS files. The PS files only need to be used to identify people with claims, but no eligibilty.
				NPI	States are supposed to start reporting the National Provider ID (NPI) into MSIS October, 2008.

State	File Type	Record Type	Crossover	Measure	Issue
_ALL	Claims	All		Program Type	Program type is supposed to indicate, for each claim, certain special circumstances. Some have to do with Federal matching rates (e.g., EPSDT services), while others are codes to augment information on coverage. Values 6 and 7 identify home and community based care waivers (1915(c) waivers), but the states did not always differentiate between values 6 and 7, so users should sum services with these values.
				SCHIP	PSF records for people enrolled any time during the year in SCHIP(M-SCHIP and S-SCHIP) are kept in the PSF. These records are identified using the SCHIP Indicator codes. Some states included claims for SSCHIP services in the source MSIS files. They should not be included as they are not paid for by Title 19. These claims were exluded starting with MAX 2004. MSCHIP claims are included as they are for services paid for by Medicaid.
				Service Tracking	Expenditures submitted by the states as service tracking claims (lump sum payments to providers for more than 1 person and multiple services) are not included in MAX as they can not be linked to specific beneficiaries. The states are not required to submit service tracking claims and there may be no submissions, partial or complete submissions. For the most part, these expenditures are for expenditures such as DSH payments, drug rebates, etc. However, some states submit some adjustments, payments for waiver services, capitation claims and adjustments as service tracking claims.
				TPL & Family Planning	States often do not include TPL or Family Planning information. TPL is sometimes isn't reported because it is a 'pay and chase' state so the amount isn't reported in the paid claims files.
				Type of Service	Starting with the 1999 MAX files, many services were reclassified from the MSIS type of service to the new MAX type of service categories. This makes the comparison on 1998 and 1999 type of service distributions and expenditures difficult in many states, particularly in the OT file.
			Crossover	All	The crossover claims generally are missing many key data elements that are present on non-crossover claims. Procedure and service codes, UB-92 revenue codes, quantity and place of service are often not reported.

State	File Type	Record Type	Crossover	Measure	Issue
_ALL	Claims	All	Crossover	Claim Count	The percent of crossover claims varies by state and over time due to changes in state rules for reimbursement methods for crossovers. In some states there is a significant shift in the percent of claims that are crossovers because of the more intensive review of the 1999 MSIS crossover claims to make sure that they were properly reported.
			IP	Delivery Claims	In some states, claims for care of the infant are filed under the mother's MSIS ID for the first few months of life.
		IP		Hospital Stays	All claims for contiguous hospital days through the date of discharge are included in a stay record. Claims for new hospital stays that begin on the date of discharge from a previous stays are used to create a new stay record, even if the claims are for the same facility. This is because a person can be re-admitted to the same facility on the day of discharge. Some states submitted claims for additional payments for a hospital stay with the begin and ending dates of service the same as the discharge date. If these are submitted as original and not adjustment claims, there is no foolproof way to determine if they are additional payment for the old stay or a new stay. In the 1999 - 2000 MAX files, debits that are not reconciled as an adjustment set end up as separate hospital stays (except for Illinois 2000 that was corrected).
		IP/LT/OT	Crossover	Amount Paid	In the 1999 MAX files, the Medicaid Amount Paid was calculated as the sum of Medicaid Coinsurance and Deductibles, if the Medicaid Amount Paid = $0. That rule was dropped starting in 2004.
				Crossover Claim Flag	During the MSIS Valids editing, a claim is flagged as a non-crossover if the Medicare Coinsurance & Deductible fields are 8-filled, otherwise it is flagged as a crossover. A few states erroneously 0-filled those fields on non-crossover claims resulting in the indicator being set to "crossover" in the early years of MSIS manditory submission.
		LT		Adjustments	Several states submit separate claims for services provided by long term care facilities that are not part of the bundled rate. These often occur in the file with an Adjustment Indicator of Debit.

State	File Type	Record Type	Crossover	Measure	Issue
_ALL	Claims	LT		Amount Paid	There are a few claims in some states with negative LT days, coinsurance & deductibles and leave days. Adjusted claims that resulted in a final bill with a negative "Medicaid Amount Paid" were deleted from the file, but single original claims with negative amounts were left in the file.
				Days	The states use a variety of time periods for billing long term care services ranging from weekly to monthly and sometimes reflecting the actual time period with covered days. This means that the number of covered days per claim varies between and within states. Also, patient liability and third party liability (TPL) amount is not usually reported on all bills for less than a month and are only reported on one bill during the month.
				Encounters	Long term care encounter records were excluded inadvertently from the MAX 1999 - 2002 files because they have $0 "Medicaid Amount Paid." They are included starting with MAX 2003.
			Crossover	Claim Count	A low percent of xover claims in the long term care file is expected because once a person transitions from Medicare Skilled Nursing Facility (SNF) to Medicaid, Medicare no longer is the first payer of services.
		OT		Clinic Services	States define Clinic Services (MAX Type of Service 12) in different ways, although most states include free-standing (non-hospital affiliated) ambulatory care centers, ranging from ambulatory surgical centers to public health clinics to independent dialysis centers to multi-specialty group practices to Federally Qualified Health Center (FQHC)s to Rural Health Center (RHC)s. Some include community mental health centers, although others report these services in Rehab Services. Users of MAX data will see large discrepancies in the rate of use of Clinic Services, and in the per user cost of such services, due to program differences and definitional differences.

State	File Type	Record Type	Crossover	Measure	Issue
_ALL	Claims	OT		Lab/Xray	Prior to 1999, claims with lab/xray service codes were classified as MAX Type of Service of Lab/xray based on the value of the service codes. In 1999, it was decided to use the states" classifications into MSIS type of service as they were provided with the specifications for those classifications. However, many states did not report lab and xray services with the MSIS type of service of lab/xray. Starting with the 2000 MAX files, once again claims with procedure codes for lab/xray services are crosswalked into the MAX type of service of lab/xray. As a result, there is a big drop in the 1999 MAX files in the percent of claims with a MAX type of service of lab/xray. Researchers using the 1999 files who are concerned about this reporting will need to use the national and state service codes to properly identify all those services.
				MAX/MSIS Service Type	Users should read the data element dictionary to understand the recoding that occurs for several MAX Types of Service -- lab/xray, durable medical equipment/supplies, residential care, psychiatric services, and adult day care. When MAX has recoded the TOS, the original MSIS TOS can still be found on each claim.
				OPD/HH	There are fields in the MSIS OT file for both a service code and a UB-92 revenue code as often outpatient hospital and home health (HH) claims are billed on a UB-92. Some claims have either a service code or UB-92 code and a few states provide both.
				Transportation	States sometimes provide non-emergency transportation services under managed care (capitated arrangements); expenditures and users of these services would not be reported under MAX Type of Service 26 Transportation. Some states offer transportation services through 1915(c) Home and Community Based Care waivers, and these services may be accurately reported in TOS 26 if they are billed in sufficient detail to identify them as transportation.
				Type of Service	Type of Service 19 is a catch-all category, where states report a wide range of services. Many of these services are recoded to MAX Types of Service. What remains in TOS 19 is an uncertain but sometimes significant group of services. In 2002 FFS Non-duals with TOS 19 claims ranged from 1 percent to 61 percent, and average expenditure per user of these services ranged from $96 to over $18,000. Users should be cautious in considering how to handle these claims, and might want to look service codes and place of service on individual records to guess what these services are.

State	File Type	Record Type	Crossover	Measure	Issue
_ALL	Claims	OT		Type of Service	Rehab Services (MAX Type of Service 33) are intended to define those services that are designated as rehabilitative services if the state covers this optional service. Many states now define Rehab Services as mental health care (e.g., community mental health services), while others cover services more traditionally labeled as "rehabilitative." However, some states have not coded MAX TOS 33 according to their state plan coverage, and instead have defined services in rehabilitation hospitals or outpatient facilities, for example. This leads to a substantial difference across states in rates of use and cost per individual, and how these services are interpreted should be considered by potential users of the data.
		PS		Recipient Indicator	The recipient indicators of 5, 6 and 7 were not properly set in the 2000 MAX PS files.
		RX		Adjustments	Most states have a very small percentage of RX adjustments because most adjustments are done POS.
				Date Prescribed	The "Date Prescribed" is not available in most states. A few states have put the "Date Filled" in the "Date Prescribed" fields, but that has been corrected starting in 2003.
				NDC	Some states report compound drugs in the NDC field as "COMPOUND." However, during the Valids editing process in 1999 - 2002 the value "COMPOUND" was converted to blanks as it didn't meet the NDC edit format specification. This was corrected starting with the 2003 Q1 MSIS files.
				Prescribing Physician	The prescribing physician ID is not available in most states as it is not collected by the states.
	PSF	All		SSN	There are some person summary records with duplicate SSNs. In most states this is a very small number, but there are a few states where is it fairly large. This can occur in states like TN that change a person's Medicaid ID number when they change managed care plan or move to another county. For the most part these are truly multiple records for a single individual and researchers may want to combine and resolve them.

State	File Type	Record Type	Crossover	Measure	Issue
_ALL	PSF	Claims		Managed Care	Starting in 1999, measures for people enrolled in PHPs are included in the fee-for-service (FFS) sections of the MAX PSF validation tables. They had been excluded from those sections in the 1996-98 PSF validation tables, often resulting in a huge increase of claims and expenditures in 1999. This makes the comparison of the 1998 and 1999 measures very difficult in states with a large PHP enrollment.
		LT		LT Days	The long term care covered days fields are no longer capped at 365 days. Some states erroneously report days on claims for supplemental services as well as the bundled rate claim. Also, days paid for by the patient as Patient Liability may be included on the claim. The level of institutionalization can be reported more easily by using months of institutional long term care, rather than days.

State	File Type	Record Type	Crossover	Measure	Issue
AK	Claims	IP		Amount Paid	The average "Medicaid Amount Paid" on IP hospital claims is higher than expected, but the state confirms that it is correct. The average amount paid per claim jumped from $6,309 in 2001 to $8,939 in 2002. There is no explanation.
				DRG	AK does not report DRGs into MSIS, and KFF reports that the state does not use DRG-based reimbursement for inpatient services.
				IHS	About 20 percent of the IP claims are billed on the IHS (Indian Healong term careh Service) claim form rather than the UB-92 and therefore do not have UB-92 ancillary codes. AK did not start reporting Program Type of IHS until FFY Q2 2003.
		IP/LT	Crossover	DX/Proc. Codes	The percent of IP crossover claims with procedure codes and the percent of LT crossover claims with diagnosis codes are low.
		LT		Diagnosis	Some diagnosis codes are padded on the right with zeros. The most common code is 311 (reported as 31100 and 3110). This situation significantly improved in 2003.
				Medicaid Amount Paid	The average "Medicaid Amount Paid" per day is about two times higher than expected, but is consistent across years.
				Patient Liability	There is a lower than expected percent of claims with patient liability.
				Type of Service	AK has a lower percent of people with Nursing Facility (NF) claims because they have a relatively small aged population and an active waiver program. They also have a state operated Pioneers Home System, not included in Medicaid, that provides services to many people who might otherwise be in a NF.
					There are no claims with either Type of Service 05 (ICF/MR) or 02 (Mental Hospital Services for the Aged) even though both are reported as covered in AK's state plan.
					At least half the claims have a type of service of Inpatient Psychiatric Under 21 years, which is much higher than expected.

State	File Type	Record Type	Crossover	Measure	Issue
AK	Claims	OT		Program Type	AK started reporting Indian Health Service (IHS) as a program type in 2003.
		RX		NDC	The link with Medispan was only 95% which is lower than expected.
				Program Type	There are no claims with a type of program of family planning (FP).
				TPL	There are only a few claims with third party liability (TPL) amount.
	Encounters	OT		Claim Count	AK does not have a managed care program but reports a small percentage of EPSDT claims as encounter claims due to the method of reimbursements.

State	File Type	Record Type	Crossover	Measure	Issue
AL	Claims	All		MSIS ID	Some adjustment claims in the source MSIS files had an extra character in position 20. The 20th position was dropped so that the claims would link with the MAX PS file.
		IP		DRG	AL does not report DRGs and KFF reports that the state does not use DRG-based reimbursement for inpatient services.
				Family Planning	There are no claims with a Program Type of Family Planning.
				Patient Status	Patient status is missing on some claims.
				Prenatal MC	Many pregnant women are enrolled in the pre-natal/deliver managed care program. However, the state submits their claims in the IP file with the global payments. These claims are missing some key data elements such as UB-92 revenue codes and procedures. The inclusion of the claims in the IP file is one reason for the big increase in fee-for-service (FFS) in 1999. These people show up as enrolled in pre-natal managed care, but do not have capitation claims.
			Crossover	Claim Count	A larger than expected percent of IP claims are flagged as crossovers, especially considering the enrollment of duals in managed care. This may be the result of improper coding of the Medicaid Coinsurance and Deductible fields. But AL says the claims are corrected coded.
		IP/LT/OT		Adjustments	During 2002, AL reported most adjustment claims improperly as crossovers.
		LT		Leave Days	They are not reported in 1999. After that the reporting varies by time period.
				NF Days	The number of Nursing Facility (NF) covered days is missing on about half the claims in 1999, but reported on most claims starting in 2000.
				TPL	Very few claims have third party liability (TPL) amount.

State	File Type	Record Type	Crossover	Measure	Issue
AL	Claims	LT		Type of Service	There are no claims with a MAX Type of Service (TOS) of Inpatient Psychiatric Facility Services for Individuals Age 21 Years and Under (MAX Type of Service (TOS) 04) even though this service is covered under its state plan.
		OT		Adjustments	AL does not include service code on adjustment claims making the adjustment process difficult and resulting in some improperly adjusted claims.
				Capitation	The OT files in general have not included complete reporting of capitation payment claims for individuals enrolled in managed care. They have sometimes been submitted as service tracking claims so are not in the MAX files.
				Type of Service	On claims with a MAX Type of Service (TOS) of '19', these are for Clozapine Support System - This is a kit, used to monitor the blood of individuals using Clozaril (a drug with significant negative side effects). The NDC code on these claims is "CLOZSS."
		RX		NDC	Adjustment claims do not have an NDC code. The state uses the ICN to link originals and adjustments and therefore didn't need to add the NDC. This means that the RX expenditures will be somewhat overstated as most RX adjustments are voids.

State	File Type	Record Type	Crossover	Measure	Issue
AR	Claims	All		MSIS ID	More than 2% of the people with claims do not have an eligibility record. About 50% of these people have capitation claims and the rest FFS.
	Claims			Adjustments	Some claims may not have been adjusted properly due to the way adjustments were submitted to MSIS.
		IP			There are a lot of sets of original and debit claims that are actually supplemental payments. As a result there are a lot of claims flagged as non-standard adjustments.
				Diagnosis	The state only reports up to two diagnosis codes.
				DRG	AR does not use DRGs and KFF reports that the state does not use DRG-based reimbursement for inpatient services
				Family Planning	There are not claims with a Program Type of Family Planning.
		LT		Patient Liability	The state does not report Patient Liability on LT claims.
				Type of Service	There are not claims with a type of service of 02 (Mental Hospital Services for the Aged) as AR does not cover this service.
		OT		Capitation	AR has submitted Primary Care Case Management (PCCM) capitation payment claims for everyone enrolled in Medicaid, instead of those enrolled in a PCCM from 1999 - 2002. The valid PCCM cap claims can be identified by linking with the PSF to find those people actually enrolled in a PCCM.
					IN 2002 AR reported their transportation capitation claims as fee-for-service (FFS).
				Revenue Codes	Outpatient hospital claims do not have UB-92 revenue codes until 2004.

State	File Type	Record Type	Crossover	Measure	Issue
AR	Claims	OT		Type of Service	In 2002 and 2003, AR reported their transportation claims as FFS.
		RX		Adjustments	The few debit claims in the source MSIS files appear to be service tracking claims rather than individual adjustments and so could not be used for properly adjusting some claims.
				Dates	The fill date is reported in both the fill and prescribed date fields, so the prescribed date should be ignored.
				Quantity	Quantity is not reported on many RX claims in the MAX 2003 files.

State	File Type	Record Type	Crossover	Measure	Issue
AZ	Claims	All		Managed Care	Since most people are enrolled in managed care plans, fee-for-service (FFS) data, and conclusions drawn from these data, are inaccurate representations of Medicaid service use.
				MSIS ID	Starting with FFY 2005 Q1, AZ changed the MSIS ID's of about 200,000 enrollees as a one time change. The state provided a cross reference file that did not completely fix the problem. An additional cross reference file was created and both were used to convert the new MSIS ID's to the old format for MAX 2004.
			Crossover	Claim Count	There are very few crossover fee-for-service (FFS) claims. This is because most dual eligibles are enrolled in managed care.
		IP		Program Type	There are no claims with a program type of family planning due to the characteristics of the special populations in fee-for-service (FFS).
				UB-92 Codes	About one quarter of the claims are missing UB-92 revenue codes as they are IHS claims.
		LT		Covered Days	Beginning in 2002, the state stopped reporting covered days on Inpatient Psychiatric Facility Services for Individuals Age 21 Years and Under (MAX Type of Service (TOS) 04) claims as it was no longer available in their system.
				TPL	There are no claims with third party liability (TPL) amount due to the small fee-for-service (FFS) population and the percent of claims with patient liability is lower than expected.
				Type of Service	The files include mostly claims with a type of service of Nursing Facility (NF) and only a few ICF/MR (depending on the quarter). Although AZ covers these types of care, there are no FFS Non-crossover claims for Mental Hospital Services for the Aged (MAX Type of Service (TOS) 02) or 05 (ICF/MR), and very few for Inpatient Psychiatric Facility Services for Individuals Age 21 Years and Under (MAX Type of Service (TOS) 04).

State	File Type	Record Type	Crossover	Measure	Issue
AZ	Claims	OT		Capitation	Arizona sometimes makes multiple capitation payments per person/month/plan to cover different plan services.
				Charges	Charge Amount is mostly missing.
				Crossover Ind	All the capitation claims are flagged as crossover claims as the Medicare coinsurance/deductible fields are 0-filled instead of 8-filled in the source MSIS files until 2003.
				Program Type	Program Type of Indian Health Service was under-reported until 2004. The switch to reporting these claims with the appropriate Program Type had a big impact on the Type of Service distributions as most people in AZ are enrolled in HMOs. There are no fee-for-service (FFS) or encounter claims with a Program Type of Waiver Services. Arizona says that waiver services are being provided as part of managed care. There are no Federally Qualified Health Center (FQHC) claims because Arizona doesn't have a FQHC program. The Program Type of Indian Health Service was under reported until 2004.
				Supplemental Claims	There are some very large supplemental payment claims that are for transplant reinsurance.
				Type of Service	Because the "Medicaid Amount Paid" is only available on the header portion of the UB-92 claim and not associated with each line item, Arizona submits the line item claims with $0 "Medicaid Amount Paid" and a summary claim without the service detail, but with the total Medicaid Paid. During MAX processing, the line item claims with $0 paid are dropped.

State	File Type	Record Type	Crossover	Measure	Issue
AZ	Claims	OT		Type of Service	There is a big decrease in the users of IP, Lab, DME in 2003. This is most likely a managed care coverage issues and most Medicaid enrollees are in managed care plans.
				UB-92	The percentage of outpatient hospital claims with UB92 revenue codes dropped from almost 100 percent in 2000 to 36 percent in 2001.
		RX		Claim Counts & Expenditures	Arizona had problems with their RX claims processing resulting in substantial changes in claims counts and amounts paid. It is expected this will be corrected in 7/02.
				TPL	"Third party liability (TPL) Amount" is always missing.

State	File Type	Record Type	Crossover	Measure	Issue
CA	All	All		MSIS ID	There are about 500,000 people in the CY 1999 MSIS files who have claims, but no eligibility record. Some of these records are for presumptively eligible pregnant women who, iff they are later deemed to be eligible for Medicaid, they are assigned a new Medicaid ID that does not link back to the Temp ID. The bulk of the unlinked claims are for dental managed care as the state usually pays the plans a year later.
	Claims	IP		Diagnosis	CA reports a maximum of two diagnosis codes on IP claims.
				DRG	CA does not use DRGs for reimbursement, but rather a negotiated daily rate amount.
				Patient Status	The percent of claims with a patient status of "still a patient" is higher than expected because of the inclusion of Short/Doyle (psych) and LA Waiver facilities.
				Procedure Codes	The state only captures a maximum of two procedures in its claims processing system.
				UB-92 Codes	Claims for Short/Doyle and LA Waiver facilities are not billed on the UB-92 forms and so are missing the UB-92 Revenue Codes
		LT		Diagnosis	The state only reports a maximum of two diagnosis codes on LT claims.
				Patient Liability	The percent of claims with patient liability is lower than expected.
		OT		Program Type	There is a low percentage of waiver claims in the file. The state reports that is correct.
				Type of Service	Outpatient hospital claims have service codes and not UB-92 Revenue Codes.
					Starting in 2002, there was a dramatic shift in claims between personal care services (PCS) (Type of Service 30), Residential Care and Hospice. This was the result of a change in the type of service crosswalk. There were almost 6 million claims with a service code of Z9525 that were moved from personal care services (PCS) (Type of Service 30) to Residential Care.

State	File Type	Record Type	Crossover	Measure	Issue
CA	Claims	RX		NDC	The NDC field is 8-filled for all 12 bytes on crossover drug claims as the NDC is unknown on these claims.

State	File Type	Record Type	Crossover	Measure	Issue
CO	Claims	Adjustments		Amount Paid	Some positive credits and negative debits due to the co-pay is deducted from line items.
		All		Capitation	There is a big decrease in HMO enrollment in 2003 resulting in the increase in the number of children with FFS claims.
				MSIS ID	In the MAX 2003 files, 2.4% of the MSIS ID's found on claims are not in the PS file. CO is investigating, but so far, there is no explanation.
		IP		DRG	CO recodes CMS DRGs into state DRGs.
		LT		Patient Liability	The drop in the percentage of claims with Patient Liabilityin 2003 reflects the change from monthly to weekly bills. Patient Liability is reported monthly.
		OT		Capitation	CO stopped paying PCCM Capitation in June 2004.
				Medicaid Paid	More claims than expected with $0 "Medicaid Amount Paid" because of the way cost sharing is applied
				Private Insurance	CO purchases private health insurance for some enrollees. The premium payments are reported with Type of Claim = 2 (capitated payment), Type of Service = 19 (Other).
				Service Codes	Service codes are missing on home health (HH), Waiver, Hospice and outpatient hospital claims as they are billed on a UB-92 form.
					In December 2003, Colorado's fiscal agent reported that the state has been "redefining" national HCPCS and CPT codes to meet its own needs for many years. Requested copy of redefined codes, as yet not received.
				Type of Service	Lab/X-ray claims have diagnosis codes as that is how they receive them from providers.

State	File Type	Record Type	Crossover	Measure	Issue
CO	Claims	RX		Claim Count	There appear to be some duplicate RX claims.

State	File Type	Record Type	Crossover	Measure	Issue
CT	Claims	All		MSIS ID	In the 2000-2002 files there are some capitation claims that do not link with the PS file using MSIS ID.
		IP		Chronic Hospitals	Chronic disease hospital claims are in IP files. This impacts UB-92, patient status codes and LOS. These facilities are not generally billed on a UB-92 form.
				DRG	The DRG and DRG grouper are missing as CT does not use a DRG-based reimbursement system for inpatient services (confirmed by KFF).
				Patient Status	The "Patient Status Code" percent for "Home" is low, but is high for "Transferred" for fee-for-service (FFS) Non-Crossover claims.
		IP/LT/OT	Crossover	Type of Service	All crossover claims (IP/LT/OT) are in the OT file for FFY 1999. CT corrected the problem beginning with FFY 2001.
		LT		Admission Date	The "Admission Date" is always missing.
		OT		Home Health	CT is an outlier, with the highest proportion of FFS Non-duals with home health care use (11 percent in 2002) and the largest average per user expenditure for these services ($10,525 in 2002). No investigation has been done on this issue.
					The percentage of HH claims is high due to the state's ability to submit line item services. Many states can only submit summary bills. 1999-2003
				MSIS ID	The MSIS 2000 - 2002 capitation claims did not always carry the same MSIS ID as was reported into the MSIS eligibility files. This could not be corrected in the construction of the MAX files.
				Place of Service	The Place of Service on Home Health claims is not reported.
				Service Codes	There are a few state specific codes that have more than one definition, but the state service code indicator is the same.

State	File Type	Record Type	Crossover	Measure	Issue
CT	Claims	OT		Type of Service	In 2003, there was a big increase in the number of TCM users due to a change in the state crosswalk.
		RX		Amount Paid	CT's Medicaid expenditure per FFS Non-Dual user of drug claims is an outlier in 2002, with an average of $3550 (median across all states is $1034). Since data quality reviews of claims revealed no anomalies, and since 57% of FFS Non-Duals had drug prescriptions, this outlier status appears to be worthy of investigation.
				Date Prescribed	Date Prescribed is missing.
				Expenditures	CT's Medicaid expenditure per user of drug claims is an outlier in 2002, with an average of $3550 (median across all states is $1034).

State	File Type	Record Type	Crossover	Measure	Issue
DC	Claims	All		MSIS ID	There was a change in the MSIS ID numbers in the MSIS FFY 2001 files.
				TPL	The third party liability (TPL) amount missing on all claims, except a very few in the RX file
		IP		Discharge Status	There is a higher percent than expected with a "Patient Status" of "still a patient."
				DRG	DRGs are not included on about 25% - 35% percent of IP claims until 2003 although KFF reports that the District does use a DRG-based reimbursement system for inpatient services.
				Length of Stay	The average length of stay is about 8 days which is higher than expected. The District confirms it is correct.
				UB-92 Codes	About 9 percent of the claims don't have UB-92 accommodation revenue codes due to bills for partial hospitalizations. (Normally, partial hospitalization claims are on the OT file, so if they continue to be on the IP file for DC, this is an error.
		IP/OT		Service Code Indicator	There are some claims with an incorrect Service Code Indicator value for the format of the service code.
		LT		Diagnosis	Most LT claims have a diagnosis code of 799.9 (Ill Defined Illness of Unspecified Cause -- a filler rather than a meaningful diagnosis)) until Q4 2002 when they were converted to "unknown."
				Leave Days	The percent of Leave Days dropped to 0.03% in 2003.
		OT		Dental Claims	There are very few dental claims in the OT file. The District confirms that is correct.
				Diagnosis	The diagnosis codes is missing on many claims in 2002.

State	File Type	Record Type	Crossover	Measure	Issue
DC	Claims	OT		Program Type	There are very few claims with a Program Type of Federally Qualified Health Center (FQHC).
					There are very few waiver claims as DC just started its waiver programs in 1999. The percent increases in 2000.
				Service Codes	In the 2002 file, some of the service code indicators were not correctly set.
				Service Place	Place of Service is missing on about one third of the OT claims.
				Type of Service	Residential Care was not reported by the state until 2003.
					Lab/Xray was under reported in 2000.
					All claims with a Type of Service of 11 (Outpatient Hospital) have service codes instead of UB-92 revenue codes since OPDs billed using the HCFA 1500.
					Type of Service 19 (Other Services) increased to more than 50% in 2002/2003.
		RX		Family Planning	There aren't any claims with a program type of family planning.

State	File Type	Record Type	Crossover	Measure	Issue
DE	All	All		MSIS ID	Almost 18% of the MSIS ID's in the claims files did not link with the MSIS ID on eligibility records in 2002, due to an error in reporting them into MSIS for one quarter.
	Claims			HMO	The decrease in HMO enrollment in 2003 resulted in more FFS enrollees with lower average Medicaid Amount paid, and an increase some some Types of Service.
				TPL	Third party liability (TPL) amount is missing on all claims.
		IP		Bundled Claims	The state pays for bundled services for Services for Children, Youth and their Families (DSCYF) that includes inpatient care. These claims do not have UB-92 revenue codes, patient status or "Admission Date." The number of these bundled claims nearly doubled between Q1 and Q2 1999.
				DRG	DRGs are not included as they aren't used for reimbursements.
				Patient Status	There were no claims with a Patient Status of "Still a Patient" until 2002.
				Program Type	There are no claims with Program Type of Family Planning.
		LT		Covered Days	There are no covered days on claims with a type of service of 04.
				Drugs	Some drugs are part of the LTC rate, so specific information on these drugs is not available.
				Type of Service	According to the "Medicaid at a Glance" chart, DE does not cover inpatient psychiatric care for those under 21 but the MAX data show users and expenditures for this Type of Service.

State	File Type	Record Type	Crossover	Measure	Issue
DE	Claims	OT		PCCM	DE did not start reporting either Primary Care Case Management (PCCM) enrollment or PCCM capitation claims until 2002. Previously the state said they were paying for PCCM services on a fee-for-service (FFS) basis when they occurred.
				Place of Service	Place of service is missing on most claims.
				Program Type	The files do not contain any claims with a Program Type of Federally Qualified Health Center (FQHC).
				Type of Service	Claims with a MAX Type of Service (TOS) of Transportation make up between 26-40 percent of all services. Starting with FFY Q1 2004, there will be a transportation managed care program.
		RX		MSIS ID	The 2002 Q4 MSIS RX file was submitted with some claims having an incorrect MSIS ID that did not link to the EL file. The state will not be resubmitting the file. This results in most of the 18 percent of people with claims that do not link to the EL file.
				Refill Indicator	Refill indicator is missing.

State	File Type	Record Type	Crossover	Measure	Issue
FL	All	All		MSIS ID	The MSIS ID consists of the SSN with a check digit in the 10th position. It turns out that the check digit was calculated differently on some claims. In MAX, the 10th position was dropped from both the claims and eligibility records in order to link the files.
	Claims	IP		Amount Paid	There are very large expenditures reported on Service Tracking claims that are excluded from the MAX files. (1999-2003)
				DRG	FL does not report DRGs into MSIS and KFF reports that the state does not use DRG-based reimbursement for inpatient services.
				UB-92 Codes	In 2003, the percentage of claims without ancillary codes is higher than expected. The state has no explanation.
		LT		Diagnosis Code	Diagnosis Codes are missing on virtually all claims
				Missing Variables	Patient Status and Admission Date are missing on most claims.
				Type of Service	FL does not submit any claims with a Type of Service of IP Psychiatric Services for under 21 even though this is a service covered under the state plan.
		OT		Capitation	Some PHP and HMO capitation payments are reported as Service Tracking claims, so they are not included in the MAX files. (2003)

State	File Type	Record Type	Crossover	Measure	Issue
GA	All	All		MSIS ID	In 2003, Georgia changed to a new MSIS ID numbering scheme. However, when they submit the MSIS source files, they replace the new numbers with the old. This means that the MSIS IDs will not directly link with non-MSIS/MAX state files.
	Claims			Adjustments	Georgia did not correctly report adjustments in their 1999 - 2003 files making it very difficult to properly adjust some of the claims.
				SSCHIP Claims	Georgia submitted claims for their SSCHIP enrollees in 2000-2005.
				SSCHIP only Claims	Georgia included claims for services provided for people enrolled in SSCHIP only in the 2003 and possibly earlier MAX files. They were deleted starting in 2004.
			Crossover	Claim Count	There is an unexplained increase in crossover claims in 2003.
		IP		DRG	DRGs were reported in the MSIS files, but they were submitted as character fields instead of numeric. For that reason, during the CMS Valids editing process they were converted to 0s. Although this problem was corrected in FFY Q3 2003 MSIS files, virtually no DRGs are included on the GA 2002 file .
				Family Planning	There are no claims with a program type of family planning.
		LT		Diagnosis	Diagnosis codes are missing on all claims.
				Leave Days	Very few claims have leave days even though Georgia covers leave days in several circumstances.
				Patient Status	GA reports almost no one with a patient status of "died."
				TPL/Liability	There is no reported third party liability (TPL) amount and the percent of claims with patient liability is lower than expected.

State	File Type	Record Type	Crossover	Measure	Issue
GA	Claims	LT		Type of Service	Georgia does cover Mental Hospital Services for the Aged [MAX Type of Service (TOS) 02] or Inpatient Psychiatric Facility Services for Individuals Age 21 Years and Under (MAX TOS 04) services, so it is appropriate that there are no services reported in these Types of Service.
		OT		Capitation	Capitation payment claims for non-emergency transportation are not included in the OT file.
				Program Type	The reporting of FQHC's and RHC's increased in the 2003 files.
				Service Type	The number of claims with a Type of Service of Rehabilitation dropped from around 17,000 to 0. The number of PT/OT claims dropped from around 17,000 to only a few.
				Type of Service	There are very few claims with a type of service of transportation due to the transportation managed care program.
					In 2003, there was a big shift in the reporting of some types of service. Increase: Other Services, Clinic, Other Practitioners, Lab, Pysch Servies. Decrease in PT/OT services, HH, rehabilitation. This is the result in a change to the states Type of Service crosswalk.
		RX		Family Planning	There are no family planning claims in the RX file.
				NDC	The NDC code is missing on a few void claims in 1999 - 2000 making those claims difficult to adjust properly. That field is either blank or 11 byte 9 filled (instead of 12 byte).

State	File Type	Record Type	Crossover	Measure	Issue
HI	All	All		MSIS ID	From Q1 2000 - Q4 2002 Hawaii submitted some MSIS IDs on claims that do not link with the eligibility files. The state is unable to provide a crosswalk so they can not be corrected.
	Claims			Adjustments	The 1999 - 2001 files contain very few adjustment claims and they are all voids with $0 paid. The files that Arizona received from Hawaii were supposedly mostly adjusted. They believe that the $0 paid voids, actually had a negative "Medicaid Amount Paid" that wasn't allowed in their system, so they were converted to $0. For this reason, it isn't possible to create correctly adjusted claims. The 2002 files have negative amounts paid on void claims, but the resubmittal claims still have $0 paid. This was fixed starting with the 2003 files.
				MSIS Files	Arizona is creating the Hawaii MSIS files. They took over what HMSA had in their legacy files for 1999 - 2002 and there are many problems/missing information in those files. Starting with 2000, Arizona took over the MMIS processing as well and they expect all these problems to be fixed.
				Source Files	The 1999 Hawaii MSIS files were created from old legacy files that were missing several key MSIS data elements.
		IP		Claim Count	There is somewhat of a shortfall (fewer records than expected) of IP claims in the 1999 and 2000 files due to the use of legacy state file.
				Covered Days	Covered days are not reported in the 1999 files.
				DRG	There are no DRGs in the IP file and KFF reports that the state does not use DRG-based reimbursement for inpatient services.
				Length of Stay	1999 - 2002: It appears that there may be some claims from long stay hospitals in the IP file as about 15 percent of the claims have a status of "still a patient" and they are missing UB-92 ancillary codes. Also the average number of days stay is 9 which is higher than expected.

State	File Type	Record Type	Crossover	Measure	Issue
HI	Claims	IP		UB-92 Codes	The percent Claims with UB-92 Ancillary codes is low for 1999 fee-for-service (FFS) Non-Crossover claims. They are reported on most claims starting in 2000.
			Crossover	ClaimCount	Very few of the IP claims in the 1999 - 2001 files are flagged as crossovers. The state believes they are in the file, but just not identified. The coinsurance and deductible amounts are carried as separate line items. Hawaii expects to fix this starting with the 2002 or 2003 files.
		IP/OT		TPL	There are very few claims with a third party liability (TPL) amount and it is always $0 or negative in 1999.
		LT		Charge	Charge Amount is always missing in the 1999 files.
				Covered Days	No covered days are reported in the 1999 files.
				Leave Days	There are no reported Leave Days in the 1999-2001 files and only a small number in 2002-2003 even though the state covers up to 12 leave days per calendar year.
				Patient Liability	Patient liability is not reported in the 1999 - 2001 files. In 2002-2003 very few claims with Patient Liability and many have a negative Medicaid Amount Paid.
			Crossover	Claim Count	There are no crossover claims in 1999 - 2001. They are reported in the 2002-2003 files.
		OT		Capitation	They are all coded as crossover claims from 1999 - 2002. This was corrected in 2003.
				Charge	Charge Amount is always missing in the 1999 files.
				Crossover Ind	All the capitation claims are flagged as crossover claims as the Medicare coinsurance/deductible fields are 0-filled instead of 8-filled in the source MSIS files.

State	File Type	Record Type	Crossover	Measure	Issue
HI	Claims	OT		Dental	Dental managed care ended in 2001resulting in an increase in dental claims in the MAX 2002 and 2003 files.
				Procedure Codes	Some of the CPT-4 codes have an invalid length of 7 in 1999. This has now been corrected.
				Program Type	Very few of the 1999 - 2001 claims have a program type of Federally Qualified Health Center (FQHC), however, Hawaii does have FQHCs.
					Hawaii did not report any Rural Health Center (RHC) claims in the 1999 - 2002 files.
					The 1999 - 2002 files do not include waiver claims as they are processed by a different state agency and weren't provided to Arizona as input into those files. Claims with a Program Type of Waiver start occurring in the 2003 files.
				Quantity	The quantity is always missing in the 1999 files. This will be fixed in the 2000 files.
				Service Code	The most frequent Service Code in the 1999 OT file is Z9020 (taxes). The taxes are carried as separate line items on Hawaii claims. These claims will be included in the 1999 files, but should be ignored except for reporting expenditures. This was corrected in the 2000 files.
				Type of Service	In 2003 there was a very large increase in Home Health expenditures, but not in users.
					Starting in 2003 the "Medicaid Amount Paid" is only available on the header portion of the UB-92 claim and not associated with each line item. Arizona submits the line item claims with $0 "Medicaid Amount Paid" and a summary claim without the service detail, but with the total Medicaid Paid. During MAX processing, the line item claims with $0 paid are dropped. Prior to 2003, each line item had the total amount paid from the header resulting in the over reporting of outpatient hospital expenditures.

State	File Type	Record Type	Crossover	Measure	Issue
HI	Claims	OT		UB-92	Fee-for-service (FFS) non-crossover outpatient hospital claims (MAX TOS=11) do not have any revenue codes or service codes in the 2000 and 2001 files. Some outpatient hospital claims had service codes in 1999.
		RX		Dates	The fill date is reported in both the fill and prescribed date fields, so the prescribed date should be ignored.
				Quantity	The service quantity is missing on most of the 1999 RX claims.

State	File Type	Record Type	Crossover	Measure	Issue
IA	Claims	IP		Family Planning	There are no family planning services in the IP file because they are billed separately on HCFA 1500 forms.
		LT		Diagnosis	The diagnosis code is missing on most claims.
				Patient Status	IA reports almost no one with a patient status of "died."
		OT		Capitation	PCCM capitation payments are reported as Service Tracking claims, therefore are not included in MAX
				Type of Service	There are no claims with a type of service of personal care services (PCS) (Type of Service 30) and hospice.

State	File Type	Record Type	Crossover	Measure	Issue
ID	All	All		MSIS ID	There was a change in the assignment of MSIS ID Numbers just prior to 1999, so the ID numbers in the previous files will not link to the post-1998 files.
	Claims	IP		DRG	ID does not report DRGs and KFF reports that the state does not use DRG-based reimbursement for inpatient services.
				Family Planning	There are no claims with the Program Type of Family Planning.
		LT		Type of Service	About 20 percent of the claims have a type of service of ICF/MR which is much higher than expected.
		OT		Capitation	ID switched from submitting individual PCCM capitation claims to reporting them as Service Tracking claims in 2004.

State	File Type	Record Type	Crossover	Measure	Issue
IL	Claims	All		SSCHIP	IL erroneously included claims for SSCHIP only enrollees through 2003. They should not have been included as they are not Title 19.
				SSCHIP only Claims	Illinois included claims for services provided for people enrolled in SSCHIP only in the 2003 and possibly earlier MAX files. They were deleted started in 2004.
		IP		Adjustments	The IP files have a large number of debit claims that do not link to original claims. They appear to be replacements without the original and void claims. These claims are missing some key information such as UB-92 and diagnosis codes. It turns out that the state specific adjustment rules were not correct. They were revised starting with the 2000 files.
				UB-92 Codes	There are some claims without UB-92 Revenue Codes or procedures because there are so many debit claims and those claims do not have that information.
		LT		Amount Paid	The "Medicaid Amount Paid" in the 1999 and 2000 files for claims with a Type of Service of 02 (Mental Hospital Services for the Aged) was very high because claims that were actually service tracking were reported as fee-for-service (FFS). This also means that covered days are not correctly reported.
				Patient Status	Discharge Status is missing on all claims.
				TPL	third party liability (TPL) amount is always missing.
				Type of Service	Up until FFY MSIS Q3 2001, Illinois incorrectly reported claims for Inpatient Psychiatric Facility Services for Individuals Age 21 Years and Under (MAX Type of Service (TOS) 04) Under age 21 with a TOS of Nursing Facility (NF).
			Crossover	Claim Count	There are very few crossover LT claims.
		OT		Capitation Claims	It was not possible to properly adjust the capitation claims because the dates of service on the original and adjustment claims did not match.

State	File Type	Record Type	Crossover	Measure	Issue
IL	Claims	OT		Type of Service	Residential Care was under reported in the 2001-2002 files.
					There are very few dental claims in the 1999 files due to confusion with the dental provider. This was corrected in 2001.
		RX		Adjustments	The RX claims could not be properly adjusted because the adjustment claims do not include the NDC and couldn't be linked with the original. Therefore, some claims that were actually voided appear in the MAX 1999 files.

State	File Type	Record Type	Crossover	Measure	Issue
IN	Claims	All		SSCHIP	IN included some SSCHIP only claims in the MSIS files and therefore are in the MAX files through 2003.
				SSCHIP only Claims	Indiana included claims for services provided for people enrolled in SSCHIP only in the 2003 and possibly earlier MAX files. They were deleted started in 2004.
		IP		Program Type	There are no claims with a program type of family planning.
				TPL	Very few claims have third party liability (TPL) amount.
		RX		Prescribed Date	The Date Filled is also in the Date Prescribed field.

State	File Type	Record Type	Crossover	Measure	Issue
KS	Claims	All		MSIS ID	KS sumitted some encounter and capitation claims with MSIS ID's that do not match the ones used on the eligibility file starting in 2003.
					Some KS encounter and capitation claims do not have the same MSIS ID as the eligibility files resulting in about 10% of the MSIS ID's with claims missing eligibility information. The state has been unable to send a cross reference file so far.
					KS included state-only (non federal financial participation (FFP)) claims in their MSIS files in 1999 through 2002 and possibly later. There is no way to identify these claims, except they are among those claims that don't link with the MAX eligibility records. They continue to include some encounter claims with MSIS ID's that do not link with the eligibility files.
		LT		Covered Days	If the state does not pay for all covered days on claim, the covered days field is not corrected on the claim, only the payment is changed for the approved number of covered days.
				Medicaid Amount Paid	There is a higher percent of claims with $0 "Medicaid Amount Paid", due to the application of spend down.
				Patient Liability	The expected percent of claims with patient share payments is lower than expected, but the state verifies that it is correct.
		OT		Capitation Claims	HMO and Primary Care Case Management (PCCM) capitation claims are under reported by about 20 percent in 1999 - 2000 and again in 2004.
				Diagnosis Codes	KS uses some local diagnosis codes.
				Program Type	There is a big decrease in the reported Family Planning, FQHC and RHC users in 2004.
				Rehabilitation	The expenditure per person for rehabilitation claims expanded dramatically in 2002 due to the implementation of a disabled to work program.

State	File Type	Record Type	Crossover	Measure	Issue
KS	Claims	OT		Type of Service	In 2003, there was an increase in the number of Type of Service 19 (Other Services) along with a much larger increase in expenditures for Other Services.
					There are some significant shifts in the distribution by Type of Service in 2004.
				UB-92	The state system does not carry UB-92 revenue codes on outpatient hospital claims, but all outpatient hospital claims have service codes.
		RX		Dates	The "Date Filled" is also reported in the "Date Prescribed" field.

State	File Type	Record Type	Crossover	Measure	Issue
KY	Claims	All		MSIS ID	In MAX 2003, 2.1% of the MSIS ID's found in the claims files do not link with the MSIS ID's in the eligibility file.
		IP		DRG	KY did not report DRGs in the MSIS files although KFF reports that the state does use DRG-based reimbursement for inpatient services.
			Crossover	Claim Count	There is a large decrease in FFS crossover claims starting in MAX 2003.
					There is a large decrease in the number of FFS crossover claims starting in 2003.
		LT		Leave Days	Kentucky does not report leave days although the state plan indicates that KY covers leave days in several circumstances.
		OT		Capitation	The 1999 files do not include individual Primary Care Case Management (PCCM) capitation claims. They are reported starting with 2000.
				Dental Codes	Dental codes flagged as state specific. They can be converted into HPCPS codes by replacing leading 0 with D
				Family Planning	There are no family planning (FP) claims.
				Type of Service	There are no claims with a Type of Service of PCS or Rehabilitation.
					Almost everyone is enrolled in a transportation managed care plan. However, there are about 25,000 people in 2003 with FFS transportation claims with an average amount paid over $400. It is possible these are payments for types of transportation not covered by the managed care plans.

State	File Type	Record Type	Crossover	Measure	Issue
LA	Claims	All		MSIS ID	In the 2003 MAX files, 6.4% of the MSIS ID's from claims do not link with the eligibility MSIS ID's. The percentage dropped to 3.8% in 2004. This appears to be the result of the failure of LA to submit linked SSN/Temporary ID eligibility files into MSIS.
		IP		DRGs	LA's IP file does not contain DRGs and KFF reports that the state does not use DRG-based reimbursement for inpatient services.
				Procedure Code	The principal procedure code date is missing.
					In the 1999 files Procedure Code two has "88" added to the end of the field. LA will fix in future.
			Crossover	Claim Count	A large percent (70 percent for MAX 2002) of LA's IP claims are crossover claims. The state verifies that this is correct.
		LT		Admission Date	The Admission Date is missing on most records.
				Diagnosis Codes	The diagnosis codes are missing on most claims.
		OT		Program Type	Beginning in 2003, the state began paying a fixed rate for FQHC and RHC services. They submit summary claims with the Medicaid Amount Paid and line items for specific services with $0 Medicaid Paid.
				Service Code Flag	About 10 percent of the 1999 claims have a service code flag of 10 (indicating use of a state-specific coding scheme), but a service code value of "0." The meaning of the 0s has not been explained.
				Type of Service	In 2003, there was a 300% increase in the users and expenditures for Other Practitioner services.

State	File Type	Record Type	Crossover	Measure	Issue
LA	Claims	OT		Type of Service	There are no claims with a Type of Service of Residential Care.

State	File Type	Record Type	Crossover	Measure	Issue
MA	Claims	All		Capitation	Capitation payments to plans are quarterly, rather than the more typical monthly payments. Even so, there appears to be somewhat of a shortfall (fewer records than expected) of capitation claims as there are fewer capitation claims than quarterly enrollment in managed care.
				SSCHIP	MA erroneously included some SSCHIP only claims in the MSIS files and therefore are in the MAX files through 2003.
				SSCHIP only Claims	MA included a few claims for services provided for people enrolled in SSCHIP only in the 2003 and possibly earlier MAX files. They were deleted started in 2004.
		IP	Crossover	Claim Count	There are a large percentage of crossover claimsin the IP file.
		LT		DiagnosisCodes	There are very few diagnosis codes on the files.
				Leave Days	No Leave Days are reported on the files although MA covers up to 35 days of leave per year.
		OT		Capitation	BHO capitation claims were reported with a Type of service of PCCM capitation until the end of 2004. As a result, there is a mixture of reporting BHO BHO capitation claims as PCCM and BHO in the MAX 2003 files. Primary Care Case Management (PCCM) payments are only made if there is actually a PCCM visit.
				Place of Service	Almost 30 percent of the original, non-crossover claims do not have a "Place of Service." Most of these claims are Outpatient Hospital department claims (MAX Type of Service (TOS) = 11) or Lab and X-ray claims (MAX Type of Service (TOS) = 15).
				Program Type	Most services to children under age 21 have a Program Type of EPSDT.

State	File Type	Record Type	Crossover	Measure	Issue
MA	Claims	OT		Program Type	In 2004 the declining enrollment in waivers resulted in a decrease in claims with a Program Type of Waiver (code 6,7).

State	File Type	Record Type	Crossover	Measure	Issue
MD	Claims	All		Managed Care	Nearly two-thirds of Medicaid recipients are enrolled in the HealthChoice Program. The remaining one-third tend to be either sicker (many institutionalized) or covered by Medicare. As a result, the distribution of Maryland's fee-for-service (FFS) claims may seem quite different from the distribution for other states.
				SSCHIP	MD included some claims for SSCHIP only enrollees through 2004. These claims should not have been included as they are not Title 19.
				SSCHIP only Claims	Maryland included a few claims claims for services provided for people enrolled in SSCHIP only in the 2003 and possibly earlier MAX files. They were deleted started in 2004.
		IP		Amount Paid	Because nearly two-thirds of Medicaid recipients are enrolled in managed care, the fee-for-service hospital costs tend to be higher than for other states with less Medicaid managed care. See above comment about types of enrollees included in fee-for-service (FFS).
				DRG	Maryland does not use DRGs for reimbursement and consequently does not report DRGs on its files.
				UB-92 Codes	MD has a unique IP hospital reimbursement system. A higher than expected percentage of original, non-crossover fee-for-service (FFS) claims do not have ancillary revenue codes.
		LT		Diagnosis Codes	Most LT claims do not have diagnosis codes.
				Leave Days	Maryland does not report "Leave Days" on its files even though the state covers leave days in various circumstances.
				Patient Status	No one has a "Patient Status Code" of "died."
					MD reports no one with a patient status of "died."

State	File Type	Record Type	Crossover	Measure	Issue
MD	Claims	LT	Crossover	Claim Count	There are no crossover claims
		OT		Type of Service	The distribution of claims, by Type of Service, is unusual due to the high percentage of individuals enrolled in managed care. Most of the original, non-crossover fee-for-service (FFS) claims are for Home Health, Physical/Occupational Therapy or Rehabilitation.
		RX		Family Planning	There are no Family Planning claims.

State	File Type	Record Type	Crossover	Measure	Issue
ME	Claims	All		Adjustments	It is not possible to properly adjust many of the adjustment claims in the file because they do not adhere to MSIS adjustment reporting standards.
				SSCHIP	ME included some SSCHIP only claims in the MSIS files and therefore are in the MAX files through 2003.
				SSCHIP only Claims	Maine included a few claims for services provided for people enrolled in SSCHIP only in the 2003 and possibly earlier MAX files. They were deleted started in 2004.
		IP		DRG	ME did not report DRGs in the MSIS files and KFF reports that ME does not use a DRG-based reimbursement system for inpatient services.
				Family Planning	Family Planning program type is not reported.
			Crossover	Coins/Deduct.	ME stopped paying the Medicare Coinsurance/Deductibles on IP claims in about 2001, so there are very few crossover claims in the file.
		LT		Leave Days	Maine does not report any "Leave Days" on its files although it covers leave days in several circumstances.
		OT		Adjustments	There are very few adjustment claims on the files. Maine has indicated that the number of adjustment claims is accurate.
				Amount Paid	Maine creates a summary bill on outpatient department claims with separate line items. Each line item should be included as a separate claim without the third party liability (TPL) amount, and then an additional claim should be included that has only the third party liability (TPL) amount. The third party liability (TPL) amount would be a negative dollar value matching the positive value in the Other Third Party Payment field. As a result, there are original and resubmittal claims with a negative "Medicaid Amount Paid."
				Capitation	ME did not start submitting Primary Care Case Management (PCCM) capitation payments until FFY 2000 Q1.

State	File Type	Record Type	Crossover	Measure	Issue
ME	Claims	OT		Capitation	ME discontinued its managed care program in 2001, so there are no more HMO capitation claims after that time.
				Type of Service	Some service codes with Service Code Indicator = 6 (HCPCS) are not the correct format for HCPCS codes. In 2002 MAX files, HCPCS are identified on 26 percent of OT FFS Non-crossover claims, and incorrectly formatted on 15 percent of these claims.
		RX		Adjustment Claims	There are no adjustment claims on the file. Maine has indicated that this is OK, because drug claims are paid at the Point of Service.

State	File Type	Record Type	Crossover	Measure	Issue
MI	Claims	All		MSCHIP Claims	When MI resubmitted the MSIS Q2-4 2004 files to include it's new M-SCHIP waiver adult group, they did not include the claims for these enrollees. About 50,000 of the enrollees are believed to be in managed care and MI believes that the capitation claims were submitted. There are about 26,000 enrollees who were enrolled in FFS that did not have claims submitted.
				TPL	third party liability (TPL) amount is missing on all claims.
		IP/RX		MSIS ID	The percentage of MSIS claims using the same MSIS ID as reported in the eligibility files started deteriorating in 2002. The decline has continued mostly on RX encounter claims. .
		LT		Amount Paid	In 2003, MI pulled out part of the Nursing Facility (NF) bundled rate and paid them as service tracking claims (Quality Assurance Supplement).
				Covered Days	Prior to 2002, MI did not report covered days on most claims with a Type of Service of Aged Mental Hospital.
		OT		Capitation	There is a slight under-reporting of individual HMO capitation payment claims in 1999 and 2000.
					The behavioral health organization (BHO) capitation payments are reported as lump sum payments in the 1999 - 2002 OT files. The state started submitting individual BHO capitation payments in 2003.
				Diagnosis	In using the 1999 files, researchers found a substantial number of elderly individuals with claims in MI files for diagnoses of "conduct disorders," a mental illness usually found in children. It is likely that these codes are incorrect, and thus users should be cautious of mental health coding quality.
				Place of Service	The Place of Service of ER is not reported in the 1999 - 2000 MSIS files.

State	File Type	Record Type	Crossover	Measure	Issue
MI	Claims	OT		Service Codes	There are no service codes or UB-92 revenue codes on outpatient hospital claims.
		RX		MSIS ID	Some encounter RX claims do not carry a MSIS ID that links with the MSIS eligibility files.
					The MSIS ID on some RX encounter claims does not match the MSIS ID used in the eligibility file.

State	File Type	Record Type	Crossover	Measure	Issue
MN	Claims	All		MSIS ID	The percentage of MAX claims that don't link with the MAX PS files is about two percent in 2002. That is slightly higher that the expected rate and no explanation has been provided by the state.
		IP		Family Planning	There are no family planning claims. The state said none meet the definition. The professional component is billed in the OT file.
				Patient Status	There was a large increase in the percentage of Patient Status = Transferred from 1998 - 1999 (5 percent to 20 percent) for fee-for-service (FFS) non-crossover claims
		IP/LT		Chemical Dependency	Starting in late 2001 the state moved their chemical dependency claims from IP to LT.
		LT		Diagnosis Codes	The diagnosis code is "00000" on many claims.
				ICF/MR claims	The percent of ICF/MR claims is greater than expected.
				ICF/MR days	The ICF/MR days are missing on many ICF/MR claims.
		OT		Lab Claims	The percent of lab claims is lower than expected in 1999.
				Provider Specialty	The provider specialty code is missing on most claims.
				Psych Services	MN is an outlier, having a high average "Medicaid Amount Paid" per user for psych services of $6211 and a high proportion of FFS Non-Duals using psych services (21%). The high user proportion may be related to high managed care penetration rates, so that the FFS population may not be representative of the Medicaid population as a whole. No investigation has been done on this issue.

State	File Type	Record Type	Crossover	Measure	Issue
MO	Claims	IP		DRG	The state does not report DRGs and KFF reports that the state does not use DRG-based reimbursement for inpatient services..
				Patient Status	The percent of claims with a patient status code of "still a patient" is higher than expected.
				Serv Code Ind	The service code indicator was erroneously reported as CPT-4 instead of ICD-9 until MAX 2004.
		LT		Admission Date	The Admission Date is missing.
		OT		Service Codes	The outpatient hospital claims have service codes instead of UB-92 revenue codes.
				Servicing ID	The Servicing ID is mostly missing
				Type of Service	About one third of the claims have a type of service of "other services." The state says these are mostly for homemaker chores.
		RX		Date Prescribed	The Date Prescribed is always missing.

State	File Type	Record Type	Crossover	Measure	Issue
MS	Claims	All		Medicaid Paid	MS went to a new claims system in FFY 2004 Q1. Because this would have caused a delay in payments to providers, they made large propective lump sum payments. Since Service Tracking claims are not included in MAX, some expenditures are not included.
		IP		DRGs	The state does not report DRGs and KFF reports that the state does not use DRG-based reimbursement for inpatient services.
				Family Planning	There are no claims with a Type of Program of Family Planning.
		LT		Type of Service	MS does not cover Mental Hospital Services for the Aged.
		OT		Capitation	The MS HMO program ended 10/99, however, there are some lagged capitation claims and around 8,000 HMO enrollees listed in the Q1 and Q2 2000 EL files.
					The state reports that they have been submitting capitation payments for disease management as service tracking claims.
				PCCM	There are few Primary Care Case Management (PCCM) claims in the 1999 files. The state starting including these claims in the FFY 2000 files. The PCCM program was discontinued in April 2002 resulting in the decrease that year in PCCM capitation claims.
				Specialty	MS stopped reporting Physician Specialty in 2004.
				Type of Service	MS reported Lab/Xray claims with a Type of Service of OPD until the end of 2004. As a result, Lab/Xray is under reported.
			Crossover	Claim Count	About 30 percent of the OT claims are flagged as crossover claims which is higher than expected, especially in a state with very little full managed care.

State	File Type	Record Type	Crossover	Measure	Issue
MS	Claims	RX		Quantity	The Quantity was not reported on most drug claims in 2000 and 2001, but starting in 2004 is reported on all claims The Quantiy is most missing in the 2002 and 2003 files.

State	File Type	Record Type	Crossover	Measure	Issue
MT	Claims	IP		DRGs	The DRGs appear to be CMS DRGs, but they are reported as state-specific.
				Program Type	There are few claims with a Program Type of Family Planning. According to the state, Family Planning services have to be identified using procedure codes resulting in under reporting.
		LT		Patient Status	1999 - 2004 files: Patient Status is not available on most claims. Montana claims that only a few facilities ever report anything in the field, and that when something is reported it is almost always "unknown."
					MT reports no one with a patient status of "died."
				TPL	The third party liability (TPL) amount is mostly combined with patient liability due to state system reporting.
				Type of Service	1999 - 2001 files: State reports that mental health services are entirely state-funded and therefore not included in MSIS.
			Crossover	Claim Count	There are no crossover claims on the file. The state does not process long term facility claims as crossovers.
		OT		Service Type	In 2003 there was a large increase in the number of claims with Type of Service 19 (Other Services) and a decrease the the Adult Day Care and Residental Care.
				Type of Service	The percent of lab claims is lower than expected in 1999.
					There are no claims with a type of service of rehabilitation in the files until 2004.

State	File Type	Record Type	Crossover	Measure	Issue
NC	Claims	All		Adjustments	There are very few adjustments as the state does most of their adjustments as cost settlements.
				SSCHIP	NC included some claims for SSCHIP only enrollees.
		IP		Adjustments	There are probably some duplicate claims in the file as a result of how adjustments were reported into MSIS. The state sometimes submitted the original claim and the resubmittal - coded as an original - without a void.
				DRG	There is a small percent of claims with state defined DRGs. (801-805, 810).
		LT		ICF/MR	There is a somewhat higher than expected percentage of ICF/MR claims, but the state confirms this is correct.
		OT		Capitation	It appears that NC submitted their behavioral health organization (BHO) capitation payments claims with a type of service 20 (HMO Cap) instead of 21 (PHP cap). These claims can be properly identified using the Plan ID.
				Place of Service	The place of service is missing or has invalid codes on most claims in 1999. The percent with valid codes has increased somewhat over time. About 60 percent of the OT claims have valid codes in the 2002 files.
				Service Code Indicator	The Service Code Indicator was not properly reported on some claims in 1999 - 2003.
				Type of Service	Some personal care services (PCS) are reported as Other Services and some as PCS. They need to be identified using service codes.
		RX		Dates	The fill date is also reported in the prescribed date field through FFY 2005 Q3. The prescribed date in the 1999-2005 files should be ignored.
				NDC	The file contains some non-standard state defined NDCs. They start with "OA."

State	File Type	Record Type	Crossover	Measure	Issue
ND	Claims	All		MSIS ID	Over 3% of the MSIS ID's used on the claims do not link with the MSIS ID's on the eligibility file in 200 and 2004.
				SSCHIP	ND included some SSCHIP only claims in the MSIS files and therefore are in the MAX files through 2003.
				SSCHIP only claims	North Dakota included claims for services provided for people enrolled in SSCHIP only in the 2003 and possibly earlier MAX files. They were deleted started in 2004.
		IP		UB-92 Codes	About 6 percent of the claims do not have ancillary codes. This is because MH and rehabilitation claims are billed using the comprehensive UB-92 code that includes accommodations and ancillary services.
		LT		Diagnosis Codes	Nearly all of the claims do not have diagnosis codes.
				Type of Service	There is a big increase in the number of claims with a Type of Service of IP <21 in the MAX 2003 files.
		OT		Service Codes	ND has some state defined service codes that are a single letter (e.g. M, L, E). The state has not submitted the definitions of those codes, even though they have been requested.
				Service Type	In 2004 there was a big increase in physician and rehabilation users.
				Type of Service	Starting in 2002 through 2005, ND did not properly report the Type of Service. Almost half of the claims have a Type of Service of Other Services.

State	File Type	Record Type	Crossover	Measure	Issue
NE	Claims	OT		Capitation	From 2002 - 2004 the state did not submit individual behavioral health organization (BHO) capitation claims, although almost everyone is enrolled in a BHO during that time. These claims were submitted as PCCM service tracking claims because they are for BHO case management.
				Service Tracking	In the 1999 and 2003 files, NE include a lump sum claims for most of their waiver, transportation, and targeted case management claims. Most of these claims are processed outside of Nebraska's MMIS. As a result, these expenditures are excluded from the MAX files.
		RX		Missing Variables	The following data elements are not available: Days Supply, Date Prescribed, and New Refill Indicator.

State	File Type	Record Type	Crossover	Measure	Issue
NH	Claims	LT		Adjustments	Many claims could not be properly adjusted because of how adjustment claims were submitted to MSIS. There are likely to be duplicates because only the original and replacement claims were reported and the voids were not included. Days are repeated on every claim, also overstating covered days.
				Admission Date	The Admission Date is missing on most claims as that information is not collected on the NH claim form.
				Type of Service	There are no claims with a Type of Service of Aged Mental Hospital even though they are in the states type of service crosswalk.
		OT		Capitation	Managed care was discontinued in 2003, so there are no capitation claims in 2004.
				Diagnosis Codes	About a quarter of the clinic claims do not contain a diagnosis code.
		RX		Adjustments	Credit claims are reported into MSIS as original claims, so that expenditures and services are overstated in the 2003 files.

State	File Type	Record Type	Crossover	Measure	Issue
NJ	Claims	All		MSIS ID	2.1% of the MSIS ID's on claims do not link with the MSIS ID's in the eligibility file in 2003. In 2004 a SSN/MSIS ID cross reference file provided by the state was used to update the SSN field and correct the MSIS ID for people with claims but not eligibility.
		LT		Type of Service	The claims from 5-6 inpatient psych hospitals were inadvertently left out of the files prior to FFY 2002. This was fixed starting with Q1 2003. The state doesn't know how long those claims were omitted.
		OT`		Service Type	There was a large increase in claims with a Type of Service of Targeted Case Management in 2004.

State	File Type	Record Type	Crossover	Measure	Issue
NM	All	All		MSIS ID	About 2.5 percent of the people with claims don't link with the eligibility file due to an error in reporting of MSIS IDs in both file types. This was corrected in 2003.
	Claims	IP		DRGs	Approximately one-quarter of NM's IP claims correctly do not show DRGs. These include Indian Health Service (IHS) claims that are reimbursed on a per diem basis.
				Duals	There are many more crossover claims than non-crossover claims, because dually eligible recipients are not in managed care, and virtually all other recipients are.
				Family Planning	There are no family planning claims until 2003.
				UB-92 Codes	Approximately one-quarter of the original, non-crossover claims do not have ancillary codes. These include Indian Health Service (IHS) inpatient per diem claims.
		LT		Diagnosis Codes	The diagnosis code is missing on most claims.
		OT		Place of Service	New Mexico does not currently have a separate Place of Service code for ER. For a UB-92 invoice, any line item with a rev code of 450, 451, or 452 would be considered an emergency room place of service. The State does not have the information needed to capture ER place of service on their physician/clinic claims.
				Program Type	Program Type of I.H.S was under reported in the 1999 files. This was corrected in 2000.
				Service Type	In 2004 there was a large increase in claims with a Type of Service of Other Services.
				Type of Service	In 2001 there was a shift in reporting claims by type of service, particularly for Lab/Xray and Other Services.
		RX		Drug Groupers	The percent of drug claims with HICL, Medispan, AHFS, GTC, GC3, and Smart Key are all on the low side indicating that some claims may have not contained valid NDCs.

State	File Type	Record Type	Crossover	Measure	Issue
NM	Claims	RX		Program Type	Drug claims for Indian Health Services (HIS) enrollees were not reported with a program type of IHS in the 1999 - 2001 MAX files. Program Type of IHS was only reported on the source MSIS files from Q2 2003 - Q1 2004.

State	File Type	Record Type	Crossover	Measure	Issue
NV	All	All		MSIS ID	NV is a SSN state. However they failed to submit temp IDs linked with the SSNs in the MSIS eligibility file. This mostly impacts the linkage for some newborns. In the 2002/2003 files about 5% of the claims did not link with the eligibility records using MSIS ID.
	Claims	IP		Diagnosis	The diagnosis code fields 2-9 are blank in the 1999-2003 files, because the state does not collect this information in its existing system.
				DRGs	The DRG code is always missing as NV doesn't use DRGs for hospital reimbursement (confirmed by KFF).
				Procedure Codes	The state put state-defined codes in the IP procedure code field that just report the type of hospital stay - like medical/surgical 1 -5 days stay. This was corrected starting in 2003.
				Revenue Codes	There are no revenue codes in the 1999-2002 files, because the state's system did not capture the revenue codes during those years. By 2004, most IP claims have UB revenue codes.
		IP, LT, OT		Diagnosis	In 1999 the diagnosis codes are padded with zeros. All diagnosis codes are five digit codes, as a result. This was fixed for the most part starting with the 2000 files.
		LT		Covered Days	Covered Days are missing for claims classified as Inpatient Psychiatric Facility Services for Individuals Age 21 Years and Under (MSIS MAX Type of Service (TOS) 04) until 2004.
				Diagnosis	Diagnosis codes are missing on most claims in 1999, but are reported for the most part starting with the 2000 files.
				Leave Days	The files do not include any "Leave Days" even though Nevada covers up to 24 leave days per year.

State	File Type	Record Type	Crossover	Measure	Issue
NV	Claims	LT		Type of Service	There are very few claims with a type of service 02 (Mental Hospital Services for the Aged) even thought they are covered services according to the state plan.
		OT		Capitation	No one is enrolled in a PHP managed care plan until 2003/2004, but there are some PHP capitation claims in the 1999 file. Starting in 2003 some people were enrolled in non-emergency manage care.
				Diagnosis	The invalid diagnosis code of "42" occurs frequently.
					About 10 percent of 1999 claims expected to have diagnosis codes, are missing them.
				Physician Claims	Less than 3 percent of the original claims are physician claims in 1999 - 2001.
				Place of Service	Place of service is missing, or no appropriate MSIS code exists, on about 20 percent of the original claims.
				Provider ID	The Provider ID Servicing Number is not reported.
				Provider Specialty	NV did not start reporting Provider Specialty until the 2003 MAX files.
				Revenue Codes	There are no revenue codes on outpatient hospital department claims. These claims do have service codes, however.
				Span	The percent of claims billed as span bills increased in 2004. They were mostly Home Health and OPD claims.
				Type of Service	The state began a transportation managed care program in 2003, but did not report individual capitation claims.
					About 40 percent of the original claims are for Lab/X-ray services in the 1999 - 2001 files.

State	File Type	Record Type	Crossover	Measure	Issue
NV	Claims	RX		Refill Indicator	The new refill indicator field is missing.
				Date Prescribed	The date prescribed is missing (1999-2003).
				Quantity	NV started reporting Quanity in 2003.

State	File Type	Record Type	Crossover	Measure	Issue
NY	Claims	IP		DRGs	New York reports DRGs on approximately two thirds of its IP claims. NY uses a DRG reimbursement methodology, except for certain psychiatric and rehabilitative service providers that are paid on a per diem basis.
				Length of Stay	The average length of stay in IP facilities is 16 days. This may be due to swing beds, inpatient psych beds (not in a separately reporting unit).
				Lombardi Payments	New York switched from submitting the Lombardi payments in 1999/2000 as service tracking claims (not included in MAX), to supplemental claims in 2001. However, Lombardi payments are supposed to be for LTC services it is unclear why they are in the IP file. This is under investigation.
		IP/OT		UB-92	The New York State Medicaid program does not utilize the UB-92 Claim Form for Hospital Inpatient services nor the HCFA-1500 Claim Form for Hospital Outpatient services. Instead the state uses the EMC Version 4.0 or 5.0. The state has its own rate codes that was included as an attachment with its application. Therefore, there are no UB-92 Revenue Codes on the IP or OT file (Outpatient Hospital Department claims).
		LT		Admission Date	Admission Date is not available in the 1999 - 2001 files.
				Amount Paid	The bundled Nursing Facility (NF) rate includes maintenance drugs. Therefore, specific information about those drugs is not available.
					Some adjustment claims have the wrong sign for the type of adjustment. This was due to a change to the reimbursement system.
				Covered Days	Almost 40% of the NF claims do not have covered days as a result of the inclusion of claims for lots of unbundled services.
				Diagnosis Codes	Only a small percent of LT claims have a diagnosis code.
				Patient Liability	The percent of claims with Patient Liability is much lower than expected.

State	File Type	Record Type	Crossover	Measure	Issue
NY	Claims	OT		Capitation	New York was unable to submit PHP (BHO) capitation payment claims in 1999/2000 and the number of Primary Care Case Management (PCCM) capitation claims was under-reported. New York continues to have a mis-match between the number of person months of enrollment in various types of managed care and the number of capitation claims.
					New York moved AIDS case management payments from Primary Care Case Management (PCCM) capitation claims to TCM after 1999. As a result the average PCCM capitation payment was quite high that year.
				FQHC	The state does not have Federally Qualified Health Center (FQHC) claims in the 1999 - 2000 files and in 2001-2003 are under-reported.
				Place of Service	The Place of Service of "home" is reported on over 40 percent of the OT claims. This corresponds to the number of claims with a Type of Service of home health (HH) or personal care services (PCS) (Type of Service 30).
				Service Codes	Many claims have local procedure codes. Most of these are state specific rate codes.
		RX		NDC	In the first half of CY 1999, the NDC field has leading zeros when it contains a HCPCS code. This was corrected beginning in 2000.

State	File Type	Record Type	Crossover	Measure	Issue
OH	Claims	LT		Admission Date	Admission Date is missing.
				Diagnosis	Diagnosis Codes are missing on virtually all LT claims.
				Leave Days	Ohio covers up to 30 leave days per person per year and "Leave Days" are reported on the files.
				Patient Status	Patient status is missing on most claims, and accordingly no one is reported as "died."
		OT		Physician Specialty	Physician specialty is not reported.
				Type of Service	There are no claims with a Type of Service of Personal Care (PCS).
		RX		Refill Indicator	The Refill Indicator is missing.
				Days Supply	Days Supply is not reported in the 1999 - 2002 files.
				TPL	Third party liability (TPL) amount is missing

State	File Type	Record Type	Crossover	Measure	Issue
OK	All	All		MSIS ID	Starting in 2003, OK began using new MSIS ID Numbers. The state submitted a crosswalk that was used to convert the "old" MSIS IDs to the "new" ones during MAX file construction.
	Claims			All	OK discontinued their HMO enrollment in Jan 2004. Most people are enrolled in Other Managed Care. This has a big impact on the PS Validation tables. That is, HMO enrollees are excluded from the FFS sections of the tables, but PHP enrollees are included. This results in a big increase in the number of people, expenditures and users in 2004 reported in the PS validation table.
		IP		DRGs	OK does not report any DRGs as the state does not use them for reimbursement (confirmed by KFF).
				Program Type	There are very few Family Planning claims through 2002. In 2003 there were none.
				UB-92	A higher than expected percent of claims do not have UB-92 revenue codes. This is because claims for the Indian Health Service (IHS) and residential treatment centers are not billed on a UB-92. However, the Program Type of IHS appears to be under-reported in the IP file. Some residential treatment centers may be incorrectly reported in the IP file.
		IP/LT/OT		Adjustments	Some void claims have an "Medicaid Amount Paid" of $0 resulting in the possible over reporting of expenditures when the adjustments process is done in MAX.
		LT		Diagnosis	Most claims do not have a diagnosis code until 2003.
				Patient Status	Patient Status Code is missing on most claims until 2003.
		OT		Capitation	Primary Care Case Management (PCCM) is covered under PHP plans for most people, so what appears to be a shortfall (fewer records than expected) of PCCM capitation claims is in reality not.

State	File Type	Record Type	Crossover	Measure	Issue
OK	Claims	OT		Diagnosis	Some of the diagnosis codes may have an extra zero or two because this field is not edited by the state.

State	File Type	Record Type	Crossover	Measure	Issue
OR	Claims	All		FFS Services	Because so many people are enrolled in managed care, the distribution of fee-for-service (FFS) services is sometimes unusual.
				SSCHIP	OR erroneously included some SSCHIP only claims in the MSIS files and therefore are in the MAX files through 2003.
				SSCHIP only Claims	Oregon included some claims for services provided for people enrolled in SSCHIP only in the 2003 and possibly earlier MAX files. They were deleted starting in 2004.
		IP		Patient Status	There aren't any claims with a patient status of "still a patient'
		LT		Patient Liability/TPL	The patient liability field contains both third party liability (TPL) amount and patient liability. This can't be corrected until the whole system is revised
			Crossover	Claim Count	There are no claims identified as crossovers.
		OT		Dental Claims	There is a low percentage of dental claims as most people are enrolled in dental managed care.
				Program Type	There aren't any Federally Qualified Health Center (FQHC) claims, even though the state has an FQHC program.
				Type of Service	About one third of the claims have a Type of Service of Transportation.
		RX		Dates	The fill date is reported in both the fill and prescribed date fields in the MAX 1999-2003 files so the prescribed date should be ignored.

State	File Type	Record Type	Crossover	Measure	Issue
PA	Claims	All		MSIS ID	Over 3% of the people with claims do not have any enrollment information. These occur mainly for people with only capitation claims, but my include some claims for non-Medicaid services.
				Non-Medicaid	The PA MMIS includes some claims for state only (non-Medicaid) services. These were submitted into MSIS and so they are included in the MAX files. This occurred primarily when someones eligibility status is retoractively changed from Medicaid to state only (such as for a delivery).
		IP		UB-92 Codes	Some IP claims are billed on non-UB92 claim forms and therefore don't contain UB-92 revenue codes.
		LT		Patient Status	Patient status is missing on most claims as it isn't available in the state system.
		LT/OT		Unbundled Services	Services billed by LTC facilities that are not part of the bundle covered by the monthly rate, were reported in the OT file until 2004 when PA started reporting them in the LT file. There is a backlog of those un-bundled claims that show up in the 2004 file.
		OT		Capitation	Global payments to managed care plans for deliveries are billed as PHP capitation claims. This is a supplemental payment.
				Diagnosis	The diagnosis code on some EPSDT screens is coded as "EPSDT."
				PCCM	There aren't any individual Primary Care Case Management (PCCM) claims in the 1999-2002 files. PA started submitting them in 2003.
				Physician Specialty	Physician specialty is not reported in the 1999 - 2002 files. It is reported starting with the 2003 files.
				Program Type	Waiver claims are included in the 1999 - 2001 files, but they are not all flagged with the Program Type of Waiver during those years.

State	File Type	Record Type	Crossover	Measure	Issue
PA	Claims	OT		UB92	The outpatient hospital claims do not have UB-92 revenue codes as they are not billed on a UB-92 form.
		RX		Charge	Charge Amount is missing on many claims.
				Date	The Fill Date is also reported in the Prescribed Date field until the end of 2004. The Prescribed Date field should be ignored.

State	File Type	Record Type	Crossover	Measure	Issue
RI	All	IP/LT/OT	Crossover	Medicaid Paid	There are some crossover claims that have extremely high Coinsurance and Total Medicaid Amount Paid values. It is an error in the input MSIS files submitted by the state. These values should be ignored.
	Claims	All		Claims Files	The 1999 claims files have serious problems that can't be fixed due to the limitation of the source files (MARS). RI will have to change their system in order to fix most of these problems.
				MSIS ID	In MAX 2003, 2.8% of the MSIS ID's on claims do not link with the eligibility file.
		IP		DRGs	There are no DRGs on the IP files and KFF reports that the state does not use DRG-based reimbursement for inpatient services..
				Procedure Codes	Very few procedure codes are included in the file.
				TPL	There are only a few very large third party liability (TPL) amount payments in the 1999 file. They appear to be service tracking claims.
				UB-92 Codes	There is only one UB-92 Revenue Code on each claim because that is all that is available in the source files. Most of claims have an accommodation code and a few have only an ancillary code.
			Crossover	Claim Count	There are an unusually high number of crossover claims. This may be due to incorrect reporting of Medicare Coinsurance and Deductible Payments.
		LT		Diagnosis	Diagnosis codes are missing on most LT claims until 2003, when they are reported on about 40% of the claims.
				Leave Days	The file does not contain any Leave Days and RI does not specify coverage of leave days in its state plan.

State	File Type	Record Type	Crossover	Measure	Issue
RI	Claims	OT		Type of Service	There are no claims with a Type of Service of 34 (Physical Therapy, Occupational Therapy, Speech Therapy and Hearing/Language Services).
		RX		Program Type	There aren't any claims with a type of program of Family Planning.
				Quantity	The quantity on most claims is 0 in the 1999 - 2001 MAX files.

State	File Type	Record Type	Crossover	Measure	Issue
SC	Claims	IP		Medicaid Paid	The states submits very large expenditures on Service Tracking claims. Since Service Tracking claims can not be linked to individuals, they are not included in MAX. (1999-2003)
				Patient Status	There aren't any claims with a Patient Status of 'still a patient'.
				Program Type	SC stopped reporting Family Planning in the IP file in 2003
			Crossover	Claim Count	The percentage of crossover IP claims in 1999 - 2001 is much higher than expected due to the change to reporting line items. Starting in 2002, crossover claims were transitioned from individual to service tracking claims. As a result there is a drop in crossover claims that year.
		IP/LT/OT		Adjustments	No IP, OT, or RX adjustment claims were reported on SC's MSIS files through 2004, and only a very small number of LT claims were adjustment records. The absence of adjustment records probably means that expenditures are overstated.
		LT		Diagnosis	"Diagnosis Codes" are reported only on claims for "Inpatient Psychiatric Facility Services for Individuals Age 21 Years and Under (MSIS MAX Type of Service (TOS) 04)."
				Leave Days	Leave Days are not reported on claims although SC covers leave days in many different situations.
				Missing Variables	The "Admission Date" and patient status are usually missing.
				Type of Service	Over 10% of the claims are for ICF/MR services. (1999-2003)
		OT			Most of the expenditures for transportation are submitted as Service Tracking claims into MSIS, therefore are not available in MAX. (1999-2003)

State	File Type	Record Type	Crossover	Measure	Issue
SC	Claims	RX		Date Prescribed	The "Date Prescribed" is missing.

State	File Type	Record Type	Crossover	Measure	Issue
SD	Claims	All		Revenue Codes	Indian Health Service claims are often billed on forms that do not include UB-92 Revenue Codes. (1999-2003)
		IP		Claim Type	In 1999 Crippled Children's Hospitals were reported in the IP instead of LT file. These claims are identified as having a Provider Number of 021xxxx.
		LT		Covered Days	The IP covered days are mostly missing on claims with a type of service 04 (Inpatient Psychiatric Facility Services for Individuals Age 21 Years and Under (MAX Type of Service (TOS) 04))
				Diagnosis	Diagnosis Codes are missing on virtually all claims on the LT file.
		OT		Dental	Virtually everyone is enrolled in Delta Dental managed care. In 1999 the PHP capitation claims are actually encounter claims from Delta Dental with the "Medicaid Amount Paid" by DD to their providers. Starting in 2000, this problem is straightened out and the file contains the true dental capitation claims with a type of service 21 (PHP).
				Type of Service	In 1999, some lab/x-ray services were reported with a type of service of physician. This was corrected in 2000.
				UB-92 Codes.	Indian Health Service (IHS) claims are billed on a UB-92, with a Type of Service of 12, Clinic. These claims have revenue codes, but do not have service codes.
		RX		Dates	The fill date is reported in both the fill and prescribed date fields, so the prescribed date should be ignored.

State	File Type	Record Type	Crossover	Measure	Issue
TN	All	All		MSIS ID	The TN Medicaid ID (RID) changes when there are changes in eligibility. From FFY 1999 Q1 - 2004 Q4 they used the original RID for the MSIS ID in the MSIS files. However, in FFY 2005 there was a processor change and they submitted the current RID resulting in about 600,000 enrollees having a different number from 2004. TN has been asked to resubmit the 2006 Q1 MSIS files using the original RID. For the MAX 2003 and 2004 processing, we are using a cross reference file sent by the state to put the original RID on all claims and eligiblity records.
	Claims			All	Calendar years 2002-2003 was the period of transition by TN from encounter to fee-for-service (FFS) reporting, so the files contain a mixture of encounter and fee-for-service (FFS) claims, making it difficult to interpret.
				Capitation	TN has received permission to continue reporting 'no-risk' HMO as managed care enrollment and to submit HMO capitation claims with the administration fee for processing the claims. (This will become confusing starting in 2007 when TN has a mixture of risk and no-risk HMO's.(2002-2003)
				Managed Care	In July 2002 TN switched from reimbursing their managed care plans with monthly capitation payments to paying the plans for services on a fee-for-service (FFS) basis plus an administrative fee. This was supposed to be a temporary measure to help bail out the plans, but is lasting longer than anticipated. Starting with FFY 2002 Q3, TN started reporting the payments for services as fee-for-service (FFS) rather than encounters. They still reported virtually all enrollees as being in both HMO and PHP managed care. So in the 2001 MAX files, there are a small percentage of fee-for-service (FFS) claims that are the result of this transition. Since they were services provided before the switch to fee-for-service (FFS), they are really probably encounters, but they are left in the MAX files as fee-for-service (FFS).
				MSIS ID	The state assigns new MSIS IDs to enrollees who change their enrollment. This results in an over reporting of the number of enrollees. TN submitted the MSIS FFY 2005 files using the current state Medicaid ID instead of the usual original Medicaid ID. A cross reference file will need to be used to convert the 'current' into 'original in the construction of the MAX 2004 and 2005 files. (2004-2005)

State	File Type	Record Type	Crossover	Measure	Issue
TN	Claims	IP		DRG	The state does not report DRGs.
				IP Services	There are no IP fee-for-service (FFS) claims except for crossover claims in the 1999 - 2001 filesdue to the statewide enrollment in managed care during those years.
		LT		LTC Services	IN 1999-2002 LTC services are carved out of managed care so the LT file contains only fee-for-service (FFS) claims.
		OT		Claim Type	The only fee-for-service (FFS) claims in the 1999 - 2002 OT files are for capitation payments and crossovers.
				Dental	Dental services were carved out from the managed care plans starting in October 2002 and were then administered by a Dental Benefits Manager (DBM). Claims for those services are also included in the source MSIS files.
				Program Type	TN does not report Program Types of FQHC or RHC. (1999-2003)
					There are very few claims with a Program Type of waiver in the files. (1999-2003)
		RX		Adjustments	RX claims can't be properly adjusted since the adjustment claims do not have the NDC.
				Claim Count	BHO pharmacy claims were not reported as FFS claims untile 2003.

State	File Type	Record Type	Crossover	Measure	Issue
TN	Claims	RX		Drug Claims	Originally drug claims were included in the managed care contracts. However, in July 1996, behavioral health organization (BHO) pharmacy claims were carved out and in July 2000 the pharmacy services for dual eligible were carved out. Starting in July 2003, all pharmacy services have been carved out of managed care. The pharmacy services are processed by their Pharmacy Benefits Manager (PBM). Even though these claims are paid for on a fee-for-service (FFS) basis, they are included in the TN files as encounter claims without any "Medicaid Amount Paid." The expenditures are not included in the MSIS files as service tracking claims either. TN has been asked to resubmit the 2002 Q4 and forward MSIS files to add the "Medicaid Amount Paid" and change the claims to fee-for-service (FFS). This means that in the 1999 - 2001 files, drug expenditures are under reported.
				Fill Date	The fill date is reported in the prescribed date field.
				NDC	The NDC is missing on adjustment claims until mid-2004.

State	File Type	Record Type	Crossover	Measure	Issue
TX	Claims	All		Crossover	Most IP/LT/OT claims had $0 Medicaid Amount Paid in 2004 as a result of discontinuing to replace the Medicaid Amount Paid with the sum of Medicare Coinsurance and Deductibles and so they were dropped in the 2004 MAX files.
				Provider ID	The provider ID numbers changed in 2001. This means that some 2001 claims can't be properly adjusted as the Provider ID is part of the adjustment sort key.
		IP		Procedure Codes	Texas uses the following procedure codes: "MXXX" and "KXXX"; these are codes on the National Heritage Insurance Company (NHIC) Procedure Master File. NHIC previously used these codes for: MXXX: Medicaid prior approval; KXXX: Chronically Ill Disabled Children (CIDC) Inpatient Prior Authorization.
		LT		Adjustments	It was difficult to properly adjust some claims due to how they were submitted to MSIS.
				Admission Date	The Admission Date is missing in the 1999 - 2001 MAX files.
				Claim Count	There is a big increase in the number of LT claims between 1999 and 2000 and then again between 2000 - 2001. The state has no explanation.
				Diagnosis	The diagnosis codes are missing on most LT claims.
				Patient Liability	Patient Liability is not reported in 1999, but is in the files from 2000 forward.
				Patient Status	Patient Status is missing on most claims in 1999 - 2001.
				TPL	Third party liability (TPL) amount is not included in the 1999 file and there are only a few TPL payments in the 2000-2003 files.
		OT		Diagnosis	In 1999 a small percentage of claims have an invalid diagnosis code (02).

State	File Type	Record Type	Crossover	Measure	Issue
TX	Claims	OT		PCCM	The Primary Care Case Management (PCCM) $3 fee is included with any expenditures for medical services during the visit and can not be separated because of the adjustment process. So the only PCCM capitation claims are those that are paid for case management only. The combination claims (PCCM + service) are assigned the TOS based on the medical service.
				Place of Service	The Place of Service is missing or invalid on about 10 percent of the claims.
				Service Code	Some 1999 - 2000 claims have an invalid combination of service codes and service code indicators based on the format of the service code.
				TPL	The TPL amount is not on most claims because it is carried only at the header level. (1999-2003)
				Transportaton	Capitation payments for transportation managed care are submitted as service tracking claims so are not in the MAX files.
				Type of Service	The transportation capitation claims and enrollment is not included in the 1999-2003 MAX files as it was not available in the source MSIS files.
					There are very few claims with a Type of Service of Other Practitioner and a much higher than expected percent of claims with a Type of Service of Physician.
					There is a big change in the distribution of claims by type of service starting during 2001 because the state changed its system and in the process reviewed how they were assigning type of service.
					TX is an outlier in the high proportion of FFS Non-Duals using psych services (33%). However, these users' per person "Medicaid Amount Paid" for these services averages only $333, substantially below the national median of $1786. The high user proportion might be related to what populations are not covered under managed care, but no investigation has been done on this issue.

State	File Type	Record Type	Crossover	Measure	Issue
TX	Claims	Sources		State Agencies	TX has a large number of state agencies responsible for the administration and processing of Medicaid claims for different parts of the program making it difficult for them to collect and report Medicaid services uniformly in MSIS

State	File Type	Record Type	Crossover	Measure	Issue
UT	All	All		MSIS ID	About 5% of the OT MSIS IDs that were incorrectly submitted and do not link with the MSIS IDs from the eligibility files. (1999-2003). Some of these may be foster care children.
	Claims			All	HMO's were discontinued in 2004 resulting in a change of pattern of FFS use.
		IP		Patient Status	No one is reported as being "still a patient."
		LT		Missing Variables	The ‘Admission Date and ‘patient status" are missing on most nursing home/institutional claims because Utah does not retain the data on the input record.
		OT		Capitation	Starting in 2004, the HMO's switched from providing services on an 'at-risk' basis to effectively acting as a claims processor (non-risk HMO). The capitation claims are only for the administrative fee paid to the plans. The services are submitted as FFS. (2003-)
					There are no Primary Care Case Management (PCCM) capitation claims in the OT file as they are paid on a FFS basis as the service occurs. (1999-2003)
					There are very few capitation claims for people enrolled in HMOs in 1999 and early 2000.
				Clinics	The average amount paid on clinic claims was about $800 in 1999 and dropped to about $225 in 2000/2001. In part this is the result of not pulling out the lab and xray claims from the 1999 files.
				Physician Specialty	The physician specialty codes are missing on 60 percent of physician claims in 1999 - 2001.
				Place of Service	Emergency room claims are under reported prior to 2003.

State	File Type	Record Type	Crossover	Measure	Issue
UT	Claims	OT		Program Type	Most claims for children have a Program Type of EPSDT
				Service Place	Place of service is missing on about 20 percent of the claims in 1999 - 2001.

State	File Type	Record Type	Crossover	Measure	Issue
VA	All	OT		PACE	VA has a very small pre-PACE program of about 20 individuals. The billing is done outside of MMIS and is not included.
	Claims	All		FFS Claims	There was a drop in FFS claims in the 2004 files due to an increase in HMO enrollment.
		IP		Covered Days	VA has a 21 day limit on adult IP care.
				Deliveries	In 2003, there is a big increase in deliveries.
				DRG	In early years of MAX data, VA did not submit DRG codes since they were assigned in a post-payment process solely for cost settlement. Since 2000, VA has reported DRGs.
				Patient Status	The percent of claims where the person is "still a patient" is somewhat higher than expected.
				Procedure Code Indicator	The IP claims all contain ICD-9 codes, but the state used the wrong Procedure Code Indicator (code 10) starting in MSIS 2004. The state will correct in future years.
			Crossover	Claim Count	IN 2003, there is a big increase in the number of crossover claims.
		LT		Leave Days	Leave Days are not carried in VA's claims files and are thus not reported in MAX data even though the state covers up to 18 leave days per year.
				Patient Liability	The percent of claims with patient liability is less than expected. This is because the providers are not always consistent about including that information on the claims.
				Type of Service	According to the "Medicaid at a Glance" chart, VA does not cover inpatient psychiatric care for those under 21 but the MAX data show users and expenditures for this Type of Service.

State	File Type	Record Type	Crossover	Measure	Issue
VA	Claims	LT		Type of Service	In 2003, the % of claims with a Type of Service of ICF/MR went from 0 to 11%.
		OT		Capitation	PCCM claims were not included in the 1999-2000 files and there are only a few in 2001. Starting in 2002, the number of PCCM claims matched the PCCM enrollment. There was a drop again in PCCM claims in 2003. Primary Care Case Management (PCCM) capitation claims are not included in the 1999 and 2000 files. There are only a very few in 2001.
				Capitation Claims	There is a decrease in the ratio of HMO and PCCM capitation claims per person monrh of enrollment in 2004. The state has not been able to provide a reason.
				Claim Count	There is a decrease in the number of fee-for-service (FFS) claims in 2002 due to increased HMO enrollment. In 2003 the number of users and expenditures increased to a reasonable level.
				Program Type	Some of the state's waiver services are either not included in MSIS or not identified as waiver services.
				Provider ID's	The servicing and billing provider ID numbers are usually the same. When available they are putting the attending provider ID in the servicing field.
				Span Bills	Due to an increase in the submission of summary OPD bills instead of line item claims there are fewer claims with large expenditures in 2004.
				Type of Service	There are many fewer claims in 2002-2003 with a type of service of transportation with a higher average payment. This may the result of creating span bills instead of individual line item transportation claims. VA did not submit individual claims for transportation services in the 1999 - 2003 files as they are provided by the counties as a type of managed care. The payments to the counties are based on the estimated number of enrollees.

State	File Type	Record Type	Crossover	Measure	Issue
VA	Claims	RX		NDC	VA does not have the capacity of using HCPCS inputs on pharmacy claims. Universal codes or '9' filled values are used for DMEs without NDCs. Pharmacy claims without NDCs can be compounds or other unidentifiable items.

State	File Type	Record Type	Crossover	Measure	Issue
VT	Claims	All		Adjustments	Across the four files, there are fewer than expected adjustment claims. Specifically, less than 1 percent of the claims are adjustment claims.
				Type of Service	The end of the VT HMO enrollment in mid-2000 has an impact on the distribution of the Type of Service.
		IP		DRGs	The State does not use DRGs.
			Crossover	Claim Count	About one half of the claims are reported as crossovers in 1999. It drops to a more reasonable 30 percent in 2000-2003.
		LT		Leave Days	Very few Leave days are reported in the file.
		OT		Capitation	HMO enrollment ended in mid 2000 resulting in a different in the validation tables between ever enrolled during the year in an HMO and enrolled in June in an HMO. In 2001 forward, the only managed care program is PCCM. In 2003, there is a decrease in the percent of individual PCCM capitation claims because VT started reporting some of the PCCM expenditures as Service Tracking claims.
				Capitation Claims	Starting in 2003, VT began reporting individual PCCM capitation claims. However, they erroneously reported MSIS ID's starting with '&' and Adjustment Indicators = 4 (gross adjustments). The MAX production system deleted them as they appeared to service tracking claims. This occurred in both the 2003 and 2004 MAX files.
				Diagnosis Codes	Through 2003, all OT claims, regardless of type of service have a diagnosis code. This is because it is required for state reporting.
				Physician Specialty	VT stopped reporting physician specialty during 1999.
				Revenue Codes	The State has State-specific Revenue Codes for Home Health and Hospice Services.

State	File Type	Record Type	Crossover	Measure	Issue
VT	Claims	RX		Dates	The fill date is also reported in the prescribed date field.

State	File Type	Record Type	Crossover	Measure	Issue
WA	All	All		MSIS ID	Some source 1999 MSIS claims, particularly adjustment records had extra S's in the MSIS ID field and thus didn't match the original claims. These had to be removed to construct the MAX files.
	Claims				In 2002, about 8 percent of the people with claims do not link to the MSIS eligibility file. These are mostly Family Planning Only waiver enrollees who have incorrect MSIS ID in the source 2003 Q3 MSIS files. WA is unable to provide a cross reference file from the invalid to valid MSIS Ids.
		IP		Family Planning	There are no claims with a Program Type of Family Planning in the IP file as WA reports that family planning (FP) IP services are always done as a secondary procedure.
		LT		Diagnosis	Most LT claims do not have any diagnosis codes.
				Leave Days	WA does not report any "Leave Days" even though the state plan specifies coverage of leave days in some circumstances.
				Missing Claims	The state submitted payments for Inpatient Psychiatric Facility Services for Individuals Age 21 Years and Under (MAX Type of Service (TOS) 04) services as lump sum payments in 1999 - 2001.
				Patient Status	None of the claims have a Patient Status code of "died."
		OT		Adjustments	The file does not contain voids for some adjusted claims, so there appear to be some duplicate claims. The state reported resubmitted claims as originals, so there are some adjustment sets with just two originals, but no void. These are left in the MAX files, but there are very few of them.
				Capitation	The behavioral health organization (BHO) capitation claims are included with the waiver claims in 2002-2003 and submitted as service tracking.

State	File Type	Record Type	Crossover	Measure	Issue
WA	Claims	OT		Capitation	There is a shortfall of Primary Care Case Management (PCCM) capitation claims, even considering the low PCCM enrollment.
					The capitation payments made to managed care plans that use FQHC's do not include the FQHC supplemental payments. The are erroneously reported with a Type of Service of Supplemental starting in 2005. (2004-2005).
				FQHC	Capitation payments to managed care plans for Federally Qualified Health Center (FQHC) services do not include the supplemental FQHC payments. Those payments are made directly to the FQHCs as a lump sum payment, so are not included in MAX.
				Program Type	WA does not include individual claims processed by 6 agencies within the Dept. of Social and Health Services. These agencies are Children's Administration, Juvenile Rehab. Administration, Mental Health, Division of Developmental Disabilities, Aging and Disabled Administration, Div of Alcohol and Substance Abuse). They were submitted as service tracking claims in the 1999 files with a TOC = 3. They are not included in the 2000 files, but will be included again as service tracking claims in the 2001 and 2002 files. Starting with 2003, WA submit some of these claims as service tracking and some as individual claims.
				Service Codes	There are some duplicate service codes that have different definitions. The state did not use different Service Code Indicators so that the meanings can be differentiated. This did not impact very many claims.
				Waivers	WA reported their waiver services as service tracking claims so they are not included in the MAX files through 2002. They also bundle their behavioral health organization (BHO) capitation payments with those waiver services. Starting in 200e they will be able to submit some, but not all of the waiver services as individual claims. The BHO capitation payments continue to be bundled on service tracking claims.
		RX		Claim Count	Drugs provided under a bundled rate for people who are institutionized (MH and dD waivers) are not separately reported in the RX file, resulting in the under reporting of drugs.

State	File Type	Record Type	Crossover	Measure	Issue
WA	Claims	RX		Dates	WA put the Date Prescribed into the Date Filled field from Q1 1999 - 2002. They corrected and resubmitted the 2003 forward RX files to correct. There are two main impacts. First, claims that were prescribed prior to the MAX CY file, but refilled during the CY, are excluded from the file. Secondly, if there are multiple refills for a drug prescribed during the year, it is not possible to correctly adjust them.

State	File Type	Record Type	Crossover	Measure	Issue
WI	All	All		MSIS ID	WI is not an SSN state, but they submit MSIS records as if they were. The MSIS ID is the SSN plus a 1 byte check digit. In order to link the EL and claims for MAX, the check digit had to be dropped and the replacement of temporary IDs with SSNs was done as if they were an SSN state.
	Claims	IP		Family Planning	Family planning is not reported in the 1999 - 2003 files.
		OT		Adjustments	The WI capitation claims could not be properly adjusted because the dates on the adjustment claims do not match those on the original claims. The result is that there are some capitation claims in the file that were actually voided.
				Capitation	WI changes the date of service to match the date of payment since the HMO capitation claims are made prospectively and their system won't allow payment for a service before it is rendered. This means that if a capitation payment for April is made in March, the dates of service will be changed to March resulting in the cap payments always being one month prior to the managed care enrollment. Also, this results in the adjustments not linking to the original claims by date of payment.
					The PHP capitation rate is very high as it is used to cover managed care services for aged and disabled beneficiaries.
				Diagnosis Codes	The state system requires diagnosis codes on all claims regardless of TOS
				PCCM Caps	The average paid on Primary Care Case Management (PCCM) capitation claims is very high as they include some other services.
				Place of Service	The Place of Service of ER is under-reported because it is only picked up using UB-92 revenue codes. The state plans a system change to pick up ER for all ER services.

State	File Type	Record Type	Crossover	Measure	Issue
WI	Claims	OT		Type of Service	Some procedure code indicator values are incorrect. Procedure codes 71110, 71111, 71120, 71130 have service indicators of both 01 and 99. Because these procedure codes can be either national or local codes, the procedure indicators should be a combination of national values and something between 10 and 87 (local). However, the codes are all mapped to either 01 or 99. This makes it impossible to distinguish the national values from the local values.
				UB-92	UB-92 code 001 occurs on many outpatient hospital claims as the state uses it for rate reimbursement
		RX		Prior Authorization	Prior authorization drugs are coded with "88888888888'

State	File Type	Record Type	Crossover	Measure	Issue
WV	Claims	All		MSIS ID	In 2003, 5% of the MSIS ID's found in the claims do not link with the eligibility MSIS ID's.
		IP		Program Type	There are no claims with Program Type of family planning in 1999 - 2003.
		LT		Diagnosis	Diagnosis codes are missing on most claims.
				Type of Service	There aren't any claims with a MAX Type of Service (TOS) of 02 (Mental Hospital Services for the Aged) although WV's state plan indicates these services are covered.
		OT		Capitation	The 1999 files does not contain individual HMO capitation claims.
				Capitation Claims	WV will switch from submitting their HMO capitation claims as service tracking claims to individual claims in FFY 2005 Q3.
				PCCM Caps	Primary Care Case Management (PCCM) capitation claims are under reported in the 1999 files.
		RX		Program Type	Family Planning is under-reported in the 1999 - 2003 files.
				TPL	third party liability (TPL) amount is missing on all claims in 1999-2000.

State	File Type	Record Type	Crossover	Measure	Issue
WY	Claims	All		MSIS ID	A MSIS ID cross reference file was used to assign the same MSIS ID's to claims and eligibility during MAX processing in 2003 and 2004. This reduced the unlinked MSIS ID's to approximately 3%.
		IP		DRG	WY does not use DRGs for inpatient hospital reimbursement and DRGs are therefore not included on the files.
		LT		Admission Date	The Admission Date is missing.
				Diagnosis Codes	The diagnosis code is missing on most records.
				Type of Service	According to the "Medicaid at a Glance" chart, WY does not cover inpatient psychiatric care for those under 21 but the MAX data show users and expenditures for this Type of Service.
		OT		Capitation	Wyoming has no managed care and therefore no capitation claims.