Medicaid Manual

Part 2 - State Organization and General Administration

Table of Contents

2700 - Federal Reporting Requirements....1

2700.10 - Maintenance Assistance Status and Basis of Eligibility....2

2700.20 - Eligibility Crosswalk....2

2700.30 - Definitions of MSIS Types of Service....2

2700.40 - Definitions of MSIS Program Type Coding....2

2700.50 - Service and Program Hierarchies....2

2700.60 - Racial/Ethnic Classifications....2

2700 - Federal Reporting Requirements

The Medicaid Statistical Information System (MSIS) was mandated by the Balanced Budget Act of 1997 (BBA). The BBA requires that States provide for electronic claims data transmission based on specifications outlined by CMS. The purpose of MSIS is to provide Medicaid data needed for program evaluation, budgeting, planning, and to respond to inquiries at the Federal level. It does not provide all of the information needed for surveillance and administration.

Following are instructions and definitions to use in creating and submitting MSIS files. The electronic MSIS files are used to report Medicaid cost and utilization data annually to CMS by States, Territories, and the District of Columbia. Unless otherwise noted, use of the word "State" in the following sections refers to all reporting jurisdictions.

The Paperwork Reduction Act of 1995 provides that no person need respond to a Federal collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0345. The time required to complete this information collection is estimated to average 32 hours for MSIS States per response, including the time to review instructions, search existing data resources, create the data tapes and transmit the files. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Report Medicaid program data through quarterly submittals of MSIS data tapes. Submit tapes containing eligibility and claims information that meet CMS's MSIS specifications.

A - Purpose

The Medicaid Statistical Information System (MSIS) creates a national Medicaid database of person-specific eligibility and claims information. This database is used for analytical research, planning, budgeting, and policy analyses associated with the Medicaid program. MSIS allows for more timely availability of program information and enhances the capacity for program information changes in the Medicaid program.

B - Requirements

The MSIS submission must follow the process and meet the systems and data specifications outlined in the document, the "Tape Specifications and Data Dictionary." This document describes each file type and the data elements within the files. The tape specifications include the coding of data fields, tape formats and record layouts of each required file. The data dictionary section contains definitions of data elements for each file, the field length, and other relevant information.

C - Preparation of MSIS Tapes

Submit quarterly eligibility and claims data tapes as outlined in the "Tape Specifications and Data Dictionary."

Below are a number of general principles that apply in preparing the MSIS data tapes.

- While most of the data required for reporting resides in the State's Medicaid Management Information System (MMIS), the reporting requirements are not restricted to data contained in the MMIS. Examples of data that may need to be merged from outside sources include capitation payment records from enrollment systems, eligibility characteristic data from eligibility intake systems, and Medicaid services processed by non-MMIS State departments, such as mental health services. These data represent crucial components of the Medicaid program, and their omission would seriously compromise the utility of the MSIS national database.

- All data fields must be included on the MSIS files. All data elements in the "Tape Specifications and Data Dictionary," are required to allow for national analysis of a broad spectrum of issues. Inconsistent reporting of required fields would limit the utility of MSIS. Any exceptions to comprehensive reporting must be agreed to by CMS on an individual basis.

- Some required fields that must be reported include, but are not limited to, Medicaid beneficiary's Social Security Number, inpatient diagnosis codes and procedure codes, inpatient revenue codes, capitated premium payments and fees (including PCCM fees), and recipient plan enrollment data, if available at the State level.

- Eligibility and service crosswalks that realign State-specific categories into standardized Federal reporting must be submitted to facilitate data validation and analysis. Most fields in the MSIS record represent direct extracts from eligibility and claims records that exist in the State's MMIS (and supplemental systems). However, data elements that represent standardized Federal reporting coding include eligibility codes (maintenance assistance status and basis of eligibility) and Federal type-of-service and program type codes. These broad categorical codes are defined in later subsections of 2700. In order to validate State data and to facilitate use of these coded values, States must supply crosswalks defining the content of each relevant code value. Update the crosswalks when State coding changes occur and provide to CMS 30 days prior to the beginning of the affected period.

- In addition to these crosswalks, you must submit State case number definitions, capitated plan identifying numbers and names, and lists of State drug-specific formularies, procedure code modifiers, and specialty codes. This information is necessary to allow interpretation and analysis of many service-related fields.

D - MSIS Data Submission Requirements

States submit the following Federal fiscal year (FFY) quarterly data files to CMS.

File ELIGIBLE - A file of basic information on all Eligibles. This file includes all eligibles enrolled in the State's Medicaid program for the reporting quarter regardless of service utilization. It includes information such as birth date, sex, race, days of eligibility, maintenance assistance status, basis of eligibility and plan enrollment.

File CLAIM-IP - A file of adjudicated claims for "Inpatient Hospital Care" for the reporting quarter. This file includes all inpatient hospital claims, mental health or general. Information collected includes types of coverage and service, dates of service, diagnosis, procedures, provider identifications, third party and Medicare payments, and Medicaid payment amounts. This file will also contain encounter records for inpatient services that are provided under a capitated plan.

File CLAIM-LT - A file of adjudicated claims for "Long Term Institutional Care" for the reporting quarter. This file includes all long-term care claims, whether ICF-MR or general. Information collected includes types of coverage and service, dates of service, diagnoses, provider identifications, third party and Medicare payments, and Medicaid payment amounts. This file will also contain encounter records for long-term care services that are provided under a capitated plan.

File CLAIM-RX - A file of all adjudicated claims for drugs for the reporting quarter. Information collected includes drug codes, date prescribed, drug units, drug days in supply, and prescribing provider. This file will contain encounter records for prescription services that are provided under a capitated plan.

File CLAIM-OT - A file of "Other" adjudicated claims that includes all other claims for services not included in CLAIM-IP, CLAIM-LT, or CLAIM-RX for the reporting

quarter. Information collected on this file includes type of service, dates of service, diagnoses, procedures, provider identification, third party and Medicare payments, and Medicaid payment amounts. This file will contain premium payments and encounter records for services that are provided under a capitated plan.

Include encounter data in appropriate claims file. Data fields that are not available for encounter records must be documented by the State.

These files must be submitted no later than 45 days after the end of each Federal fiscal quarter. Under certain conditions, alternate submission schedules can be arranged. However, all departures from already approved submission timetables must be approved in advance by CMS central office. Submit data files to the following address:

CMS Data Center
Attn: Foreign Tape Library
7500 Security Blvd.
Baltimore, Maryland 21244

E - Quality Assurance Criteria (Edit Checks and Error Tolerances)

After the quarterly MSIS tape files are submitted, CMS will run edits for validation purposes. (All MSIS tape files submitted to CMS undergo thorough editing and validation testing.) In general, four types of edits are performed:

- Range checks on individual data elements;
- Missing data checks;
- Logical consistency checks among two or more data elements; and
- Distributional checks for reasonableness.

Each element in the MSIS files includes an associated error tolerance. Tolerances vary from element to element and can be as low as 0.1 percent. Lists of error tolerances are presented in the "Tape Specifications and Data Dictionary."

MSIS tape files are considered acceptable after two sets of quality criteria are met. For the first check, the edit run is acceptable if every data element in the file has an error rate that is below its tolerance. The second process is a data quality and distributional review, which validates the reasonableness of individual data elements and compares totals and distributions across months and quarters. CMS will notify the States of all validation problems after processing the tapes. If you have received notice of validation problems, you have an additional 30 workdays from the date of that notification to correct and resubmit the tape(s). As with other MSIS submission deadlines, CMS exercises flexibility when unusual circumstances arise. However, all deadline changes require prior approval from CMS central office.

2700.10 - Maintenance Assistance Status and Basis of Eligibility

A - Maintenance Assistance Status

Individuals certified eligible for Medicaid are grouped by Maintenance Assistance Status (MAS). Those categories are:

- Individuals Receiving Cash Assistance or Eligible under §1931 of the Act;
- Medically Needy Eligibles;
- Poverty-Related Eligibles;
- Other Eligibles; and
- Section 1115 Demonstration Medicaid Expansion Eligibles.

Use the following sets of descriptions as definitions of the contents of each MAS category.

Individuals Receiving Cash Assistance, or Eligible Under §1931 of the Act

These are individuals who are eligible for Medicaid by meeting the specified requirements of one of the following groups. Those reported as individuals receiving cash assistance or eligible under §1931 of the Act are:

- Individuals qualifying for Medicaid under §1931 of the Act (low-income families with children);
- Individuals receiving SSI benefits (including participants in the §1619(b) work incentive and those receiving optional State supplementation); and
- Individuals receiving mandatory State supplements.

Medically Needy Eligibles

The medically needy are individuals who are not categorically needy and who have insufficient finances to meet the cost of their medical care and/or expenses. These individuals meet the categorical requirements for Medicaid, but have too much income or resources to qualify for cash assistance. This group also includes individuals who have too much income to qualify under related group or any other eligibility group the State opts to cover.

Some applicants have incomes that exceed the Medically Needy Income Level (MNIL). There are two ways for medically needy individuals with excess income to qualify. First, such individuals may qualify for Medicaid by **spending down** to a State established level by incurring expenses for necessary medical and remedial care.

An individual who does not qualify for Medicaid under the preceding paragraph may apply an alternative methodology for establishing medically needy eligibility, such as the

pay-in spenddown option. If you elect this option, Medicaid applicants may establish eligibility after paying an amount which, when combined with expenses incurred in prior months, will reduce the individual's income below the applicable income limitations. Therefore, the applicant may become eligible after payment of this amount to the State instead of becoming eligible only after having actually incurred expenses.

Poverty Related Eligibles

This category encompasses all individuals who have become eligible for Medicaid because their family income falls below a specified percentage of the Federal Poverty Level (FPL) except for persons made eligible under the authority of the §1115 waivers. These individuals are generally eligible as a result of legislative changes that began in 1986, allowing States to delink eligibility for Medicaid from eligibility for cash assistance. This legislation includes the Medicare and Medicaid Catastrophic Assistance Act of 1986 that established the QMB and SLMB coverage provisions, the Omnibus Budget Reconciliation Bills from 1986-1990 that expanded Medicaid income thresholds for children and pregnant women, and more recently under the Balanced Budget Act of 1997 that created the State Child Health Insurance Program (SCHIP) under Title XXI. This heading includes the following mandatory and optional coverage groups:

- Aged and disabled persons with incomes up to 100% of the FPL who are qualified Medicare beneficiaries and eligible for full Medicaid cost sharing benefits, but not full Medicaid benefits (QMBs only) ;

- Aged and disabled persons with incomes up to 120% of the FPL who are specified low-income Medicare beneficiaries and eligible for limited Medicare cost-sharing benefits, but not full Medicaid benefits (SLMBs only);

- Qualified disabled working persons (QDWI) with incomes up to 200% of the FPL who are entitled to premium payments for Part A Medicare, but not full Medicaid benefits;

- Aged and disabled persons with incomes up to 135% of the FPL (QI-1s) and 175% of the FPL (QI-2s) who are eligible for limited Medicare cost-sharing, but not full Medicaid benefits;

- Aged and disabled persons with incomes up to 100% of the FPL who receive full Medicaid coverage;

- Pregnant women and infants with incomes above 133% and not in excess of 185% of the FPL;

- Pregnant women, infants under age 1, and children under age 6 whose family incomes are below 133% of the FPL;

- Mandatory groups of children born after September 30, 1983 whose family incomes are at or below 100% of the FPL;

- Individuals made eligible under the more liberal income and resource disregards

of §1902(r)(2) of the Act;

- Children and adults eligible for expanded Medicaid coverage under the State Child Health Insurance Program (SCHIP). (Children covered under separate SCHIP, but not under expanded Medicaid coverage should not be included in this group); and
- Individuals covered under the Breast and Cervical Cancer Prevention and Treatment Act of 2000.

Other Eligibles

This category contains all other Title XIX groups of individuals, mandatory and optional, who are eligible based on provisions that are not tied to cash assistance, the medically needy program, or a relationship to the FPL. They include, but are not limited to, the following eligibility categories:

- Children receiving Title IV-E foster care payments or adoption assistance;
- Individuals who are institutionalized and eligible under a special income level that does not exceed 300% of the SSI Federal benefit rate;
- Individuals who, because of coverage under a home and community based waiver are not in a medical institution, but who would be eligible if they were;
- Individuals who receive hospice care, who would be eligible if in a medical institution;
- Katie Beckett children, which is a group of certain disabled children under age 19 who live at home, but who would be eligible if in a medical institution;
- Families receiving up to 12 months of extended benefits ;
- Individuals who are ineligible for AFDC-related Medicaid because of requirements that do not apply under Title XIX;
- Certain blind or disabled individuals, age 18 or older, who are ineligible for SSI due only to OASDI benefits;
- Title II widow(er)s, who would continue to be eligible for SSI but for their Title II benefits, who have not become eligible for Medicare Part A;
- Aliens who are not lawful, permanent residents or who do not have PRUCOL status, but who are otherwise qualified, and who require emergency care;
- Individuals who would be eligible for AFDC-related Medicaid, SSI, or an optional State supplement if not in a medical institution;
- Individuals who would be eligible for AFDC-related Medicaid if the State used the broadest allowable AFDC criteria;

- Caretaker relatives who, but for income and resources, would be eligible for AFDC-related Medicaid or SSI;
- Individuals who are ineligible for SSI because of requirements that do not apply under title XIX; and
- Children leaving foster care due to age.

Section 1115 Demonstration - Medicaid Expansion Eligibles

The individuals in this category are eligible solely due to Medicaid expansions based on a §1115 Demonstration. Section 1115 eligibles may quality for full or limited Medicaid benefits. Usually, eligibility is determined by comparing family income to some percent of the FPL. Eligibles may include aged, disabled, child and/or adult individuals. Cost sharing may be required.

B - Basis of Eligibility

All individuals certified eligible for Medicaid must be classified under a basis of eligibility (BOE) for medical care. The following bases of eligibility are used in a matrix format with the maintenance assistance status categories:

- Aged;
- Blind/disabled;
- Children;
- Adults;
- Children and adults based on unemployed parent (UP) deprivation (optional category);
- Foster care children; and
- Individuals covered under the Breast and Cervical Cancer Prevention and Treatment Act of 2000.

Use the following sets of descriptions as definitions of the contents of each BOE category.

Aged or Blind or Disabled

Except for States that elect, under §209(b) of the Act, to supply more restrictive criteria, use the definitions established by the Supplemental Security Income (SSI) program to determine whether an individual is aged, or blind or disabled. It is important to note that disabled children are also included in this basis of eligibility.

NOTE: The blind and disabled group has been combined to assist in more efficient reporting.

Children

These non-disabled individuals must be under age 18 or, at State's option, may be age 18 and attending a secondary or vocational school. The age limit may also be raised to 19, 20, or 21 if the individual otherwise qualifies for Medicaid benefits.

NOTE: Children who are receiving either title IV-E or non-title-IV-E foster care payments or subsidized adoption payments, as well as qualifying for any other child welfare program should not be reported in this category. Report as Foster Care Child below.

Adults

These are caretaker relatives or pregnant women who qualify for Medicaid and are not aged, blind, or disabled under SSI rules. They may be parents or other blood relatives, step-parents, step-brothers, step-sisters, adoptive parents, grandparents, or any of their spouses. Adults without dependent children may also be included in this group, using a §1115 demonstration waiver.

Unemployed Parent (UP) - Children and Adults (Optional Category)

These individuals are children and adults eligible based on an unemployed parent deprivation factor. This category is optional for those States with eligibility codes identifying this group. If this optional category is not used, report these individuals in the appropriate adult and children categories.

Foster Care Children

These are children for whom the State makes adoption assistance and/or foster care maintenance payments. This grouping includes both those children who are covered by the provisions of title IV-E and those who are not, as well as children who are leaving foster care due to age.

Individuals Covered under the Breast and Cervical Cancer Prevention and Treatment Act of 2000.

These individuals are women under age 65 who have been found to have breast or cervical cancer, including precancerous conditions. This category is optional to States.

NOTE: Legal aliens who qualify for full Medicaid coverage are reported under the MAS and BOE groupings appropriate for those individuals. While all aliens should be reported, undocumented aliens do not have satisfactory immigration status and are therefore eligible to receive only emergency Medicaid services under §1903(v) of the Act. These individuals should be reported only under "Other" . Do not include non-Title XIX refugees in your mapping.

2700.20 - Eligibility Crosswalk

MAS/BOE - INDIVIDUALS RECEIVING CASH ASSISTANCE OR ELIGIBLE UNDER SECTION 1931 OF THE ACT-AGED
MSIS Coding (MAS-1, BOE-1)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Aged individuals receiving SSI, eligible spouses or persons receiving SSI pending a final determination of disposal of resources exceeding SSI dollar limits; and persons considered to be receiving SSI under §1619(b) of the Act.	42 CFR 435.120, §1619(b) of the Act, §1902(a)(10)(A)(I)(II) of the Act, PL 99-643, §2.
2	Aged individuals who meet more restrictive requirements than SSI and who are either receiving or not receiving SSI; or who qualify under §1619 of the Act.	42 CFR 435.121, §1619(b)(3) of the Act, §1902(f) of the Act, PL 99-643, §7.
3	Aged individuals receiving mandatory State supplements.	42 CFR 435.130.
4	Aged individuals who receive a State supplementary payment (but not SSI) based on need.	42 CFR 435.230, §1902(a)(10)(A)(ii) of the Act.

MAS/BOE - INDIVIDUALS RECEIVING CASH ASSISTANCE OR ELIGIBLE UNDER SECTION 1931 OF THE ACT - BLIND/DISABLED
MSIS Coding (MAS-1, BOE-2)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Blind and/or disabled individuals receiving SSI, eligible spouses or persons receiving SSI pending a final determination of blindness, disability, and/or disposal of resources exceeding SSI dollar limits; and persons considered to be receiving SSI under §1619(b) of the Act.	42 CFR 435.120, §1619(b) of the Act, §1902(a)(10)(A)(I)(II) of the Act, PL 99-643, §2.
2	Blind and/or disabled individuals who meet more restrictive requirements than SSI and who are either receiving or not receiving SSI; or who qualify under §1619.	42 CFR 435.121, §1619(b)(3) of the Act, §1902(f) of the Act, PL 99-643, §7.
3	Blind and/or disabled individuals receiving mandatory State supplements.	42 CFR 435.130.
4	Blind and/or disabled individuals who receive a State supplementary payment (but not SSI) based upon need.	42 CFR 435.230, §1902(a)(10)(A)(ii)of the Act.

MAS/BOE - INDIVIDUALS RECEIVING CASH ASSISTANCE OR ELIGIBLE UNDER SECTION 1931 OF THE ACT - CHILDREN
MSIS Coding (MAS-1, BOE-4)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Low Income Families with Children qualified under §1931 of the Act.	42 CFR 435.110, §1902(a)(10)(A)(I)(I) of the Act, §1931 of the Act.
2	Children age 18 who are regularly attending a secondary school or the equivalent of vocational or technical training.	42 CFR 435.110, §1902(a)(10)(A)(I)(I).

MAS/BOE - INDIVIDUALS RECEIVING CASH ASSISTANCE OR ELIGIBLE UNDER SECTION 1931 OF THE ACT - ADULTS
MSIS Coding (MAS-1, BOE-5)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Adults deemed essential for well-being of a recipient [see 45 CFR 233.20(a)(2)(vi)] qualified for Medicaid under §1931 of the Act.	42 CFR 435.110, §1902(a)(10)(A)(I)(I)of the Act, §1931 of the Act.
2	• Pregnant women who have no other eligible children. • Other adults in "adult only" units.	42 CFR 435.110, §1902(a)(10)(A)(I)(I)of the Act.

MAS/BOE - INDIVIDUALS RECEIVING CASH ASSISTANCE OR ELIGIBLE UNDER SECTION 1931 -U CHILDREN - (OPTIONAL)
MSIS Coding (MAS-1, BOE-6)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Unemployed Parent Program - Cash assistance benefits to low income individuals in two parent families where the principle wage earner is employed fewer than 100 hours a month.	42 CFR 435.110, §1902(a)(10)(A)(I)(I) of the Act, §1931 of the Act.
2	Children age 18 who are regularly attending a secondary school or the equivalent of vocational or technical training.	42 CFR 435.110, §1902(a)(10)(A)(I)(I) of the Act.

MAS/BOE - INDIVIDUALS RECEIVING CASH ASSISTANCE OR ELIGIBLE UNDER SECTION 1931 - U ADULTS - (OPTIONAL)
MSIS Coding (MAS-1, BOE-7)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Adults deemed essential for well-being of a recipient (see 45 CFR 233.20(a)(2)(vi)) qualified under §1931 of the Act (Low Income Families with Children).	42 CFR 435.110, §1902(a)(10)(A)(I)(I) of the Act, §1931 of the Act.
2	• Pregnant women who have no other eligible children. • Other Adults in "adult only" units.	42 CFR 435.110, §1902(a)(10)(A)(I)(I) of the Act.

MAS/BOE - MEDICALLY NEEDY - AGED
MSIS Coding (MAS-2, BOE-1)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Aged individuals who would be ineligible if not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212, and the same rules apply to medically needy individuals.	42 CFR 435.326.
2	Aged	42 CFR 435.320, 42 CFR 435.330.

MAS/BOE - MEDICALLY NEEDY - BLIND/DISABLED
MSIS Coding (MAS-2, BOE-2)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Blind and/or disabled individuals who would be ineligible if not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.	42 CFR 435.326.
2	Blind/Disabled	42 CFR 435.322, 42 CFR 435.324, 42 CFR 435.330.
3	Blind and/or disabled individuals who meet all Medicaid requirements except current blindness and/or disability criteria, and have been continuously eligible since 12/73 under the State's requirements.	42 CFR 435.340.

MAS/BOE - MEDICALLY NEEDY - CHILDREN
MSIS Coding (MAS-2, BOE-4)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Individuals under age 18 who, but for income and resources, would be eligible.	§1902(a)(10)(C)(ii)(I) of the Act, PL 97-248, §137.
2	Infants under the age of 1 and who were born after 9/30/84 to and living in the household of medically needy women.	§1902(e)(4) of the Act, PL 98-369, §2362.
3	Other financially eligible individuals under age 18-21, as specified by the State.	42 CFR 435.308.
4	Children who would be ineligible if not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.	42 CFR 435.326.

MAS/BOE - MEDICALLY NEEDY - ADULTS
MSIS Coding (MAS-2, BOE-5)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Pregnant women.	42 CFR 435.301.
2	Caretaker relatives who, but for income and resources, would be eligible.	42 CFR 435.310.
3	Adults who would be ineligible if not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.	42 CFR 435.326.

MAS/BOE - POVERTY RELATED ELIGIBLES - AGED
MSIS Coding (MAS-3, BOE-1)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Qualified Medicare Beneficiaries (QMBs) who are entitled to Medicare Part A, whose income does not exceed 100% of the Federal poverty level, and whose resources do not exceed twice the SSI standard.	§§1902(a)(10)(E)(I) and 1905(p)(1) of the Act, PL 100-203, §4118(p)(8), PL 100-360, §301(a) & (e), PL 100-485, §608(d)(14), PL 100-647, §8434.
2	Specified Low-Income Medicare Beneficiaries (SLMBs) who meet all of the eligibility requirements for QMB status, except for the income in excess of the QMB income limit, but not exceeding 120% of the Federal poverty level.	§4501(b) of OBRA 90, as amended in §1902(a)(10)(E) of the Act.
3	Qualifying individuals having higher income than allowed for QMBs or SLMBs.	§1902(a)(10)(E)(iv) of the Act.
4	Aged individual not described in §1902(a)(10)(A)(1) of the Act, with income below the poverty level and resources within state limits, who are entitled to full Medicaid benefits.	§1902(a)(10)(A)(ii)(X), 1902(m)(1) of the Act, PL 99-509, §§9402 (a) and (b).

MAS/BOE - POVERTY RELATED ELIGIBLES - BLIND/DISABLED
MSIS Coding (MAS-3, BOE-2)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Qualified Medicare Beneficiaries (QMBs) who are entitled to Medicare Part A, whose income does not exceed 100% of the Federal poverty level, and whose resources do not exceed twice the SSI standard.	§§1902(a)(10)(E)(I) and 1905(p)(1) of the Act, PL 100-203, §4118(p)(8), PL 100-360, §301(a) & (e), PL 100-485, §608(d)(14), PL 100-647, §8434.
2	Specified Low-Income Medicare Beneficiaries (SLMBs) who meet all of the eligibility requirements for QMB status, except for the income in excess of the QMB income limit, but not exceeding 120% of the Federal poverty level.	§4501(b) of OBRA 90 as amended in §1902(a)(10)(E)(I) of the Act.
3	Qualifying individuals having higher income than allowed for QMBs or SLMBs.	§1902(a)(10)(E)(iv) of the Act.
4	Qualified Disabled Working Individuals (QDWIs) who are entitled to Medicare Part A.	§§1902(a)(10)(E)(ii) and 1905(s) of the Act.
5	Disabled individuals not described in §1902(a)(10)(A)(1) of the Act, with income below the poverty level and resources within state limits, which are entitled to full Medicaid benefits.	§§1902(a)(10)(A)(ii)(X), 1902(m)(1) and (3) of the Act, P.L. 99-509, §§9402 (a) and (b).

MAS/BOE - POVERTY RELATED ELIGIBLES - CHILDREN
MSIS Coding (MAS-3, BOE-4)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Infants and children up to age 6 with income at or below 133% of the Federal Poverty Level (FPL).	§§1902(a)(10)(A)(I)(IV) & (VI), 1902(l)(1)(A), (B), & (C) of the Act, PL 100-360, §302(a)(1), PL 100-485, §608(d)(15).
2	Children under age 19 (born after 9/30/83) whose income is at or below 100% of the Federal poverty level within the State's resource requirements.	§1902(a)(10)(A)(I) (VII) of the Act.
3	Infants under age 1 whose family income is below 185% of the poverty level and who are within any optional State resource requirements.	§§1902(a)(10)(A)(ii) (IX) and 1902(l)(1)(D) of the Act, PL 99-509, §§9401(a) & (b), PL 100-203, §4101.
4	Children made eligible under the more liberal income and resource requirements as authorized under §1902(r)(2) of the Act when used to disregard income on a poverty-level-related basis.	§1902(r)(2) of the Act.
5	Children made eligible by a Title XXI Medicaid expansion under the State Child Health Insurance Program (SCHIP)	P.L. 105-100.

MAS/BOE - POVERTY RELATED ELIGIBLES - ADULTS
MSIS Coding (MAS-3, BOE-5)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Pregnant women with incomes at or below 133% of the Federal Poverty Level.	§1902(a)(10)(A)(I), (IV) and (VI); §1902(l)(1) (A), (B), & (C) of the Act, PL 100-360, §302(a)(1), PL 100-485, §608(d)(15).
2	Women who are eligible until 60 days after their pregnancy, and whose incomes are below 185% of the FPL and have resources within any optional State resource requirements.	§§1902(a)(10)(A)(ii)(IX) and 1902(l)(1)(D) of the Act, PL 99-509, §§9401(a) & (b), PL 100-203, §4101.
3	Caretaker relatives and pregnant women made eligible under more liberal income and resource requirements of §1902(r)(2) of the Act when used to disregard income on a poverty-level related basis.	§1902(r)(2) of the Act.
4	Adults made eligible by a Title XXI Medicaid expansion under the State Child Health Insurance Program (SCHIP).	Title XXI of the Social Security Act.

MAS/BOE - POVERTY RELATED ELIGIBLES - ADULTS
MSIS Coding (MAS-3, BOE-A)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Women under age 65 who are found to have breast or cervical cancer, or have precancerous conditions.	§1902(a)(10)(a)(ii)(XVIII), P.L. 106-354.

MAS/BOE - OTHER ELIGIBLES - AGED
MSIS Coding (MAS-4, BOE-1)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Aged individuals who meet more restrictive requirements than SSI and who are either receiving or not receiving SSI; or who qualify under §1619 of the Act.	42 CFR 435.121, §1619(b)(3) of the Act, §1902(f) of the Act, PL 99-643, §7.
2	Aged individuals who are ineligible for optional State supplements or SSI due to requirements that do not apply under title XIX.	42 CFR 435.122.
3	Aged essential spouses considered continuously eligible since 12/73; and some spouses who share hospital or nursing facility rooms for 6 months or more.	42 CFR 435.131.
4	Institutionalized aged individuals who have been continuously eligible since 12/73 as inpatients or residents of Title XIX facilities.	42 CFR 435.132.
5	Aged individuals who would be SSI/SSP eligible except for the 8/72 increase in OASDI benefits.	42 CFR 435.134.
6	Aged individuals who would be eligible for SSI but for title II cost-of-living adjustment(s).	42 CFR 435.135.
7	Aged aliens who are not lawful, permanent residents or who do not have PRUCOL status, but who are otherwise qualified, and who require emergency care.	PL 99-509, §9406.
8	Aged individuals who would be eligible for AFDC, SSI, or an optional State supplement if not in a medical institution.	42.CFR 435.211, §1902(a)(10)(A)(ii) and §1905(a) of the Act.
9	Aged individuals who meet income and resource requirements for AFDC, SSI, or an optional State supplement.	42 CFR 435.210, §1902(a)(10)(A)(ii) and §1905 of the Act.

ITEM	DESCRIPTION	CFR/PL CITATIONS
10	Aged individuals who have become ineligible and who are enrolled in a qualified HMO or "§1903(m)(2)(G) entity" that has a risk contract.	42 CFR 435.212 §1902(e)(2), PL 99-272, §9517, PL 100-203, §4113(d).
11	Aged individuals who, solely because of coverage under a home and community based waiver, are not in a medical institution, but who would be eligible if they were.	42 CFR 435.217, §1902(a)(10)(A)(ii),(VI); PL 100-13.
12	Aged individuals who elect to receive hospice care who would be eligible if in a medical institution.	§1902(a)(10)(A)(ii), (VII) of the Act, PL 99-272, §9505.
13	Aged individuals in institutions who are eligible under a special income level specified in Supplement 1 to Attachment 2.6-A of the State's title XIX Plan.	42 CFR 435.236, §1902(a)(10)(A)(ii) of the Act.

MAS/BOE - OTHER ELIGIBLES - BLIND/DISABLED
MSIS Coding (MAS-4, BOE-2)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Blind and/or disabled individuals who meet more restrictive requirements than SSI, including both those receiving and not receiving SSI payments.	42 CFR 435.121, §1619(b)(3) of the Act, §1902(f) of the Act, PL 99-643, §7.
2	Blind and/or disabled individuals who are ineligible for optional State supplements or SSI due to requirements that do not apply under title XIX.	42 CFR 435.122.
3	Blind and/or disabled essential spouses considered continuously eligible since 12/73; and some spouses who share hospital or nursing facility rooms for 6 months or more.	42 CFR 435.131.
4	Institutionalized blind and/or disabled individuals who have been continuously eligible since 12/73 as inpatients or residents of Title XIX facilities.	42 CFR 435.132.
5	Blind and/or disabled individuals who would be SSI/SSP, eligible except for the 8/72 increase in OASDI benefits.	42 CFR 435.134.
6	Blind and/or disabled individuals who would be eligible for SSI but for title II cost-of-living adjustment(s).	42 CFR 435.135, §503 PL 94-566.
7	Blind and/or disabled aliens who are not lawful, permanent residents or who do not have PRUCOL status, but who are otherwise qualified, and who require emergency care.	PL 99-509, §9406.
8	Blind and/or disabled individuals who meet all Medicaid requirements except current blindness, or disability criteria, who have been continuously eligible since 12/73 under the State's 12/73 requirements.	42 CFR 435.133.

ITEM	DESCRIPTION	CFR/PL CITATIONS
9	Blind and/or disabled individuals, age 18 or older, who became blind or disabled before age 22 and who lost SSI or State supplementary payments eligibility because of an increase in their OASDI (childhood disability) benefits.	§1634(c) of the Act; PL 99-643, §6.
10	Blind and/or disabled individuals who would be eligible for AFDC, SSI, or an optional State supplement if not in a medical institution.	42 CFR 435.211, §§1902(a)(10)(A)(ii) and 1905(a) of the Act.
11	Qualified severely impaired blind or disabled individuals under age 65, who, except for earnings, are eligible for SSI.	§§1902(a)(10)(A)(I)(II) and 1905(q) of the Act, PL 99-509, §9404 and §1619(b)(8) of the Act, PL 99-643, §7
12	Blind and/or disabled individuals who meet income and resource requirements for AFDC, SSI, or an optional State supplement.	42 CFR 435.210, §§1902(a)(10)(A)(ii) and 1905 of the Act.
13	Working disabled individuals who buy-in to Medicaid	§1902(a)(10)(A)(ii)(XIII).
14	Blind and/or disabled individuals who have become ineligible who are enrolled in a qualified HMO or "§1903(m)(2)(G) entity" that has a risk contract.	42 CFR 435.212, §1902(e)(2) of the Act; PL 99-272, §9517; PL 100-203, §4113(d).
15	Blind and/or disabled individuals who, solely because of coverage under a home and community based waiver, are not in a medical institution and who would be eligible if they were.	42 CFR 435.217, §1902(a)(10)(A)(ii)(VI) of the Act, 50 PL 100-13.
16	Blind and/or disabled individuals who elect to receive hospice care, and who would be eligible if in a medical institution.	§1902(a)(10)(A)(ii)(VII), PL 99-272, §9505
17	Blind and/or disabled individuals in	42 CFR 435.231,

ITEM	DESCRIPTION	CFR/PL CITATIONS
	institutions who are eligible under a special income level specified in Supplement 1 to Attachment 2.6-A of the State's title XIX Plan.	§1902(a)(10)(A)(ii) of the Act.
18	Blind and/or disabled widows and widowers who have lost SSI/SSP benefits but are considered eligible for Medicaid until they become entitled to Medicare Part A.	§1634 of the Act, PL 101-508, §5103.
19	Certain disabled children, 18 or under, who live at home, but who, if in a medical institution, would be eligible for SSI or a State supplemental payment.	42 CFR 435.225; §1902(e)(3) of the Act.
20	Continuation of Medicaid eligibility for disabled children who lose SSI benefits because of changes in the definition of disability.	§1902(a)(10)(A)(ii) of the Act; P.L. 15-32, §491.
21	Disabled individuals with medically improved disabilities made eligible under the Ticket to Work and Work Incentives Improvement Act (TWWIIA) of 1999.	§1902(a)(10)(A)(ii)(XV) of the Act.

MAS/BOE - OTHER ELIGIBLES - CHILDREN
MSIS Coding (MAS-4, BOE-4)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Children of families receiving up to 12 months of extended Medicaid benefits (for those eligible after 4/1/90).	§1925 of the Act, PL 100-485, §303.
2	"Qualified children" under age 19 born after 9/30/83 or at an earlier date at State option, who meet the State's AFDC income and resource requirements.	§§1902(a)(10)(A)(I)(III) and 1905(n) of the Act, PL 98-369, §2361, PL 99-272, §9511, PL 100-203, §4101.
3	Children of individuals who are ineligible for AFDC-related Medicaid because of requirements that do not apply under title XIX.	42 CFR 435.113.
4	Children of individuals who would be eligible for Medicaid under §1931 of the Act (Low income families with children) except for the 7/1/72 (PL 92-325) OASDI increase and were entitled to OASDI and received cash assistance in 8/72.	42 CFR 435.114.
5	Children whose mothers were eligible for Medicaid at the time of childbirth, and are deemed eligible for one year from birth as long as the mother remained eligible, or would have if pregnant, and the child remains in the same household as the mother.	42 CFR 435.117, §1902(e)(4) of the Act, PL 98-369, §2362.
6	Children of aliens who are not lawful, permanent residents or who do not have PRUCOL status, but who are otherwise qualified, and who require emergency care.	PL 99-509, §9406.
7	Children who meet income and resource requirements for AFDC, SSI, or an optional State supplement	42 CFR 435.210, §1902(a)(10)(A)(ii) and §1905 of the Act.
8	Children who would be eligible for AFDC,	42 CFR 435.211,

ITEM	DESCRIPTION	CFR/PL CITATIONS
	SSI, or an optional State supplement if not in a medical institution.	§1902(a)(10)(A)(ii) and §1905(a) of the Act.
9	Children who have become ineligible who are enrolled in a qualified HMO or "§1903(m)(2)(G) entity" that has a risk contract.	42 CFR 435.212, §1902(e)(2) of the Act, PL 99-272, §9517, PL 100-203, §4113(d).
10	Children of individuals who elect to receive hospice care, and who would be eligible if in a medical institution.	§1902(a)(10)(A)(ii)(VII), PL 99-272, §9505.
11	Children who would be eligible for AFDC if work-related child care costs were paid from earnings rather than received as a State service.	42 CFR 435.220.
12	Children of individuals who would be eligible for AFDC if the State used the broadest allowable AFDC criteria.	42 CFR 435.223, §§1902(a)(10)(A)(ii) and 1905(a) of the Act.
13	Children who solely because of coverage under a home and community based waiver, are not in a medical institution, but who would be eligible if they were.	42 CFR 435.217, §1902(a)(10)(A)(ii)(VI) of the Act.
14	Children not described in §1902(a)(10)(A)(I) of the Act, "Ribikoff Kids", who meet AFDC income and resource requirements, and are under a State-established age (18-21).	§§1902(a)(10)(A)(ii) and 1905(a)(I) of the Act, PL 97-248, §137.

MAS/BOE - OTHER ELIGIBLES - ADULTS
MSIS Coding (MAS-4, BOE-5)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Families receiving up to 12 months of extended Medicaid benefits (if eligible on or after 4/1/90).	§1925 of the Act, PL 100-485, §303.
2	Qualified pregnant women whose pregnancies have been medically verified and who meet the State's AFDC income and resource requirements.	§§1902(a)(10)(A)(I)(III) and 1905(n) of the Act, PL 98-369, §2361, PL 99-272, §9511, PL 100-203 §4101.
3	Adults who are ineligible for AFDC-related Medicaid because of requirements that do not apply under title XIX.	42 CFR 435.113.
4	Adults who would be eligible for Medicaid under §1931 of the Act (Low income families with children) except for the 7/1/72 (PL 92-325) OASDI increase; and were entitled to OASDI and received cash assistance in 8/72.	42 CFR 435.114.
5	Women who were eligible while pregnant, and are eligible for family planning and pregnancy related services until the end of the month in which the 60th day occurs after the pregnancy	§1902(e)(5) of the Act, PL 98-369, PL 100-203, §4101, PL 100-360, §302(e).
6	Adult aliens who are not lawful, permanent residents or who do not have PRUCOL status, but who are otherwise qualified, and who require emergency care.	PL 99-509, §9406.
7	Adults who meet the income and resource requirements for AFDC, SSI, or an optional State Supplement.	42 CFR 435.210, §§1902(a)(10)(A)(ii) and 1905 of the Act.
8	Adults who would be eligible for AFDC, SSI, or an optional State Supplement if not in a	42 CFR 435.211,

ITEM	DESCRIPTION	CFR/PL CITATIONS
	medical institution.	§§1902(a)(10)(A)(ii) and 1905(a) of the Act.
9	Adults who have become ineligible who are enrolled in a qualified HMO or "§1903(m)(2)(G) entity" that has a risk contract.	42 CFR 435.212, §1902(e)(2)(A) of the Act, PL 99-272, §9517, PL 100-203, §4113(d).
10	Adults who solely because of coverage under a home and community based waiver, are not in a medical institution, but who would be eligible if they were.	42 CFR 435.217, §1902(a)(10)(A)(ii)(VI) of the Act.
11	Adults who elect to receive hospice care, and who would be eligible if in a medical institution.	§1902(a)(10)(A)(ii), (VII); PL 99-272, §9505.
12	Adults who would be eligible for AFDC if work-related child care costs were paid from earnings rather than received as a State service.	42 CFR 435.220.
13	Pregnant women who have been granted presumptive eligibility.	§§1902(a)(47) and 1920 of the Act, PL 99-509, §9407.
14	Adults who would be eligible for AFDC if the State used the broadest allowable AFDC criteria.	42 CFR 435.223, §§1902(a)(10)(A)(ii) and 1905(a) of the Act.

MAS/BOE - OTHER ELIGIBLES - FOSTER CARE CHILDREN
MSIS Coding (MAS-4, BOE-8)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Children for whom the State makes adoption assistance or foster care maintenance payments under Title IV-E.	42 CFR 435.145, §1902(a)(10)(A)(i)(I) of the Act.
2	Children with special needs covered by State foster care payments or under a State adoption assistance agreement which does **not** involve Title IV-E.	§1902(a)(10)(A)(ii) (VIII) of the Act, PL 99-272, §9529.
3	Children leave foster care due to age.	Foster Care Independence Act of 1999.

MAS/BOE - SECTION 1115 DEMONSTRATION MEDICAID EXPANSION
MSIS Coding (MAS-5, BOE-1)

ITEM	DESCRIPTION	CFR/PL CITATION
1	Aged individuals made eligible under the authority of a §1115 waiver due to poverty-level related eligibility expansions.	§1115(a)(1), (a)(2) & (b)(1) of the Act, §1902(a)(10), and §1903(m) of the Act.

MAS/BOE - SECTION 1115 DEMONSTRATION MEDICAID EXPANSION
MSIS Coding (MAS-5, BOE-2)

ITEM	DESCRIPTION	CFR/PL CITATION
1	Blind and/or disabled individuals made eligible under the authority of a §1115 waiver due to poverty-level-related eligibility.	§1115(a)(1), (a)(2) & (b)(1) of the Act,

MAS/BOE - SECTION 1115 DEMONSTRATION MEDICAID EXPANSION
MSIS Coding (MAS-5, BOE-4)

ITEM	DESCRIPTION	CFR/PL CITATION
1	Children made eligible under the authority of a §1115 waiver due to poverty-level-related eligibility expansions.	§1115(a)(1), (a)(2) & (b)(1) of the Act, §1902(a)(10),and §1903(m) of the Act

MAS/BOE - SECTION 1115 DEMONSTRATION MEDICAID EXPANSION
MSIS Coding (MAS-5, BOE-5)

ITEM	DESCRIPTION	CFR/PL CITATION
1	Caretaker relatives, pregnant women and/or adults without dependent children made eligible under the authority of at §1115 waiver due to poverty-level-related eligibility expansions.	§1115(a)(1) and (a)(2) of the Act, §1902(a)(10), §1903(m).

2700.30 - Definitions of MSIS Types of Service

Below is a listing of all MSIS types of service codes and their names as defined later in this appendix.

MSIS Code	Type of Service
01	Inpatient Hospital Services
02	Mental Hospital Services for the Aged
04	Inpatient Psychiatric Facility Services for Individuals Age 21 Years and Under
05	ICF Services for the Mentally Retarded
07	Nursing Facilities - All Other
08	Physicians Services
09	Dental Services
10	Other Practitioners Services
11	Outpatient Hospital Services
12	Clinic Services
13	Home Health Services
15	Lab and X-Ray Services
16	Prescribed Drugs Services
19	Other Services
20	Capitated Payments to HMO or HIO Plans
21	Capitated Payments to Prepaid Health Plans (PHPs)
22	Capitated Payments for Primary Care Case Management (PCCM) Plans
24	Sterilization Services
25	Abortion Services
26	Transportation Services
30	Personal Care Services
31	Targeted Case Management Services
33	Rehabilitation Services
34	PT, OT, Speech, Hearing Language Services
35	Hospice Benefits
36	Nurse Midwife Services
37	Nurse Practitioner Services
38	Private Duty Nursing Services
39	Religious Non-Medical Health Care Institution Services

The following definitions are adaptations of those given in the Code of Federal Regulations (CFR). These definitions, although abbreviated, are intended to facilitate the classification of medical care and services for reporting purposes. They do not modify any requirements of the Act or supersede in any way the definitions included in the CFR. They are listed and grouped together based on common analytical combinations.

A - Inpatient Hospital Services

Inpatient Hospital Services - (MSIS Type of Service (TOS) Code = 01)

(See 42 CFR 440.10)

These are services that are:

- Ordinarily furnished in a hospital for the care and treatment of inpatients;
- Furnished under the direction of a physician or dentist (except in the case of nurse-midwife services per 42 CFR 440.165); and
- Furnished in an institution that:
  - Is maintained primarily for the care and treatment of patients with disorders other than mental diseases;
  - Is licensed or formally approved as a hospital by an officially designated authority for State standard setting;
  - Meets the requirements for participation in Medicare (except in the case of medical supervision of nurse-midwife services per 42 CFR 440.165); and
  - Has in effect a utilization review plan applicable to all Medicaid patients that meet the requirements in 42 CFR 482.30 unless a waiver has been granted by the Secretary of Health and Human Services.

This type of service **does not include** nursing facility services furnished by a hospital with swing-bed approval. However, **include** services provided in a psychiatric wing of a general hospital if the psychiatric wing is not administratively separated from the general hospital.

B - Mental Health Facility Services

The following 2 services fall under Mental Health Facility Services. (See 42 CFR 440.140, 440.160, and 435.1009)

1. Inpatient Psychiatric Facility Services for Individuals Under Age 21 - (MSIS TOS Code = 04)

(See 42 CFR 440.160 and 441.150(ff))

An institution for mental diseases is a hospital, nursing facility, or other institution that is primarily engaged in providing diagnosis, treatment or care of individuals with mental diseases, including medical care, nursing care, and related services. These are services that:

- Are provided under the direction of a physician;

- Are provided in a psychiatric facility or inpatient program accredited by the Joint Commission on the Accreditation of Hospitals; and

- Meet the requirements set forth in 42 CFR Part 441, Subpart D (inpatient psychiatric services for individuals under age 21 in psychiatric facilities or programs).

2. Other Mental Health Facility Services (Individuals Age 65 or Older) - (MSIS TOS Code = 02)

(See 42 CFR 440.140(a) and Part 441, Subpart C)

These are services provided to beneficiaries aged 65 and older in an institution for mental diseases which is defined as a hospital, nursing facility, or other institution that is primarily engaged in providing diagnosis, treatment or care of individuals with mental diseases, including medical care, nursing care, and related services. These are services provided the direction of a physician.

C - Nursing Facility Services

Nursing Facilities (NF) Services - (MSIS TOS Code = 07)

(See 42 CFR 440.40 and 440.155)

These are services provided in an institution (or a distinct part of an institution) that:

- Is primarily engaged in providing to residents:

  - Skilled nursing care and related services for residents who require medical or nursing care;

  - Rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or

  - On a regular basis, health-related care and services to individuals who, because of their mental or physical condition, require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental diseases; and

- Meet the requirements for a nursing facility described in subsections 1919(b), (c), and (d) of the Act regarding:

  - Requirements relating to provision of services;

  - Requirements relating to residents rights; and

  - Requirements relating to administration and other matters; or

- Are the services provided in other long stay hospitals such as hospitals for

crippled children, AD&D, and rehabilitation.

D - ICF-MR Services

ICF Services for the Mentally Retarded - (MSIS TOS Code = 05)

(See 42 CFR 440.150 and Part 483 of Subpart I)

These are services provided in an institution for mentally retarded persons or persons with related conditions if the:

- Primary purpose of the institution is to provide health or rehabilitative services to such individuals;
- Institution meets the requirements at 42 CFR 442, Subpart C (certification of ICF/MR); and
- The mentally retarded recipients for whom payment is requested are receiving active treatment as defined at 42 CFR 483.440(a).

E - Physician Services

Physicians' Services - (MSIS TOS Code = 08)

(See 42 CFR 440.50)

Whether furnished in a physician's office, a recipient's home, a hospital, a NF, or elsewhere, these are services excluding laboratory, x-ray, DME, supplies and transportation services, provided:

- Within the scope of practice of medicine or osteopathy as defined by State law; and
- By or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy, or if State law allows such services to be provided by a physician Regardless of the site in which the service is provided, but billed by a physician or physician group.

NOTE: Laboratory, x-ray, DME, supplies and transportation services, even if billed by a physician are not included in this type of service.

F - Outpatient Hospital Services

Outpatient Hospital Services - (MSIS TOS Code = 11)

(See 42 CFR 440.20)

These are preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished:

- To outpatients;
- Except in the case of nurse-midwife services (see 42 CFR 440.165), under the direction of a physician or dentist; and
- By an institution that:
  - Is licensed or formally approved as a hospital by an officially designated authority for State standard setting; and
  - Except in the case of medical supervision of nurse midwife services (see 42 CFR 440.165), meets the requirements for participation in Medicare as a hospital.

NOTE: The following services are not included in this type of service, even if provided and/or billed by an outpatient department of a hospital: laboratory, x-ray, DME, supplies and transportation.

G - Prescribed Drugs

Prescribed Drugs - (MSIS TOS Code = 16)

(See 42 CFR 440.120(a))

These are simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease or for health maintenance that are:

- Prescribed by a physician or other licensed practitioner within the scope of professional practice as defined and limited by Federal and State law;
- Dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and
- Dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.

H - Dental Services

Dental Services - (MSIS TOS Code = 09)

(See 42 CFR 440.100)

These are diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his or her profession, including treatment of:

- The teeth and associated structures of the oral cavity; and
- Disease, injury, or an impairment that may affect the oral or general health of the beneficiary.

A dentist is an individual licensed to practice dentistry or dental surgery. Dental services

include dental screening and dental clinic services. Dental services also include dental x-rays, dental supplies and dental DME.

Dental services **do not include** services provided as part of inpatient hospital, outpatient hospital, non-dental clinic, or laboratory services and billed by the hospital, non-dental clinic, or laboratory or services that meet the requirements of 42 CFR 440.50(b) (i.e., are provided by a dentist but may be provided by either a dentist or physician under State law).

I - Other Licensed Practitioners' Services

Other Licensed Practitioners' Services- (MSIS TOS Code = 10)

(See 42 CFR 440.60)

These are medical or remedial care services, other than physician services or services of a dentist, provided by licensed practitioners within the scope of practice as defined under State law. Examples (if covered under State law) include: chiropractors, podiatrists, psychologists and optometrists.

Other Licensed Practitioners' Services **include** eyeglasses only if they are billed directly by the professional practitioner. If billed by a physician, they are reported as Physicians' Services. Otherwise, report them under Other Care.

Other Licensed Practitioners' Services **do not include** laboratory, x-ray, DME, or supplies billed by other practitioners that are included in inpatient or outpatient hospital bills. These services are reported as types of service as appropriate. Chiropractors' services include only services that are provided by a chiropractor (who is licensed by the State) and consist of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by the State to perform.

NOTE: Speech therapists, audiologists, opticians, physical therapists, and occupational therapists **are not included** within Other Licensed Practitioners' Services. These services should be reported under TOS Code=34 under Personal Support Services.

J - Clinic Services

Clinic Services - (MSIS TOS Code = 12)

(See 42 CFR 440.90)

Clinic services include preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that are provided:

- To outpatients;
- By a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients including services furnished outside the clinic by clinic personnel to individuals without a fixed home or mailing address. Consider

a group of physicians who share, only for mutual convenience, space, services of support staff, etc., as physicians, rather than a clinic,even though they practice under the name of the clinic.

- Except in the case of nurse-midwife services (see 42 CFR 440.165), are furnished by, or under, the direction of a physician.

NOTE: Place dental clinic services under Dental Services. Report any services not included above under Other Care. A clinic staff may include practitioners with different specialties.

K - Lab and X-Ray Services

Laboratory and X-Ray Services - (MSIS TOS Code = 15)

(See 42 CFR 440.30)

These are professional or technical laboratory and radiological services that are: ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by State law or ordered and billed by a physician but provided by referral laboratory (or radiology provider).

X-ray services provided by dentists are reported under Dental Services.

L - Sterilizations

Sterilizations - (MSIS TOS Code = 24)

(See 42 CFR 441, Subpart F)

These are medical procedures, treatment or operations for the purpose of rendering an individual permanently incapable of reproducing.

M - Home Health Services

Home Health Services - (MSIS TOS Code = 13)

(See 42 CFR 440.70)

These are services provided at the patient's place of residence, in compliance with a physician's written plan of care that the physician reviews every 60 days. The following services are mandatory.

- Nursing services, as defined in the State Nurse Practice Act, which is provided on a part-time or intermittent basis by a home health agency (a public or private agency or organization, or part of any agency or organization, that meets the requirements for participation in Medicare). If there is no agency in the area, a registered nurse who:
    - Is licensed to practice in the State;

- ° Receives written orders from the patient's physician;
- ° Documents the care and services provided;
- ° Has had orientation to acceptable clinical and administrative record keeping from a health department nurse;

- Home health aide services provided by a home health agency; and
- Medical supplies, equipment, and appliances suitable for use in the home and billed by a home health agency.

The following therapy services are optional: physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or by a facility licensed by the State to provide these medical rehabilitation services (see 42 CFR 441.15).

Place of residence is normally interpreted to mean the patient's home and does not apply to hospitals or NFs. Except for services received in a NF that are different from those normally provided as part of the institution's care For example, a registered nurse may provide short-term care for a recipient in a NF during an acute illness to avoid the recipient's transfer to another NF and this may qualify as home health services.

N - Personal Support Services

The following 9 services all fall under Personal Support Services.

1. Personal Care Services - (MSIS TOS Code = 30)

(See 42 CFR 440.167)

These are services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are:

Authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State; and

Provided by an individual who is qualified to provide such services and who is not a member of the individual's family.

2. Targeted Case Management Services - (MSIS TOS Code = 31)

(See §1915(g)(2) of the Act)

These are services that are furnished to individuals to gain access to needed medical, social, educational, and other services. The agency may make case management services available to:

- Specific geographic areas within a State, without regard to statewide requirement in 42 CFR 431.50; and
- Specific groups of individuals eligible for Medicaid, without regard to the comparability requirements in 42 CFR 440.240.

The agency must permit individuals to freely choose any qualified Medicaid provider except when obtaining case management services in accordance with 42 CFR 431.51.

3. Rehabilitative Services - (MSIS TOS Code = 33)

(See 42 CFR 440.130(d))

These include any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under State law for maximum reduction of physical or mental disability and restoration of a recipient to his/her best possible functional level.

4. Physical Therapy, Occupational Therapy, and Services for Individuals with Speech, Hearing, and Language Disorders - (MSIS TOS Code =34)

(See 42 CFR 440.110)

These are services prescribed by a physician or other licensed practitioner within the scope of his or her practice under State law and provided to a beneficiary by, or under the direction of, a qualified physical therapist, occupational therapist, speech pathologist, or audiologist. This type of service includes any necessary supplies and equipment such as hearing aids.

5. Hospice Services - (MSIS TOS Code = 35)

(See 42 CFR 418.202)

Whether received in a hospice facility or elsewhere, these are services that are:

- Furnished to a terminally ill individual, as defined in 42 CFR 418.3;
- Furnished by a hospice, as defined in 42 CFR 418.3, that meets the requirements for participation in Medicare specified in 42 CFR 418, Subpart C or by others under an arrangement made by a hospice program that meets those requirements and is a participating Medicaid provider; and
- Furnished under a written plan that is established and periodically reviewed by:
    - The attending physician;
    - The medical director or physician designee of the program, as described in 42 CFR 418.54; and
    - The interdisciplinary group described in 42 CFR 418.68.

6. Nurse Midwife - (MSIS TOS Code = 36)

(See 42 CFR 440.165 and 441.21)

These are services that are concerned with management and the care of mothers and newborns throughout the maternity cycle and are furnished within the scope of practice authorized by State law or regulation.

7. Nurse Practitioner - (MSIS TOS Code = 37)

(See 42 CFR 440.166 and 441.22)

These are services furnished by a registered professional nurse who meets State's advanced educational and clinical practice requirements, if any, beyond the 2 to 4 years of basic nursing education required of all registered nurses.

8. Private Duty Nursing - (MSIS TOS Code = 38)

(See 42 CFR 440.80)

These are services of registered nurses or licensed practical nurses provided under direction of a physician to recipients in their own homes, hospitals or nursing facilities (as specified by the State).

9. Religious Non-Medical Health Care Institutions - (MSIS TOS Code = 39)

(See 42 CFR 440.170(b)(c))

These are non-medical health care services equivalent to a hospital or extended care level of care provided in facilities that meet the requirements of §1861 (ss) (1) of the Act.

O - Other Care

The following 3 types of services all fall under Other Care. These services do not meet the definition of, and are not classified under, any of the previously described categories.

1. Transportation - (MSIS TOS Code = 26)

(See 42 CFR 440.170(a))

Services include transportation and other related travel services determined necessary by you to secure medical examinations and treatment for a recipient.

2. Abortions (MSIS TOS Code = 25)

(See 42 CFR 441, Subpart E)

In accordance with the terms of the DHHS Appropriations Bill and 42 CFR 441, Subpart E, FFP is available for abortions:

- When a physician has certified in writing to the Medicaid agency that the woman

suffers from a physical disorder, injury, or illness so that the woman is in danger of death if an abortion is not performed; or

- When the abortion is performed to terminate a pregnancy resulting from an act of rape or incest. FFP is not available for an abortion under any other circumstances.

3. Other Services - (MSIS TOS Code = 19)

These services do not meet the definitions of any of the other described service categories. They may include, but are not limited to:

Prosthetic devices (see 42 CFR 440.120(c)) which are replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of practice as defined by State law to:

- Artificially replace a missing portion of the body;
- Prevent or correct physical deformity or malfunctions; or
- Support a weak or deformed portion of the body.

Other services also include most unspecified waivers services and residential treatment.

P - Capitated Care

The following 2 services fall under Capitated Care Services.

1. Health Maintenance Organization (HMO) and Health Insuring Organization (HIO) - (MSIS TOS Code = 20)

These are capitation payments to plans contracted to provide capitated comprehensive services. An HMO is a public or private organization that contracts on a prepaid capitated risk basis to provide a comprehensive set of services and is federally qualified or State-plan defined. An HIO is an entity that provides for or arranges for the provision of care and contracts on a prepaid capitated risk basis to provide a comprehensive set of services.

2. Prepaid Health Plans (PHP) - (MSIS TOS Code = 21)

These are capitation payments to plans that are contracted to provide less- than-comprehensive services. Under a non-risk or risk arrangement, the State may contract with (but not limited to these entities) a physician, physician group, or clinic for a limited range of services under capitation. A PHP is an entity that provides a non-comprehensive set of services on either capitated risk or non-risk basis or the entity provides comprehensive services on a non-risk basis.

NOTE: Include dental, mental health, and other plans covering limited services under PHP.

Q - Primary Care Case Management Services

Primary Care Case Management (PCCM) (MSIS TOS Code = 22)

(See §1915(b)(1) of the Act)

These are capitated payments to primary care providers who agree to be responsible for the provision and/or coordination of medical services. This category includes only PCCM monthly case management payments to primary care physicians for being responsible for PCCM. It does not include payments for specific case management services that are billed only when these services are incurred.

Case management that includes services other than gatekeeping should be reported as PHP capitation payments.

2700.40 - Definitions of MSIS Program Type Coding

The following definitions describe special Medicaid programs that are coded independently of type of service for MSIS purposes. These programs cover bands of services that may cut across many types of service.

Program Type 1 - Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

(See 42 CFR 440.40(b))

This includes either general health screening services and vision, dental, and hearing services furnished to Medicaid eligibles under age 21 to fulfill the requirements of the EPSDT program or services rendered based on referrals from EPSDT visits. The Act specifies two sets of EPSDT screenings:

- Periodic screenings, which are provided at distinct intervals determined by the State, and which must include the following services:
  - A comprehensive health and developmental history assessment (including assessment of both physical and mental health development);
  - A comprehensive unclothed physical exam;
  - Appropriate immunizations according to the Advisory Committee on Immunization Practices schedule;
  - Laboratory tests (including blood lead level assessment);
  - Health education (including anticipatory guidance); and
- Interperiodic screenings, which are provided when medically necessary to determine the existence of suspected physical or mental illness or conditions.

Program Type 2 - Family Planning

(See 42 CFR 440.40(c))

Only items and procedures clearly provided or performed for family planning purposes and matched at the 90 percent FFP rate should be included as Family Planning. Services covered under this program include, but are not limited to:

- Counseling and patient education and treatment furnished by medical professionals in accordance with State law;
- Laboratory and X-ray services;
- Medically approved methods, procedures, pharmaceutical supplies, and devices to prevent conception;

- Natural family planning methods; and
- Diagnosis and treatment for infertility.

NOTE: MS's Revised Financial Management Review Guide for Family Planning Services describes items and procedures eligible for the enhanced match as family planning services.

Program Type 3 - Rural Health Clinics (RHC)

(See 42 CFR 440.20(b))

These include services (as allowed by State law) furnished by a rural health clinic that has been certified in accordance with the conditions of 42 CFR Part 491 (certification of certain health facilities). Services performed in RHCs include, but are not limited to:

- Services furnished by a physician within the scope of his or her profession as defined by State law. The physician performs these services in or away from the clinic and has an agreement with the clinic providing that he or she will be paid by the clinic for these services;
- Services furnished by a physician assistant, nurse practitioner, nurse midwife, or other specialized nurse practitioner (as defined in 42 CFR 405.2401 and 491.2) if the services are furnished in accordance with the requirements specified in 42 CFR 405.2412(a);
- Services and supplies provided in conjunction with professional services furnished by a physician, physician assistant, nurse practitioner, nurse midwife, or specialized nurse practitioner. (See 42 CFR 405.2413 and 405.2415 for the criteria determining whether services and supplies are included here.); or
- Part-time or intermittent visiting nurse care and related medical supplies (other than drugs and biologicals) if:
    - The clinic is located in an area in which the Secretary has determined that there is a shortage of home health agencies (see 42 CFR 405.2417);
    - The services are furnished by a registered nurse or licensed practical or vocational nurse employed, or otherwise compensated for the services, by the clinic;
    - The services are furnished under a written plan of treatment that is either established and reviewed at least every 60 days by a supervising physician of the clinic, or that is established by a physician, physician's assistant, nurse practitioner, nurse midwife, or specialized nurse practitioner and reviewed and approved at least every 60 days by a supervising physician of the clinic; and
    - The services are furnished to a homebound patient. For purposes of visiting

nurse services, a homebound recipient means one who is permanently or temporarily confined to a place of residence because of a medical or health condition and leaves the place of residence infrequently. For this purpose, a place of residence does not include a hospital or nursing facility.

Program Type 4 - Federally Qualified Health Centers (FQHC)

(See §1905(a)(2)(A) of the Act)

FQHCs are facilities or programs more commonly known as community health centers, migrant health centers, and health care for the homeless programs. A facility or program qualifies as a FQHC providing services covered under Medicaid if:

- They receive grants under - §§329, 330, or 340 of the Public Health Service Act (PHS);
- The Health Resources and Services Administration, PHS, certifies the center as meeting FQHC requirements; or
- The Secretary determines that the center qualifies through waiver of the requirements.

Services performed in FHQCs are defined as the same for services provided by rural health clinics. They may include physician services, services provided by physician assistants, nurse practitioners, clinical psychologists, clinical social workers, and services and supplies incident to such services as are otherwise covered if furnished by a physician, or as incident to a physician's services. In certain cases, services to a homebound Medicaid patient may be provided. Any other ambulatory service included in the State's Medicaid plan is considered covered by a FQHC program if the center offers it.

Program Type 5 - Indian Health Services

(See §911 of the Act; see 42 CFR 431.110)

These are services provided by the Indian Health Service (IHS), an agency charged with providing the primary source of health care for American Indian and Alaska Native people who are members of federally recognized tribes and organizations. A State plan must provide that an IHS facility, meeting State plan requirements for Medicaid participants, must be accepted as a Medicaid provider on the same basis as any other qualified provider.

Program Type 6 - Home and Community-Based Care for Functionally Disabled Elderly and for Individuals Age 65 and Older

(See§1929 of the Act; see 42 CFR 441, Subpart H)

This code is for services covered under §1915(b) waivers. These waivers are an option within the Medicaid program to provide home and community-based care to functionally

disabled individuals age 65 or older who are otherwise eligible for Medicaid or for non-disabled elderly individuals.

G - Program Type 7 - Home and Community-Based Waivers

(See §1915(c) of the Act and 42 CFR 440.180)

This code is for services covered under §1915(c) waivers under the provisions in 42 CFR Part 441, Subpart G (home and community-based services; waiver requirements).

2700.50 - Service and Program Hierarchies

Service Hierarchy

Experience has demonstrated there can be instances when more than one service area category could be applicable for a provided service. The following rules apply to these instances:

The basis for classifying services and the type of service hierarchy is defined in Attachment 4 of the MSIS Tape Specifications and Data Element Dictionary. Many of those classifications are based more on the billing provider type than the actual service provided. This sometimes results in the same service being put into different type of service categories depending on billing provider type. For example, crutches that are provided by a physician are classified as a Physician Service, while the same crutches provided by an medical supply company are mapped to Other Services. Listed below are some guidelines on service hierarchy.

- Lab and x-ray services provided by physicians, clinics, other practitioners are to be reported as Lab/x-ray.
- Dental x-rays and denture related services go into the Dental Type of Service category.
- Medical supplies prescribed by a physician and provided by a pharmacy and are reported in the RX files and coded with a type of service of Other Services. These claims may carry either NDC, HCPCS or state specific codes in the NDC field, although NDCs are preferred.
- All other medical supplies are reported in the OT file. Supplies provided by a medical device supplier are coded as Other Services, otherwise the type of service is based on the provider type. For example, supplies provided by a physician are classified as Physician Services).
- Drugs and injectables prescribed by a physician and provided by a pharmacy are reported with a type of service of Prescribed Drugs in the RX file. Otherwise drugs and injectables are to be put into the CLAIMOT file and are the type of service is based on the provider type. For example, injectables administered by a physician are classified as Physician Services. The service code field for these claims should contain either a HCPCS or state specific code (NDC codes will not fit in the OT service code field).
- All services provided by a Home Health agency are classified as Home Health except for Hospice. Hospice services provided by a HH agency are to be reported with a type of service of Hospice.
- The services rendered under special programs are to be mapped into the appropriate Type of Service category if possible, but otherwise should be classified as Other Services. Regardless of the program type, the specific type of

service must be coded for all claims.

Program Hierarchy

If there is an overlap of program types for a particular claim, for example EPSDT screens performed in a RHC, the highest level program type should be assigned using the following hierarchy:

Family Planning

Waiver Services

EPSDT

Indian Health

RHC

FQHC

2700.60 - Racial/Ethnic Classifications

The following classifications are not to be interpreted as scientific or anthropological in nature, nor are they to be used to determine eligibility for the Medicaid program. They have been developed and correspond directly to requirements established by the executive branch and the Congress.

Definitions

White - A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

Black or African American - A person having origins in any of the black racial groups of Africa.

American Indian or Alaskan Native - A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian - A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

Hispanic or Latino - A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.

Native Hawaiian or Other Pacific Islander - A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Hispanic or Latino and one or more races - A person who is identified as being Hispanic or Latino who also reports race data.

More than one race - A person who reports being more than one of the above races, but does not indicate a Hispanic or Latino ethnicity.