November 2017

T-MSIS Data Dictionary Appendices

Version: 2.1

Contents

Appendix A: Valid Values

Managed Care Plan Information File Valid Values

ACCREDITATION-ORGANIZATION

Code	Description
01	National committee for quality assurance – excellent
02	National committee for quality assurance – commendable
03	National committee for quality assurance – provisional
04	National committee for quality assurance – new plan – ***no longer a valid accreditation level***
05	URAC – full
06	URAC – conditional
07	URAC – provisional
08	Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) – 3 years
09	Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) – 1 year - ***no longer valid accreditation level***
10	Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) – 6 months - ***no longer valid accreditation*** level
11	Not accredited
12	Other
13	National committee for quality assurance-- accredited
14	National committee for quality assurance - interim
15	National committee for quality assurance - denied

Additional accreditation information can be found at:

NCQA
http://www.ncqa.org/Programs/Accreditation/HealthPlanHP/AccreditationLevels.aspx
AAAHC
http://www.aaahc.org/en/accreditation/General-information/policies/terms-of-accreditation/

CORE-BASED-STATISTICAL-AREA-CODE

Code	Description
1	The MCO's service area falls partially or entirely inside one or more metropolitan areas.
2	The MCO's service area falls partially or entirely inside one or more micropolitan areas, but not within any metropolitan areas.
3	The MCO's service area falls entirely outside of all metropolitan and micropolitan areas.

FILE-ENCODING-SPECIFICATION

Code	Description
FLF	The file follows a fixed length format.
PSV	The file follows a pipe-delimited format.

FILE-NAME

Code	Description
MNGDCARE	Managed Care Plan Information File

FILE-STATUS-INDICATOR

Code	Description
P	Production File
T	Test File

MANAGED-CARE-ADDR-TYPE

Code	Description
1	MCO's corporate address and contact information
2	MCO's mailing address
3	MCO's service location address
4	MCO's Billing address and contact information
5	CEO's address and contact information
6	CFO's address and contact information
7	Other

MANAGED-CARE-COUNTY

http://www.census.gov/geo/reference/codes/cou.html

MANAGED-CARE-PLAN-POP

See **Appendix F: Eligibility Group Table** for listing of valid values.

MANAGED-CARE-PLAN-TYPE

Code	Description
01	Comprehensive MCO
02	Traditional PCCM Provider
03	Enhanced PCCM Provider
04	Health Insuring Organization (HIO)
05	Medical-only PIHP (risk or non-risk/non-comprehensive/with inpatient hospital or institutional services)
06	Medical-only PAHP (risk or non-risk/non-comprehensive/no inpatient hospital or institutional services)
07	Long Term Care Services and Supports (LTSS) PIHP
08	Mental Health (MH) PIHP
09	Mental Health (MH) PAHP
10	Substance Use Disorders (SUD) PIHP
11	Substance Use Disorders (SUD) PAHP
12	Mental Health (MH) and Substance Use Disorders (SUD) PIHP
13	Mental Health (MH) and Substance Use Disorders (SUD) PAHP
14	Dental PAHP
15	Transportation PAHP
16	Disease Management PAHP
17	PACE
18	Pharmacy PAHP
19	Individual is enrolled in Long-Term Services & Supports (LTSS) and Mental Health (MH) PIHP
20	Other
60	Accountable Care Organization
70	Health/Medical Home
80	Integrated Care For Dual Eligibles

MANAGED-CARE-PROFIT-STATUS

Code	Description
01	501(C)(3) NON-PROFIT
02	FOR-PROFIT, CLOSELY HELD
03	FOR-PROFIT, PUBLICLY TRADED
04	OTHER

MANAGED-CARE-PROGRAM

Code	Description
1	Medicaid State Plan
2	CHIP State Plan
3	Both Medicaid and CHIP

MANAGED-CARE-SERVICE-AREA

Code	Description
1	Statewide- The managed care entity provides services to beneficiaries throughout the entire state.
2	County- The managed care entity provides services to beneficiaries in specified counties.
3	City- The managed care entity provides services to beneficiaries in specified cities.
4	Region- The managed care entity provides services to beneficiaries in specified regions, not defined by individual counties within the state (“region” is state-defined).
5	Zip Code- The managed care entity program provides services to beneficiaries in specified zip codes.
6	Other- The managed care entity provides services to beneficiaries in "other" area(s), not Statewide, County, City, or Region.

MANAGED-CARE-SERVICE-AREA-NAME

http://www.census.gov/geo/reference/ansi.html

MANAGED-CARE-STATE

http://www.census.gov/geo/reference/ansi_statetables.html

NATIONAL-HEALTH-CARE-ENTITY-ID-TYPE

Code	Description
1	**Controlling Health Plan (CHP) ID** – the national health plan identifier of a health plan that either controls its own business activities, actions, or policies, or is controlled by an entity that is not a health plan and exercises sufficient control over the subhealth plan(s) under it so as to direct its own business activities, actions, or policies, as well as those of any subhealth plans under it. Every health plan will have a CHP.
2	**Subhealth Plan (SHP) ID** – the national health plan identifier of a health plan whose business activities, actions, or policies are directed by a controlling health plan. All subhealth HPIDs should be reported. Note: While all health plans will have a CHP, not all plans will have one or more SHPs.
3	**Other Entity Identifier (OEID)** – a national identifier for entities that are not health plans, health care providers, or individuals (as defined in 45 CFR 160.103), but that need to be identified in standard transactions (including, for example, third party administrators, transaction vendors, clearinghouses, and other payers). Other entities are not required to obtain an OEID, but they could obtain and use one if they need to be identified in covered transactions.

OPERATING-AUTHORITY

Code	Description
01	1115 demonstration waiver program – demonstration projects under which most provisions of Section 1902 of the Social Security Act are waived and/or expenditures that would not otherwise be eligible for FFP are authorized. States use these to expand eligibility, restructure Medicaid coverage and secure programmatic flexibility.
02	1915(b) waiver program – waivers of most provisions of Section 1902 of the Social Security Act in order to limit beneficiaries' freedom of choice of provider; selectively contract with providers; or provide additional services to beneficiaries (State may include BBA special populations)
03	1932(a) state plan option to use managed care for MCO and PCCM programs – mandatory managed care programs implemented through the state plan (State must exclude or permit voluntary enrollment of specific populations)
04	1915(a) voluntary managed care program – an MCO managed care program in which enrollment is voluntary and therefore does not require a waiver.
05	Concurrent 1915(b)/1915(c) waivers– programs, or portions thereof, operating under both 1915(b) managed care and 1915(c) home and community-based services waivers.
06	Concurrent 1915(a)/1915(c) waivers– programs, or portions thereof, operating under both 1915(a) voluntary managed care and 1915(c) home and community-based services waiver
07	Concurrent 1932(a)/1915(c) waivers - programs, or portions thereof, operating under both 1932(a) managed care and 1915(c) home and community-based services waiver.
08	PACE – program that provides pre-paid, capitated comprehensive, health care services to the frail elderly.
09	1905(t) voluntary PCCM program – A PCCM managed care program in which enrollment is voluntary and therefore does not require a waiver.
10	1937benchmark benefit program—programs to provide benefits that differ from Medicaid state plan benefits using managed care and implemented through the state plan.
11	1902(a)(70) non-emergency medical transportation program –non-emergency medical transportation brokerage programs implemented through the state plan which can vary scope of services, operate on a less-than-statewide basis, and limit freedom of choice
12	Concurrent 1915(b)/1915(i) HCBS state plan services - the optional 1915(i) state plan Home and Community-Based Services (HCBS) benefit operated in conjunction with a 1915(b) managed care waiver program.
13	Concurrent 1915(a)/ 1915(i) HCBS state plan services - the optional 1915(i) state plan Home and Community-Based Services (HCBS) benefit operated in conjunction with a 1915(a) voluntary managed care program.
14	Concurrent 1932(a)/ 1915(i) HCBS state plan services - the optional 1915(i) state plan Home and Community-Based Services (HCBS) benefit operated in conjunction with a 1932(a) managed care state plan option.
15	1945 Health Homes.

RECORD-ID

Code	Description
MCR00001	FILE-HEADER-RECORD-MANAGED-CARE
MCR00002	MANAGED-CARE-MAIN
MCR00003	MANAGED-CARE-LOCATION-AND-CONTACT-INFO
MCR00004	MANAGED-CARE-SERVICE-AREA
MCR00005	MANAGED-CARE-OPERATING-AUTHORITY
MCR00006	MANAGED-CARE-PLAN-POPULATION-ENROLLED
MCR00007	MANAGED-CARE-ACCREDITATION-ORGANIZATION
MCR00008	NATIONAL-HEALTH-CARE-ENTITY-ID-INFO
MCR00009	CHPID-SHPID-RELATIONSHIP

REIMBURSEMENT-ARRANGEMENT

Code	Description
01	Risk-based Capitation, no incentives or risk-sharing
02	Risk-based Capitation with Incentive Arrangements
03	Risk-based Capitation with other risk-sharing Arrangements
04	Non-Risk Capitation
05	Fee-For-Service
06	Primary Care Case Management Payment
07	Other
08	Primary Care Case Management Payment plus Fee-For-Service

SUBMISSION-TRANSACTION-TYPE

Code	Description
C	**Create File—**a file that contains a complete set of transactions/changes processed since the last Create file submission. States may submit only one valid Create file per reporting period and data file type.
R	**Replacement File—**a Replacement submission is a replacement of the month's data. It will completely replace the immediate prior submission. If a later replacement entry is received, it will overwrite the previous replacement, as well as a prior Create or Update submission for the same data type and reporting period.
U	**Update File—**a file that contains T-MSIS record segments created in response to business rule rejects. Note: ***The records in an Update file are not generated as a result of a change processed in the state's Medicaid or Medicaid-related systems during the current reporting month.*** These Update file record segments may be unchanged from the ones submitted previously for various reasons (for example, the state may be unable to process a change record in their Medicaid / Medicaid-related systems to correct the issue because the state is simply passing through to T-MSIS data that originated outside of the state's systems).[1] Conversely, the records may be different from those previously submitted, but the change is the result of a fix whose root cause problem was an issue in the T-MSIS file-creation or replacement process at CMS. Regardless, the record was not generated from a change that occurred in the state's source data.

[1][1] CMS will provide direction at a later date concerning resubmission of records that states are unable to correct.

SUBMITTING-STATE

http://www.census.gov/geo/reference/ansi_statetables.html

Provider File Valid Values

ACCEPTING-NEW-PATIENTS-IND

Code	Description
0	No
1	Yes
8	N/A – The individual only practices as a member of a group.

ADDR-BORDER-STATE-IND

Code	Description
0	No
1	Yes
8	N/A - State does not distinguish “border state providers”.

ADDR-COUNTY

http://www.census.gov/geo/reference/codes/cou.html

ADDR-STATE

http://www.census.gov/geo/reference/ansi_statetables.html

ADDR-TYPE

Code	Description
1	Provider Billing
2	Provider Mailing
3	Provider Practice
4	Provider Service Location

AFFILIATED-PROGRAM-TYPE

Code	Description
1	Health Plan (NHP-ID) – The value in the AFFILIATED-PROGRAM-ID data element contains the National Health Plan Identifier of health plan in which the provider is enrolled to provide services including through the state plan and a waiver.
2	Health Plan (state-assigned health plan ID) – The value in the AFFILIATED-PROGRAM-ID data element contains the state-assigned health plan Identifier of health plan in which the provider is enrolled to provide services including through the state plan and a waiver.
3	Waiver – The value in the AFFILIATED-PROGRAM-ID data element contains an identifier for the waiver in which a provider is allowed to deliver services to eligible beneficiaries.
4	Health Home Entity – The value in the AFFILIATED-PROGRAM-ID data element contains the name of the health home in which a provider is participating. The health home entity is responsible for providing health home services to the patient in conformance with the Health Home SPA. This is the name that the state uses to uniquely identify the health home team. This entity can be a designated provider (e.g., physician, clinic, behavioral health organization), a health team which links to a designated provider, or a health team (physicians, nurses, behavioral health professionals).
5	Other – The value in the AFFILIATED-PROGRAM-ID data element contains an identifier for something other than a health plan, waiver, or health home entity

BED-TYPE-CODE

Code	Description
1	Intermediate Care Facility for the Intellectually Disabled
2	Inpatient
3	Nursing Facility
4	Title 18 Skilled Nursing Facility (T18 SNF)

FACILITY-GROUP-INDIVIDUAL-CODE

Code	Description
01	Facility – The entity identified by the associated SUBMITTING-STATE-PROV-ID is a facility.
02	Group – The entity identified by the associated SUBMITTING-STATE-PROV-ID is a group of individual practitioners.
03	Individual – The entity identified by the associated SUBMITTING-STATE-PROV-ID is an individual practitioner.

FILE-ENCODING-SPECIFICATION

Code	Description
FLF	The file follows a fixed length format.
PSV	The file follows a pipe-delimited format.

FILE-NAME

Code	Description
PROVIDER	Provider File

FILE-STATUS-INDICATOR

Code	Description
P	Production file
T	Test file

LICENSE-TYPE

Code	Description
1	State, county, or municipality professional or business license
2	DEA license
3	Professional society accreditation
4	CLIA accreditation
5	Other

OWNERSHIP-CODE

Code	Description
01	Voluntary – Non-Profit – Religious Organizations
02	Voluntary – Non-Profit – Other
03	Voluntary – multiple owners
04	Proprietary – Individual
05	Proprietary – Corporation
06	Proprietary – Partnership
07	Proprietary – Other
08	Proprietary – multiple owners
09	Government – Federal
10	Government – State
11	Government – City
12	Government – County
13	Government – City-County
14	Government – Hospital District
15	Government – State and City/County
16	Government – other multiple owners
17	Voluntary /Proprietary
18	Proprietary/Government
19	Voluntary/Government
88	N/A – The individual only practices as part of a group, e.g., as an employee

PROV-CLASSIFICATION-TYPE

Code	Description
1	Taxonomy code
2	Provider specialty code
3	Provider type code
4	Authorized category of service code

If **PROV-CLASSIFICATION-TYPE** is **1** (Provider taxonomy) then reference the following table for the appropriate **PROV-CLASSIFICATION-CODE** valid value

http://www.wpc-edi.com/reference/codelists/healthcare/health-care-provider-taxonomy-code-set/

If **PROV-CLASSIFICATION-TYPE** is **2** (Provider specialty code) then reference the following table for the appropriate **PROV-CLASSIFICATION-CODE** valid value

PROV-CLASSIFICATION-TYPE = 2

Code	Provider Specialty Description
01	General Practice
02	General Surgery
03	Allergy/Immunology
04	Otolaryngology
05	Anesthesiology C
06	Cardiology
07	Dermatology
08	Family Practice
09	Interventional Pain Management
10	Gastroenterology
11	Internal Medicine
12	Osteopathic Manipulative Therapy
13	Neurology
14	Neurosurgery
15	Speech Language Pathologist
16	Obstetrics/Gynecology
17	Hospice and Palliative Care
18	Ophthalmology
19	Oral Surgery (dentists only)
20	Orthopedic Surgery
21	Cardiac Electrophysiology
22	Pathology
23	Sports Medicine
24	Plastic and Reconstructive Surgery
25	Physical Medicine and Rehabilitation
26	Psychiatry
27	Geriatric Psychiatry
28	Colorectal Surgery (formerly proctology)
29	Pulmonary Disease
30	Diagnostic Radiology
31	Cardiac Rehabilitation & Intensive Cardiac Rehabilitation

32	Anesthesiologist Assistant
33	Thoracic Surgery
34	Urology
35	Chiropractic
36	Nuclear Medicine
37	Pediatric Medicine
38	Geriatric Medicine
39	Nephrology
Code	**Provider Specialty Description**
40	Hand Surgery
41	Optometry
42	Certified Nurse Midwife
43	Certified Registered Nurse Anesthetist (CRNA)
44	Infectious Disease
45	Mammography Center
46	Endocrinology
47	Independent Diagnostic Testing Facility (IDTF)
48	Podiatry
49	Ambulatory Surgical Center
50	Nurse Practitioner
51	Medical Supply Company with Orthotist
52	Medical Supply Company with Prosthetist
53	Medical Supply Company with Orthotist-Prosthetist
54	Other Medical Supply Company
55	Individual Certified Orthotist
56	Individual Certified Prosthetist
57	Individual Certified Orthotist-Prosthetist
58	Medical Supply Company with Pharmacist
59	Ambulance Service Provider
60	Public Health or Welfare Agency
61	Voluntary Health or Charitable Agency
62	Psychologist, Clinical
63	Portable X-Ray Supplier
64	Audiologist
65	Physical Therapist in Private Practice
66	Rheumatology
67	Occupational Therapist in Private Practice
68	Psychologist, Clinical
69	Clinical Laboratory
70	Single or Multispecialty Clinic or Group Practice
71	Registered Dietitian or Nutrition Professional
72	Pain Management
73	Mass Immunization Roster Biller

74	Radiation Therapy Center
75	Slide Preparation Facility
76	Peripheral Vascular Disease
77	Vascular Surgery
78	Cardiac Surgery
Code	**Provider Specialty Description**
79	Addiction Medicine
80	Licensed Clinical Social Worker
81	Critical Care (Intensivists)
82	Hematology
83	Hematology/Oncology
84	Preventive Medicine
85	Maxillofacial Surgery
86	Neuropsychiatry
87	All Other Suppliers
88	Unknown Supplier/Provider Specialty
89	Certified Clinical Nurse Specialist
90	Medical Oncology
91	Surgical Oncology
92	Radiation Oncology
93	Emergency Medicine
94	Interventional Radiology
95	Advance Diagnostic Imaging
96	Optician
97	Physician Assistant
98	Gynecological/Oncology
99	Undefined physician type (provider is an MD)
A0	Hospital-General
A1	Skilled Nursing Facility
A2	Intermediate Care Nursing Facility
A3	Other Nursing Facility
A4	Home Health Agency
A5	Pharmacy
A6	Medical Supply Company with Respiratory Therapist
A7	Department Store
A8	Grocery Store
A9	Indian Health Service facility
B1	Oxygen supplier
B2	Pedorthic personnel
B3	Medical supply company with pedorthic personnel
B4	Rehabilitation Agency
B5	Ocularist

If **PROV-CLASSIFICATION-TYPE is 3** (Provider type code) then reference the following table for the appropriate **PROV-CLASSIFICATION-CODE** valid value

PROV-CLASSIFICATION-TYPE – 3 (Provider Type Code)

Code	Provider Type Description
01	Physician
02	Speech Language Pathologist
03	Oral Surgery (Dentist only)
04	Cardiac Rehabilitation and Intensive Cardiac Rehabilitation
05	Anesthesiology Assistant
06	Chiropractic
07	Optometry
08	Certified Nurse Midwife
09	Certified Registered Nurse Anesthetist (CRNA)
10	Mammography Center
11	Independent Diagnostic Testing Facility (IDTF)
12	Podiatry
13	Ambulatory Surgical Center
14	Nurse Practitioner
15	Medical Supply Company with Orthotist
16	Medical Supply Company with Prosthetist
17	Medical Supply Company with Orthotist-Prosthetist
18	Other Medical Supply Company
19	Individual Certified Orthotist
20	Individual Certified Prosthetist
21	Individual Certified Prosthetist-Orthotist
22	Medical Supply Company with Pharmacist
23	Ambulance Service Provider
24	Public Health or Welfare Agency
25	Voluntary Health or Charitable Agency
26	Psychologist, Clinical
27	Portable X-Ray Supplier
28	Audiologist
29	Physical Therapist in Private Practice
30	Occupational Therapist in Private Practice
31	Clinical Laboratory

Code	Provider Type Description
32	Clinic or Group Practice
33	Registered Dietitian or Nutrition Professional
34	Mass Immunizer Roster Biller
35	Radiation Therapy Center
36	Slide Preparation Facility
37	Licensed Clinical Social Worker
38	Certified Clinical Nurse Specialist
39	Advance Diagnostic Imaging
40	Optician
41	Physician Assistant
42	Hospital-General
43	Skilled Nursing Facility
44	Intermediate Care Nursing Facility
45	Other Nursing Facility
46	Home Health Agency
47	Pharmacy
48	Medical Supply Company with Respiratory Therapist
49	Department Store
50	Grocery Store
51	Indian Health Service facility
52	Oxygen supplier
53	Pedorthic personnel
54	Medical supply company with pedorthic personnel
55	Rehabilitation Agency
56	Ocularist
57	All Other

If **PROV-CLASSIFICATION-TYPE** is **4** (Authorized category of service code) then reference the following table for the appropriate **PROV-CLASSIFICATION-CODE** valid value

PROV-CLASSIFICATION-TYPE = 4

Code	Authorized Category Of Service Code Description
001	Inpatient hospital services, other than services in an institution for mental diseases
002	Outpatient hospital services
003	Rural health clinic services
004	Other ambulatory services furnished by a rural health clinic
005	Professional laboratory services
006	Technical laboratory services
007	Professional radiological services
008	Technical radiological services
009	Nursing facility services for individuals age 21 or older (other than services in an institution for mental disease)
010	Early and periodic screening and diagnosis and treatment (EPSDT) services
011	Family planning services and supplies for individuals of child-bearing age
012	Physicians' services
013	Medical and surgical services of a dentist
014	Outpatient substance abuse treatment services.
015	Medical or other remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under State law
016	Home health services - Nursing services
017	Home health services - Home health aide services
018	Home health services - Medical supplies, equipment, and appliances suitable for use in the home
019	Home health services - Physical therapy provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services
020	Home health services - Occupational therapy provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services
021	Home health services - Speech pathology and audiology services provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services
022	Private duty nursing services
023	Advanced practice nurse services
024	Pediatric nurse
025	Nurse-midwife service
026	Nurse practitioner services
027	Respiratory care for ventilator-dependent individuals
028	Clinic services

029	Dental services
030	Physical therapy services (when not provided under home health services)
Code	**Authorized category of service code Description**
031	Occupational therapy services (when not provided under home health services)
032	Speech, hearing, and language disorders services (when not provided under home health services)
033	Prescribed drugs
034	Over-the-counter medications.
035	Dentures
036	Prosthetic devices
037	Eyeglasses
038	Hearing Aids
039	Diagnostic services
040	Screening services
041	Preventive services
042	Well-baby and well-child care services as defined by the State.
043	Rehabilitative services
044	Inpatient hospital services for individuals age 65 or older in institutions for mental diseases
045	Nursing facility services for individuals age 65 or older in institutions for mental diseases
046	Intermediate care facility (ICF/IIDICF/IID) services
047	Nursing facility services, other than in institutions for mental diseases
048	Inpatient psychiatric services for individuals under age 21
049	Outpatient mental health services, other than Outpatient substance abuse treatment services. This TOS includes services furnished in a State-operated mental hospital and including community-based services.
050	Inpatient substance abuse treatment services and residential substance abuse treatment services.
051	Personal care services
052	Primary care case management services
053	Targeted case management services
054	Case Management services other than those that meet the definition of primary care case management services or targeted case management services
055	Care coordination services.
056	Transportation services
057	Enabling services
058	Services furnished in a religious nonmedical health care institution
059	Skilled nursing facility services for individuals under age 21
060	Emergency hospital services
061	Critical access hospital services
062	HCBS - Case management services

Code	Authorized category of service code Description
063	HCBS - Homemaker services
064	HCBS - Home health aide services
065	HCBS - Personal care services
066	HCBS - Adult day health services
067	HCBS - Habilitation services
068	HCBS - Respite care services
069	HCBS - Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness
070	HCBS - Day Care
071	HCBS - Training for family members
072	HCBS - Minor modification to the home
073	HCBS - Other services requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization
074	HCBS - Expanded habilitation services - Prevocational services
075	HCBS - Expanded habilitation services - Educational services
076	HCBS - Expanded habilitation services - Supported employment services, which facilitate paid employment
077	HCBS-65-plus - Case management services
078	HCBS-65-plus - Homemaker services
079	HCBS-65-plus - Home health aide services
080	HCBS-65-plus - Personal care services
081	HCBS-65-plus - Adult day health services
082	HCBS-65-plus - Respite care services
083	HCBS-65-plus - Other medical and social services
084	Sterilizations
085	Prenatal care and pre-pregnancy family planning services and supplies.
086	Other Pregnancy-related Procedures
087	Hospice services
088	Any other health care services or items specified by the Secretary and not excluded under regulations.
115	Residential care

PROV-ENROLLMENT-METHOD

Code	Description
1	Enrolled through use of Medicare enrollment system (State did not require that provider submit application. Rather Provider is active Medicare provider and state Medicaid program accepted these credentials as sufficient to participate as state Medicaid provider.)
2	Enrolled through use of state-based provider application
3	Other

PROV-IDENTIFIER-TYPE

Code	Description
1	State-specific Medicaid Provider ID
2	NPI
3	Medicare ID
4	NCPDP ID
5	Federal Tax ID
6	State Tax ID
7	SSN
8	Other

PROV-MEDICAID-ENROLLMENT-STATUS-CODE

Code	Description
01	Active - Active Do Not Pay
02	Active - Active Reinstated
03	Active - Active
04	Active - Eligibility Verification
05	Active - Encounter Only
06	Active - Financial Trans Only
20	Denied - Denied Two Provider Numbers
21	Denied - For Other Reasons
22	Denied - Invalid License
23	Denied - Not Eligible
24	Denied - Same Number Assigned
40	Pending - Enrollment
41	Pending - License/Cert Verification
42	Pending - Missing Documentation
43	Pending - No License/Temp License
44	Pending - NPI Invalid
45	Pending - Rate Determination
46	Pending - Signed Agreement
47	Pending - Status Approval
48	Pending - W9 Missing or Incomplete
60	Term - Abuse of billing privileges
61	Term - Action Taken by Medicaid/CHIP
62	Term - Action Taken by Medicare
63	Term - Change of Ownership
64	Term - Failure to report a change of address/ownership
65	Term - False or misleading information
66	Term - Federal exclusion/ debarment, etc.
67	Term - Felony conviction
68	Term - Involuntary Termination
69	Term - License Expired
70	Term - License Revoked
71	Term - Loss of license or other State action
72	Term - Medicare/Medicaid Exclusion
73	Term - Medicaid Authority
74	Term - Medicare Termination
75	Term - Misuse of billing number
76	Term - No Claims Activity
77	Term - Non-Compliance
78	Term - Onsite review/ Provider is no longer operational
Code	Description
79	Term - Other

80	Term - Provider Deceased
81	Term - State exclusion/ debarment, etc.
82	Term - Unknown
83	Term - Voluntary Termination

PROV-PROFIT-STATUS

Code	Description
01	501(C)(3) NON-PROFIT
02	FOR-PROFIT, CLOSELY HELD
03	FOR-PROFIT, PUBLICLY TRADED
04	OTHER
88	N/A – The individual only practices as part of a group
99	Unknown

RECORD-ID

Code	Description
PRV00001	FILE-HEADER-RECORD-PROVIDER
PRV00002	PROV-ATTRIBUTES-MAIN
PRV00003	PROV-LOCATION-AND-CONTACT-INFO
PRV00004	PROV-LICENSING-INFO
PRV00005	PROV-IDENTIFIERS
PRV00006	PROV-TAXONOMY-CLASSIFICATION
PRV00007	PROV-MEDICAID-ENROLLMENT
PRV00008	PROV-AFFILIATED-GROUPS
PRV00009	PROV-AFFILIATED-PROGRAMS
PRV00010	PROV-BED-TYPE-INFO

SEX

Code	Description
F	Female
M	Male
U	Unknown

STATE-PLAN-ENROLLMENT

Code	Description
1	Medicaid
2	CHIP
3	Both Medicaid and CHIP
4	Not state plan affiliated

SUBMISSION-TRANSACTION-TYPE

Code	Description
C	**Create File—**a file that contains a complete set of transactions/changes processed since the last Create file submission. States may submit only one valid Create file per reporting period and data file type.
R	**Replacement File—**a Replacement submission is a replacement of the month's data. It will completely replace the immediate prior submission. If a later replacement entry is received, it will overwrite the previous replacement, as well as a prior Create or Update submission for the same data type and reporting period.
U	**Update File—**a file that contains T-MSIS record segments created in response to business rule rejects. Note: ***The records in an Update file are not generated as a result of a change processed in the state's Medicaid or Medicaid-related systems during the current reporting month.*** These Update file record segments may be unchanged from the ones submitted previously for various reasons (for example, the state may be unable to process a change record in their Medicaid / Medicaid-related systems to correct the issue because the state is simply passing through to T-MSIS data that originated outside of the state's systems).[1] Conversely, the records may be different from those previously submitted, but the change is the result of a fix whose root cause problem was an issue in the T-MSIS file-creation or replacement process at CMS. Regardless, the record was not generated from a change that occurred in the state's source data.

[1][1] CMS will provide direction at a later date concerning resubmission of records that states are unable to correct.

SUBMITTING-STATE

http://www.census.gov/geo/reference/ansi_statetables.html

TEACHING-IND

Code	Description
0	No
1	Yes

Eligible File Valid Values

1115A-DEMONSTRATION-IND

Code	Description
0	No
1	Yes

ADDR-TYPE

Code	Description
01	Primary home address and contact information, used for the eligibility determination process
02	Primary work address and contact information
03	Secondary residence and contact information
04	Secondary work address and contact information
05	Other category of address and contact information
06	Eligible person's official mailing address

AMERICAN-INDIAN-ALASKAN-NATIVE-INDICATOR

Code	Description
0	Individual does not meet the definition of an American Indian/Alaskan Native.
1	Individual meets the definition of an American Indian/Alaskan Native.

CHIP-CODE

Code	Description
1	Individual was Medicaid eligible, but was not included in either Medicaid-Expansion CHIP or a separate title XXI CHIP) program for the month. These include blind and disabled people and low-income families with dependent children.
2	Individual was included in the Medicaid-Expansion CHIP program and subject to enhanced Federal matching for the month. States with Medicaid-Expansion programs have built upon existing Medicaid programs to include low-income children whose family incomes are above Medicaid income eligibility thresholds.
3	Individual was not Medicaid-Expansion CHIP eligible, but was included in a separate title XXI CHIP program for the month. States using Separate CHIP have used CHIP funds to create separate programs outside of their Medicaid programs.

CITIZENSHIP-IND

Code	Description
0	No
1	Yes

CITIZENSHIP-VERIFICATION-FLAG

Code	Description
0	No
1	Yes

CONCEPTION-TO-BIRTH-IND

Code	Description
0	No
1	Yes

DISABILITY-TYPE-CODE

Code	Description
01	Individual is deaf or has serious difficulty hearing.
02	Individual is blind or has serious difficulty seeing, even when wearing glasses.
03	Individual has serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition. (Applicable only to people who are 5 years old or older.)
04	Individual has serious difficulty walking or climbing stairs. (Applicable only to people who are 5 years old or older.)
05	Individual has difficulty dressing or bathing. (Applicable only to people who are 5 years old or older.)
06	Individual has difficulty doing errands alone such as visiting a doctor's office or shopping because of a physical, mental, or emotional condition. (Applicable only to people who are 15 years old or older.)
07	Other
08	None

DUAL-ELIGIBLE-CODE

Code	Description
00	Eligible is not a Medicare beneficiary
01	Eligible is entitled to Medicare- QMB only
02	Eligible is entitled to Medicare- QMB AND Medicaid coverage
03	Eligible is entitled to Medicare- SLMB only
04	Eligible is entitled to Medicare- SLMB AND Medicaid coverage
05	Eligible is entitled to Medicare- QDWI
06	Eligible is entitled to Medicare- Qualifying individuals
08	Eligible is entitled to Medicare- Other Dual Eligibles (Non QMB, SLMB, QDWI or QI)
09	Eligible is entitled to Medicare – Other (*This code is to be used only with specific CMS approval.*)
10	Separate CHIP Eligible is entitled to Medicare

ELIGIBILITY-CHANGE-REASON

Code	Description
01	Excess income
02	Excess assets
03	Income reduced
04	Aged out of program
05	No longer in the foster care system
06	Death
07	No longer disabled
08	No longer institutionalized
09	No longer in need of long-term care services resides
10	Obtained employer sponsored insurance (ESI)
11	Gained access to public employees health plan
12	Obtained other coverage (not ESI or public employees health plan)
13	Failure to respond
14	Failure to pay premium or enrollment fees
15	Moved to a different state
16	Voluntary request for termination
17	Lack of verifications
18	Fraud
19	Suspension due to incarceration
20	Residence in an Institution for Mental Disease (IMD)
21	Suspension/Termination with reason unknown
22	Other

ELIGIBILITY-GROUP

See Appendix F: Eligibility Group Table for listing of valid values.

ELIGIBLE-COUNTY-CODE

http://www.census.gov/geo/reference/codes/cou.html

ELIGIBLE-STATE

http://www.census.gov/geo/reference/ansi_statetables.html

ENROLLMENT-TYPE

Code	Description
1	Medicaid or Medicaid Expansion CHIP
2	Separate Title XXI CHIP

ETHNICITY-CODE

Code	Description
0	Not of Hispanic or, Latino/a, or Spanish origin
1	Mexican, Mexican American, Chicano/a
2	Puerto Rican
3	Cuban
4	Another Hispanic, Latino, or Spanish origin
5	Hispanic or Latino Unknown
6	Ethnicity Unspecified

FILE-ENCODING-SPECIFICATION

Code	Description
FLF	The file follows a fixed length format.
PSV	The file follows a pipe-delimited format

Eligible File Valid Values

FILE-NAME

Code	Description
ELIGIBLE	Eligible File

FILE-STATUS-INDICATOR

Code	Description
P	Production file
T	Test file

HCBS-CHRONIC-CONDITION-NON-HEALTH-HOME-CODE

Code	Description
001	Aged
002	Physical Disabilities
003	Intellectual Disabilities
004	Autism Spectrum Disorder
005	Developmental Disabilities
006	Mental Illness and/or Serious Emotional Disturbance
007	Brain Injury
008	HIV/AIDS
009	Technology Dependent or Medically Fragile
010	Disabled (other)

HEALTH-HOME-CHRONIC-CONDITION

Code	Description
A	Mental health
B	Substance abuse
C	Asthma
D	Diabetes
E	Heart disease
F	Overweight (BMI of >25)
G	HIV/AIDS
H	Other

HOUSEHOLD-SIZE

Code	Description
01	1 person
02	2 people
03	3 people
04	4 people
05	5 people
06	6 people
07	7 people
08	8 or more people

IMMIGRATION-STATUS

Code	Description
1	Qualified non-citizen
2	Lawfully present under CHIPRA 214
3	Eligible only for payment for emergency services
8	U.S. citizen

IMMIGRATION-VERIFICATION-FLAG

Code	Description
0	No
1	Yes

INCOME-CODE

Code	Description
01	Individual's State-defined family income is from 0 to 100% of the FPL
02	Individual's State-defined family income is from 101 to 133% of the FPL
03	Individual's State-defined family income is from 134 to 150% of the FPL
04	Individual's State-defined family income is from 151 to 200% of the FPL
05	Individual's State-defined family income is from 201 to 255% of the FPL
06	Individual's State-defined family income is from 256 to 300% of the FPL
07	Individual's State-defined family income is from 301 to 400% of the FPL
08	Individual's State-defined family income is over 400% of the FPL

LEVEL-OF-CARE-STATUS

Code	Description
001	Hospital as defined in 42 CFR §440.10
002	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
003	Nursing Facility
004	ICF/IDD
005	Other Type of Facility
888	Not Applicable (Not in LTSS program)

LOCKED-IN-SRVCS

For a list of provider type codes, see the PROV-CLASSIFICATION-CODE in PROVIDER-FILE where PROV-CLASSIFICATION-TYPE = 3 (Provider Type Code).

LTSS-LEVEL-CARE

Code	Description
1	Skilled Care
2	Intermediate Care
3	Custodial Care

MAINTENANCE-ASSISTANCE-STATUS

Code	Description
0	Eligible for Separate CHIP only
1	Receiving Cash or eligible under section 1931 of the Act
2	Medically Needy
3	Poverty Related
4	Other
5	1115 - Demonstration expansion eligible

MANAGED-CARE-PLAN-TYPE

Code	Description
01	Comprehensive MCO
02	Traditional PCCM Provider arrangement
03	Enhanced PCCM Provider arrangement
04	Health Insuring Organization (HIO)
05	Medical-only PIHP (risk or non-risk/non-comprehensive/with inpatient hospital or institutional services)
06	Medical-only PAHP (risk or non-risk/non-comprehensive/no inpatient hospital or institutional services)
07	Long Term Care (LTC) PIHP
08	Mental Health (MH) PIHP
09	Mental Health (MH) PAHP
10	Substance Use Disorders (SUD) PIHP
11	Substance Use Disorders (SUD) PAHP
12	Mental Health (MH) and Substance Use Disorders (SUD) PIHP
13	Mental Health (MH) and Substance Use Disorders (SUD) PAHP
14	Dental PAHP
15	Transportation PAHP
16	Disease Management PAHP
17	Program for All-Inclusive Care for the Elderly (PACE)
18	Pharmacy PAHP
60	Accountable Care Organization
70	Health/Medical Home
80	Integrated Care For Dual Eligibles

MARITAL-STATUS

Code	Description
01	Legally Married (to opposite sex), spouse present
02	Legally Married (to opposite sex), spouse absent
03	Legally Married (to same sex), spouse present
04	Legally Married (to same sex), spouse absent
05	Partnered or in Civil Union (to opposite sex), spouse present
06	Partnered or in Civil Union (to opposite sex), spouse absent
07	Partnered or in Civil Union (to same sex), spouse present
08	Partnered or in Civil Union (to same sex), spouse absent
09	Legally separated (and not married or partnered)
10	Divorced (and not currently married or partnered)
11	Separated (and not currently married or partnered)
12	Widower/Widow (and not currently married or partnered)
13	Never married/partnered
14	Other

MEDICAID-BASIS-OF-ELIGIBILITY

Code	Description
00	Eligible for Separate CHIP only
01	Aged Individual
02	Blind/Disabled Individual
03	Not used
04	Child (not Child of Unemployed Adult, not Foster Care Child)
05	Adult (not based on unemployed status)
06	Child of Unemployed Adult (optional)
07	Unemployed Adult (optional)
08	Foster Care Child
10	Refugee Medical Assistance (45 CFR Sub-part G)
11	Individual covered under the Breast and Cervical Cancer Prevention and Treatment Act of 2000

MFP-LIVES-WITH-FAMILY

Code	Description
0	No
1	Yes
2	No MFP Participation

MFP-QUALIFIED-INSTITUTION

Code	Description
00	Default- No MFP Participation
01	Nursing Facility
02	ICF/IID (Intermediate Care Facilities for individuals with Intellectual Disabilities)
03	IMD (Institution for Mental Diseases)
04	Hospital
05	Other

MFP-QUALIFIED-RESIDENCE

Code	Description
00	Default - No MFP Participation
01	Home owned by participant
02	Home owned by family member
03	Apartment leased by participant, not assisted living
04	Apartment leased by participant, assisted living
05	Group home of no more than 4 people

MFP-REASON-PARTICIPATION-ENDED

Code	Description
00	Default – No MFP Participation
01	Completed 365 days of participation
02	Suspended eligibility
03	Re-institutionalized
04	Died
05	Moved
06	No longer needed services
07	Other

MFP-REINSTITUTIONALIZED-REASON

Code	Description
00	Default- No MFP Participation
01	Acute care hospitalization followed by long term rehabilitation
02	Deterioration in cognitive functioning
03	Deterioration in health
04	Deterioration in mental health
05	Loss of housing
06	Loss of personal care giver
07	By request of participant or guardian
08	Lack of sufficient community services

NATIONAL-HEALTH-CARE-ENTITY-ID-TYPE

Code	Description
1	**Controlling Health Plan (CHP) ID** – the national health plan identifier of a health plan that either controls its own business activities, actions, or policies, or is controlled by an entity that is **not** a health plan and exercises sufficient control over the subhealth plan(s) under it so as to direct its own business activities, actions, or policies, as well as those of any subhealth plans under it.
2	**Subhealth Plan (SHP) ID** – the national health plan identifier of a health plan whose business activities, actions, or policies are directed by a controlling health plan. All subhealth HPIDs should be reported.
3	**Other Entity Identifier (OEID)** – a national identifier for entities that are not health plans, health care providers, or individuals (as defined in 45 CFR 160.103), but that need to be identified in standard transactions (including, for example, third party administrators, transaction vendors, clearinghouses, and other payers). Other entities are not required to obtain an OEID, but they could obtain and use one if they need to be identified in covered transactions.

PREGNANCY-IND

Code	Description
0	No
1	Yes

PRIMARY-LANGUAGE-CODE

See language codes **in Appendix G: ISO 639 Language Codes Reference** for a list of all valid language codes.

PRIMARY-LANGUAGE-ENGL-PROF-CODE

Code	Description
0	Very Well
1	Well
2	Not well
3	No spoken proficiency

RACE

Code	Description
001	White
002	Black or African American
003	American Indian or Alaskan Native
004	Asian Indian
005	Chinese
006	Filipino
007	Japanese
008	Korean
009	Vietnamese
010	Other Asian
011	Asian Unknown
012	Native Hawaiian
013	Guamanian or Chamorro
014	Samoan
015	Other Pacific Islander
016	Native Hawaiian or Other Pacific Islander Unknown
017	Unspecified

RECORD-ID

Code	Description
ELG00001	FILE-HEADER-RECORD-ELIGIBILITY
ELG00002	PRIMARY-DEMOGRAPHICS-ELIGIBILITY
ELG00003	VARIABLE-DEMOGRAPHICS-ELIGIBILITY
ELG00004	ELIGIBLE-CONTACT-INFORMATION
ELG00005	ELIGIBILITY-DETERMINANTS
ELG00006	HEALTH-HOME-SPA-PARTICIPATION-INFORMATION
ELG00007	HEALTH-HOME-SPA-PROVIDERS
ELG00008	HEALTH-HOME-CHRONIC-CONDITIONS
ELG00009	LOCK-IN-INFORMATION
ELG00010	MFP-INFORMATION
ELG00011	STATE-PLAN-OPTION-PARTICIPATION
ELG00012	WAIVER-PARTICIPATION
ELG00013	LTSS-PARTICIPATION
ELG00014	MANAGED-CARE-PARTICIPATION
ELG00015	ETHNICITY-INFORMATION
ELG00016	RACE-INFORMATION
ELG00017	DISABILITY-INFORMATION
ELG00018	1115A-DEMONSTRATION-INFORMATION
ELG00020	HCBS-CHRONIC-CONDITIONS-NON-HEALTH-HOME
ELG00021	ENROLLMENT-TIME-SPAN

RESTRICTED-BENEFITS-CODE

Code	Description
1	Individual is eligible for Medicaid or CHIP and entitled to the full scope of Medicaid or CHIP benefits.
2	Individual is eligible for Medicaid or Medicaid-Expansion CHIP, but only entitled to restricted benefits based on alien status.
3	Individual is eligible for Medicaid but only entitled to restricted benefits based on Medicare dual-eligibility status (e.g., QMB, SLMB, QDWI, QI).
4	Individual is eligible for Medicaid or CHIP but only entitled to restricted benefits for pregnancy-related services.
5	Individual is eligible for Medicaid or Medicaid-Expansion CHIP but, for reasons other than alien, dual-eligibility or pregnancy-related status, is only entitled to restricted benefits (e.g., restricted benefits based upon substance abuse, medically needy or other criteria).
6	Individual is eligible for Medicaid or Medicaid-Expansion CHIP but only entitled to restricted benefits for family planning services.
7	Individual is eligible for Medicaid and entitled to Medicaid benefits under an alternative package of benchmark-equivalent coverage, as enacted by the Deficit Reduction Act of 2005.
D	Individual is eligible for Medicaid and entitled to benefits under a “Money Follows the Person” (MFP) rebalancing demonstration, as enacted by the Deficit Reduction Act of 2005, to allow States to develop community based long term care opportunities.
	(Intentionally Blank)
A	Individual is eligible for Medicaid and entitled to benefits under the Psychiatric Residential Treatment Facilities Demonstration Grant Program (PRTF), as enacted by the Deficit Reduction Act of 2005. PRTF grants assist States to help provide community alternatives to psychiatric resident treatment facilities for children.
B	Individual is eligible for Medicaid and entitled to Medicaid benefits using a Health Opportunity Account (HOA)
C	Individual is eligible for S-separate CHIP dental coverage (supplemental dental wraparound benefit to employer-sponsored insurance)

SEX

Code	Description
F	Female
M	Male
U	Unknown

SSDI-IND

Code	Description
0	No
1	Yes

SSI-IND

Code	Description
0	No
1	Yes

SSI-STATE-SUPPLEMENT-STATUS-CODE

Code	Description
000	Not Applicable
001	Mandatory
002	Optional

SSI-STATUS

Eligible File Valid Values

Code	Description
000	Not Applicable
001	SSI
002	SSI Eligible Spouse
003	SSI Pending a Final Determination of Disposal of Resources Exceeding SSI Dollar Limits

SSN-INDICATOR

Code	Description
0	State does not use SSN as MSIS-IDENTIFICATION-NUMBER
1	State uses SSN as MSIS-IDENTIFICATION-NUMBER

SSN-VERIFICATION-FLAG

Code	Description
0	SSN not verified
1	SSN successfully verified by SSA
2	SSN is pending SSA verification

STATE-PLAN-OPTION-TYPE

Code	Description
00	Not Applicable
01	Community First Choice
02	1915(i)
03	1915(j)
04	1932(a)
05	1915(a)
06	1937 (Alternative Benefit Plans)

SUBMISSION-TRANSACTION-TYPE

Code	Description
C	**Create File—**a file that contains a complete set of transactions/changes processed since the last Create file submission. States may submit only one valid Create file per reporting period and data file type.
R	**Replacement File—**a Replacement submission is a replacement of the month's data. It will completely replace the immediate prior submission. If a later replacement entry is received, it will overwrite the previous replacement, as well as a prior Create or Update submission for the same data type and reporting period.
U	**Update File—**a file that contains T-MSIS record segments created in response to business rule rejects. Note: ***The records in an Update file are not generated as a result of a change processed in the state's Medicaid or Medicaid-related systems during the current reporting month.*** These Update file record segments may be unchanged from the ones submitted previously for various reasons (for example, the state may be unable to process a change record in their Medicaid / Medicaid-related systems to correct the issue because the state is simply passing through to T-MSIS data that originated outside of the state's systems).[1] Conversely, the records may be different from those previously submitted, but the change is the result of a fix whose root cause problem was an issue in the T-MSIS file-creation or replacement process at CMS. Regardless, the record was not generated from a change that occurred in the state's source data.

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SUBMITTING-STATE

http://www.census.gov/geo/reference/ansi_statetables.html

TANF-CASH-CODE

Code	Description
1	Individual did not receive TANF benefits
2	Individual did receive TANF benefits (States should only use this value if they can accurately separate eligible receiving TANF benefits from other 1931 eligible)

VETERAN-IND

Code	Description
0	No
1	Yes

WAIVER-TYPE

Code	**Description**
01	1115 Other demonstration
02	1915(b)(1) – These waivers permit freedom-of-choice or mandatory managed care with some voluntary managed care.
03	1915(b)(2) – These waivers allow states to use enrollment brokers.
04	1915(b)(3) – These waivers allow states to use savings to provide additional services that are not in the State Plan.
05	1915(b)(4) – These waivers allow fee for service selective contracting.
06	1915(c)—Aged and Disabled
07	1915(c)— Aged
08	1915(c)— Physical Disabilities
09	1915(c)— Intellectual Disabilities
10	1915(c)— Intellectual and Developmental Disabilities
11	1915(c)— Brain Injury
12	1915(c)— HIV/AIDS
13	1915(c)— Technology Dependent or Medically Fragile
14	1915(c)— Disabled (other)
15	1915(c)— Enrolled in 1915(c) waiver for unspecified or unknown populations
16	1915(c)— Autism/Autism spectrum disorder
17	1915(c)— Developmental Disabilities
18	1915(c)— Mental Illness—Age 18 or Older
19	1915(c)— Mental Illness—Under Age 18
20	1915(c) waiver concurrent with an 1115 or 1915(b) managed care authority
22	1115 Pharmacy demonstration
23	1115 Disaster-related demonstration
24	1115 Family planning demonstration
25	1115 Substance use demonstration
26	1115 Premium Assistance demonstration
27	1115 Beneficiary engagement demonstration
28	1115 Former foster care youth from another state
29	1115 Managed long term services and support
30	1115 Delivery system reform
31	1332 Demonstration
32	1915(b) waiver
33	1915(c) waiver

Third-party Liability File Valid Values

COVERAGE-TYPE

Code	Description
01	Drug
02	Professional (Physician) Visit – Office
03	Dental Care
04	Inpatient Hospital
05	Outpatient Hospital
06	Nursing Home
07	Vision
08	Durable Med Equip (rent)
09	Durable Med Equip (purchase)
10	Home Health
11	Mental health—outpatient
12	Mental health –inpatient
13	Psychiatric care- outpatient
14	Psychiatric care- inpatient
15	Rehabilitation
16	Cancer
17	Emergency Services
18	Chiropractic
19	Surgical
20	Diagnostic Medical, including X-ray and Lab Services
21	PT/OT/ST
22	Hospice
23	Transportation
98	Other

FILE-ENCODING-SPECIFICATION

Code	Description
FLF	The file follows a fixed length format.
PSV	The file follows a pipe-delimited format.

FILE-NAME

Code	Description
TPL-FILE	Third Party Liability File

FILE-STATUS-INDICATOR

Code	Description
P	Production File
T	Test File

INSURANCE-CARRIER-STATE

http://www.census.gov/geo/reference/ansi_statetables.html

INSURANCE-PLAN-TYPE

Code	Description
01	Medical or comprehensive health insurance plan (e.g. HMO)
02	Dental health insurance plan
03	Vision health insurance plan
04	Prenatal/delivery health insurance plan
05	Long term care health insurance plan (Long Term PIHP)
06	Transportation health insurance plan (Transportation PAHP)
07	A managed care plan
08	Disease management health insurance plan (Disease Management PAHP)
09	PAHP (Medical only)
10	Comprehensive health insurance and Long Term Care (hybrid)
11	Other health insurance plan
12	Veterans Administration health benefits
13	Indian Health Service Program health benefits
14	TRICARE health benefits
15	Eligible enrolled in private LTC insurance
16	Fee-for-Service insurance

NATIONAL-HEALTH-CARE-ENTITY-ID-TYPE

Code	Description
1	**Controlling Health Plan (CHP) ID** – the national health plan identifier of a health plan that either controls its own business activities, actions, or policies, or is controlled by an entity that is **not** a health plan and exercises sufficient control over the subhealth plan(s) under it so as to direct its own business activities, actions, or policies, as well as those of any subhealth plans under it.
2	**Subhealth Plan (SHP) ID** – the national health plan identifier of a health plan whose business activities, actions, or policies are directed by a controlling health plan. All subhealth HPIDs should be reported.
3	**Other Entity Identifier (OEID)** – a national identifier for entities that are not health plans, health care providers, or individuals (as defined in 45 CFR 160.103), but that need to be identified in standard transactions (including, for example, third party administrators, transaction vendors, clearinghouses, and other payers). Other entities are not required to obtain an OEID, but they could obtain and use one if they need to be identified in covered transactions.

POLICY-OWNER-CODE

Code	Description
02	Spouse
03	Custodial Parent
04	Noncustodial Parent (Child Support Enforcement in effect)
05	Noncustodial Parent without child support enforcement in effect
06	Grandparent
07	Guardian
08	Domestic Partner
09	Other

RECORD-ID

Code	Description
TPL00001	FILE-HEADER-RECORD-TPL
TPL00002	TPL-MEDICAID-ELIGIBLE-PERSON-MAIN
TPL00003	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO
TPL00004	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-CATEGORIES
TPL00005	TPL-MEDICAID-ELIGIBLE-OTHER-THIRD-PARTY-COVERAGE-INFORMATION
TPL00006	TPL-ENTITY-CONTACT-INFORMATION

SSN-INDICATOR

Code	Description
0	State does not use SSN as MSIS-IDENTIFICATION-NUMBER
1	State uses SSN as MSIS-IDENTIFICATION-NUMBER

SUBMISSION-TRANSACTION-TYPE

Code	Description
C	**Create File—**a file that contains a complete set of transactions/changes processed since the last Create file submission. States may submit only one valid Create file per reporting period and data file type.
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[1][1] CMS will provide direction at a later date concerning resubmission of records that states are unable to correct.

SUBMITTING-STATE

http://www.census.gov/geo/reference/ansi_statetables.html

TPL-ENTITY-ADDR-TYPE

Code	Description
06	TPL-Entity Corporate Location
07	TPL-Entity Mailing
08	TPL-Entity Satellite Location
09	TPL-Entity Billing
10	TPL-Entity Correspondence
11	TPL-Other

TPL-HEALTH-INSURANCE-COVERAGE-IND

Code	Description
0	Medicaid/CHIP eligible individual has no TPL insurance coverage.
1	Medicaid/CHIP eligible individual does have TPL insurance coverage.

TPL-OTHER-COVERAGE-IND

Code	Description
0	Medicaid/CHIP eligible individual has no other TPL funding available.
1	Medicaid/CHIP eligible individual does have other TPL funding available.

TYPE-OF-OTHER-THIRD-PARTY-LIABILITY

Code	Description
2	Medical Malpractice
3	Estate (an estate, annuity or designated trust)
4	Liens
5	Worker's Compensation
6	Payments from an individual or group who has either voluntarily or been assigned legal responsibility for the health care of one or more Medicaid recipients; fraternal groups; unions
7	Other – unidentified

Claims Files Valid Values

All valid values for CLAIM-IP, CLAIM-LT, CLAIM-OT, and CLAIM-RX files are included

1115A-DEMONSTRATION-IND

Code	Description
0	No
1	Yes

ADJUSTMENT-IND

Code	Description of Use
0	Original Claim/Encounter/Payment – Indicates that this is the first (and, when applicable, only) fully adjudicated transaction in a claim family (one or more claims with the related ICN-ORIG and/or ICN-ADJ and typically the same MSIS ID and provider ID(s) also).
1	Void/Reversal/Cancel of a prior submission – Use this code to convey that the purpose of the transaction is to void/reverse/cancel a previously paid/approved claim/encounter/payment where the claim/encounter/payment is not being replaced by a new paid/approved version of the claim/encounter/payment. Typically this would be the last claim/encounter/payment that would ever be associated with a given claim family. These records must have the same ICN-ORIG or ICN-ADJ as the claim/encounter being voided. CMS expects a void transaction to also have the same MSIS ID and provider ID(s) as the claim/encounter/payment being voided/reversed/canceled.
4	Replacement/Resubmission of a previously paid/approved claim/encounter/payment – Use when the purpose of the transaction is to replace a previously paid/approved claim/encounter/payment with a new paid/approved version of the claim/encounter/payment. These records must have the same ICN-ORIG or ICN-ADJ as the claim/encounter being replaced. CMS expects a replacement transaction to also have the same MSIS ID and provider ID(s) as the claim/encounter/payment being replaced/resubmitted.
5	Credit Gross Adjustment – Use this code to indicate an aggregate provider-level recoupment of payments (e.g., not attributable to a single beneficiary). Amounts on these claims should be expressed as negative numbers. If a credit gross adjustment is reported with an ICN that is related to an ICN(s) of another gross adjustment (credit or debit) then CMS will interpret this to mean that the credit gross adjustment with the more recent adjudication date should completely replace the preceding related gross adjustment. If the ICNs of a credit gross adjustment are not related to any other gross adjustments (credit or debit) then the credit gross adjustment will always be treated as a distinct financial transaction.
6	Debit Gross Adjustment – Use this code to indicate an aggregate provider-level payment to a provider (e.g., not attributable to a single beneficiary). Amounts on these claims should be expressed as positive numbers. If a debit gross adjustment is reported with an ICN that is related to an ICN(s) of another gross adjustment (credit or debit) then CMS will interpret this to mean that the credit gross adjustment with the more recent adjudication date should completely replace the preceding related gross adjustment. If the ICNs of a debit gross adjustment are not related to any other gross adjustments (credit or debit) then the debit gross adjustment will always be treated as a distinct financial transaction.

ADJUSTMENT-REASON-CODE

http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/_

ADMISSION-HOUR

Code	Description
00	0:00-0:59
01	1:00-1:59
02	2:00-2:59
03	3:00-3:59
04	4:00-4:59
05	5:00-5:59
06	6:00-6:59
07	7:00-7:59
08	8:00-8:59
09	9:00-9:59
10	10:00-10:59
11	11:00-11:59
12	12:00-12:59
13	13:00-13:59
14	14:00-14:59
15	15:00-15:59
16	16:00-16:59
17	17:00-17:59
18	18:00-18:59
19	19:00-19:59
20	20:00-20:59
21	21:00-21:59
22	22:00-22:59
23	23:00-23:59

ADMISSION-TYPE

Code		Description
1	EMERGENCY	The patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency room.
2	URGENT	The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient is admitted to the first available and suitable accommodation.
3	ELECTIVE	The patient's condition permits adequate time to schedule the availability of a suitable accommodation.
4	NEWBORN	The patient is a newborn delivered either inside the admitting hospital (UB04 FL 15 value "5" [A baby born inside the admitting hospital] or outside of the hospital (UB04 FL 15 value "6" [A baby born outside the admitting hospital]).
5	TRAUMA	The patient visits a trauma center (A trauma center means a facility licensed or designated by the State or local government authority authorized to do so, or as verified by the American College of surgeons and involving a trauma activation.)
9	UNKNOWN	Information not available.

ADMITTING-DIAGNOSIS-CODE

http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html
http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/ICD10.html

ADMITTING-DIAGNOSIS-CODE-FLAG

Code	Description
1	ICD-9
2	ICD-10

ADMITTING-PROV-NPI-NUM

https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/

ADMITTING-PROV-SPECIALTY

See Appendix A under PROV-CLASSIFICATION-CODE #2 for a listing of valid values.

ADMITTING-PROV-TAXONOMY

http://www.wpc-edi.com/reference/

ADMITTING-PROV-TYPE

See Appendix A under PROV-CLASSIFICATION-CODE #3 for a listing of valid values.

ALLOWED-CHARGE-SRC

Code	Description
1	Priced using QMB Pricing
2	Lab panel bundled
4	Priced using RBRVS
5	Anesthesia pricing
7	APC priced
	(Intentionally Blank)
A	Manually priced
B	By report
C	Maximum fee
D	Percent of charges
E	Reimbursement Rate
F	Lower level screening fee
G	Billed Charges
H	Denied
I	Medicare Coins and deductible
K	Medicare allowed amount
M	Medicare prevailing
P	DRG
R	DRG w/cost outlier
U	DRG priced by proration
V	Mid-level priced
Z	ATP Bundled

BENEFIT-TYPE

Code	Code Definition
Mandatory Benefits for Categorically Needy (Mandatory and Options for Coverage) Individuals and Optional Benefits for Medically Needy Individuals	
001	Inpatient Hospital Services
002	Outpatient Hospital Services
003	Rural health clinic services
004	FQHC services
005	Other Laboratory and X-Ray Services
006	Nursing Facility Services for 21 and over
007	EPSDT
008	Family Planning Services
009	Mandatory tobacco cessation counseling for pregnant women under 1905(a)(4)(D)
010	Physicians' Services
011	Medical and Surgical Services Furnished by a Dentist
012	Nurse-midwife services
013	Certified pediatric or family nurse practitioners' services
014	Free Standing Birth Center Services
015	Home Health Services - Intermittent or part-time nursing services provided by a home health agency
016	Home Health Services - Home Health Aide Services Provided by a Home Health Agency
017	Home Health Services - Medical supplies, equipment, and appliances suitable for use in the home
Optional Benefits for Categorically Needy (Mandatory and Options for Coverage) and Medically Needy Individuals	
018	Medical care and any type of remedial care recognized under State law - Podiatrists' Services
019	Medical care and any type of remedial care recognized under State law - Optometrists' Services
020	Medical care and any type of remedial care recognized under State law - Chiropractors' Services
021	Medical care and any type of remedial care recognized under State law - Other Practitioners' Services within scope of practice as defined by State law
022	Home Health Services - Physical therapy; occupational therapy; speech pathology; audiology provided by a home health agency
023	Private Duty Nursing
024	Clinic Services
025	Dental Services
026	Physical Therapy and Related Services - Physical Therapy
027	Physical Therapy and Related Services - Occupational Therapy
028	Physical Therapy and Related Services - Services for individuals with speech, hearing and language disorders
029	Prescription drugs, dentures, and prosthetic devices; and eyeglasses - Prescribed Drugs
030	Prescription drugs, dentures, and prosthetic devices; and eyeglasses - Dentures
031	Prescription drugs, dentures, and prosthetic devices; and eyeglasses - Prosthetic Devices

Code	Code Definition
032	Prescription drugs, dentures, and prosthetic devices; and eyeglasses - Eyeglasses
033	Other diagnostic, screening, preventive, and rehabilitative services - Diagnostic Services
034	Other diagnostic, screening, preventive, and rehabilitative services - Screening Services
035	Other diagnostic, screening, preventive, and rehabilitative services - Preventive Services
036	Other diagnostic, screening, preventive, and rehabilitative services - Rehabilitative Services
037	Services for individuals over age 65 in IMDs - Inpatient hospital services
038	Services for individuals over age 65 in IMDs - Nursing facility services
039	Intermediate Care Facility Services for individuals with intellectual disabilities or persons with related conditions
040	Inpatient psychiatric facility services for under 21
041	Hospice Care
042	Case Management Services and TB related services - Case management services as defined in the State Plan in accordance with section 1905(a)(19) or 1915(g)
043	Case Management Services and TB related services - Special TB related services under section 1902(z)(2)
044	Respiratory care services under 1902(e)9)(A) through (C)
045	Personal care services
046	Primary care case management services
047	Special sickle-cell anemia-related services
048	Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary - Transportation
049	Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary - Services provided in religious non-medical health care facilities
050	Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary - Nursing facility services for patients under 21
051	Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary - Emergency hospital services
052	Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary - Critical Access Hospitals
053	Extended services for pregnant women - Additional Services for any other medical conditions that may complicate pregnancy
054	Community First Choice
055	Health Home Services
Special Benefit Provisions	
056	Limited Pregnancy-Related Services for Pregnant Women with Income Above the Applicable Income Limit
057	Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period
058	Benefits for Families Receiving Transitional Medical Assistance
059	Standards for Coverage of Transplant Services
060	School-Based Services Payment Methodologies
061	Indian Health Services and Tribal Health Facilities
062	Methods and Standards to Assure High Quality Care

Code	Code Definition
Coordination of Medicaid with Medicare and other Insurance	
063	Medicare Premium Payments
064	Medicare Coinsurance and Deductibles
065	Other Medical Insurance Premium Payments
Special Benefit Programs	
066	Programs for Distribution of Pediatric Vaccines
Home and Community-Based Services	
067	Laboratory and x-ray services
068	Home Health Services - Home health aide services provided by a home health agency
069	Private duty nursing services
070	Physical Therapy and Related Services - Audiology services
071	Extended services for pregnant women - Additional Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.
072	Home and Community Care for Functionally Disabled Elderly individuals as defined and described in the State Plan
073	Emergency services for certain legalized aliens and undocumented aliens
074	Licensed or Otherwise State-Approved Free-Standing Birthing Center and other ambulatory services that are offered by a freestanding birth center
075	Homemaker
076	Home Health Aide
077	Adult Day Health services
078	Habilitation
079	Habilitation: Residential Habilitation
080	Habilitation: Supported Employment
081	Habilitation: Education (non IDEA available)
082	Habilitation: Day Habilitation
083	Habilitation: Pre-Vocational
084	Habilitation: Other Habilitative Services
085	Respite
086	Day Treatment (mental health service)
087	Psychosocial rehabilitation
088	Environmental Modifications (Home Accessibility Adaptations)
089	Vehicle Modifications
090	Non-Medical Transportation
091	Special Medical Equipment (minor assistive Devices)
092	Home Delivered meals
093	Assistive Technology (i.e., communication devices)
094	Personal Emergency Response (PERS)
095	Nursing Services
096	Community Transition Services
097	Adult Foster Care
098	Day Supports (non-habilitative)
099	Supported Employment

Code	Code Definition
100	Supported Living Arrangements
101	Supports for Consumer Direction (Supports Facilitation)
102	Participant Directed Goods and Services
103	Senior Companion (Adult Companion Services)
104	Assisted Living
Other	
105	Program for All-inclusive Care for the Elderly (PACE) Services
106	Self-directed Personal Assistance Services under 1915(j)

BILLING-PROV-NPI-NUM

https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/

BILLING-PROV-SPECIALTY

See Appendix A under PROV-CLASSIFICATION-CODE #2 for a listing of valid values.

BILLING-PROV-TAXONOMY

http://www.wpc-edi.com/reference/

BILLING-PROV-TYPE

See Appendix A under PROV-CLASSIFICATION-CODE #3 for a listing of valid values.

BILLING-UNIT

Code	Code Definition
01	Per Day
02	Per Hour
03	Per Case
04	Per Encounter
05	Per Week
06	Per Month
07	Other Arrangements

BORDER-STATE-IND

Code	Description
0	No
1	Yes

BRAND-GENERIC-IND

Code	Description
0	Not a Drug
1	Generic
2	Brand

CLAIM-DENIED-INDICATOR

Code	Description
0	Denied: The payment of claim in its entirety was denied by the state.
1	Not Denied: The state paid some or all of the claim.

CLAIM-LINE-STATUS
http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/

CLAIM-PYMT-REM-CODE-1 to CLAIM-PYMT-REM-CODE-4
http://www.wpc-edi.com/reference/codelists/healthcare/remittance-advice-remark-codes)

CLAIM-STATUS
http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/

CLAIM-STATUS-CATEGORY
http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/

CMS-64-CATEGORY-FOR-FEDERAL-REIMBURSEMENT

Code	Description
01	Federal funding under Title XIX
02	Federal funding under Title XXI
03	Federal funding under ACA
04	Federal funding under other legislation

COMPOUND-DOSAGE-FORM

Code	Description
01	Capsule
02	Ointment
03	Cream
04	Suppository
05	Powder
06	Emulsion
07	Liquid
10	Tablet
11	Solution
12	Suspension
13	Lotion
14	Shampoo
15	Elixir
16	Syrup
17	Lozenge
18	Enema

COMPOUND-DRUG-IND

Code	Description
0	Not Compound
1	Compound

COPAY-WAIVED-IND

Code	Description
0	Not Waived: The provider did not waive the beneficiary's copayment,
1	Waived: The provider waived the beneficiary's copayment.

CROSSOVER-INDICATOR

Code	Description
0	Not Crossover Claim
1	Crossover Claim

DESTINATION-STATE

http://www.census.gov/geo/reference/ansi_statetables.html

DIAGNOSIS-CODE-1 to DIAGNOSIS-CODE-12
http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html

http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/ICD10.html

DIAGNOSIS-CODE-FLAG-1 to DIAGNOSIS-CODE-FLAG-12

Code	Description
1	ICD-9
2	ICD-10

DIAGNOSIS-POA-FLAG-1 to DIAGNOSIS-POA-FLAG-12

Code	Description
Y	Diagnosis was present at time of inpatient admission
N	Diagnosis was not present at time of inpatient admission
U	Documentation insufficient to determine if condition was present at the time of inpatient admission
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.
BLANK	Exempt from POA reporting.

DISCHARGE-HOUR

Code	Description
00	0:00-0:59
01	1:00-1:59
02	2:00-2:59
03	3:00-3:59
04	4:00-4:59
05	5:00-5:59
06	6:00-6:59
07	7:00-7:59
08	8:00-8:59
09	9:00-9:59
10	10:00-10:59
11	11:00-11:59
12	12:00-12:59
13	13:00-13:59
14	14:00-14:59
15	15:00-15:59
16	16:00-16:59
17	17:00-17:59
18	18:00-18:59
19	19:00-19:59
20	20:00-20:59
21	21:00-21:59
22	22:00-22:59
23	23:00-23:59

DISPENSING-PRESCRIPTION-DRUG-PROV-NPI
https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/

DISPENSING-PRESCRIPTION-DRUG-PROV-TAXONOMY
http://www.wpc-edi.com/reference/

DRG-DESCRIPTION
http://www.cms.hhs.gov/MedicareFeeforSvcPartsAB/Downloads/DRGdesc06.pdf

http://edocket.access.gpo.gov/2009/pdf/E9-12907.pdf

DRUG-UTILIZATION-CODE

439-E4 (Reason for Service Code) for the Conflict Codes

Code (439-E4)	Description
AD	Additional Drug Needed
AN	Prescription Authentication
AR	Adverse Drug Reaction
AT	Additive Toxicity
CD	Chronic Disease Management
CH	Call Help Desk
CS	Patient Complaint/Symptom
DA	Drug-Allergy
DC	Drug-Disease (Inferred)
DD	Drug-Drug Interaction
DF	Drug-Food interaction
DI	Drug Incompatibility
DL	Drug-Lab Conflict
DM	Apparent Drug Misuse
DS	Tobacco Use
ED	Patient Education/Instruction
ER	Overuse
EX	Excessive Quantity
HD	High Dose
IC	Iatrogenic Condition
ID	Ingredient Duplication
LD	Low Dose
LK	Lock In Recipient
LR	Underuse
MC	Drug-Disease (Reported)
MN	Insufficient Duration
MS	Missing Information/Clarification
MX	Excessive Duration
NA	Drug Not Available
NC	Non-covered Drug Purchase
ND	New Disease/Diagnosis
NF	Non-Formulary Drug
NN	Unnecessary Drug
NP	New Patient Processing
NR	Lactation/Nursing Interaction
NS	Insufficient Quantity
OH	Alcohol Conflict
PA	Drug-Age
PC	Patient Question/Concern
PG	Drug-Pregnancy

PH	Preventive Health Care
PN	Prescriber Consultation
PP	Plan Protocol
PR	Prior Adverse Reaction
PS	Product Selection Opportunity
Code (439-E4)	**Description**
RE	Suspected Environmental Risk
RF	Health Provider Referral
SC	Suboptimal Compliance
SD	Suboptimal Drug/Indication
SE	Side Effect
SF	Suboptimal Dosage Form
SR	Suboptimal Regimen
SX	Drug-Gender
TD	Therapeutic
TN	Laboratory Test Needed
TP	Payer/Processor Question

44Ø-E5 (Professional Service Code) for the Intervention Codes

Code 440-E5	Description
ØØ	No intervention
AS	Patient assessment
CC	Coordination of care
DE	Dosing evaluation/determination
FE	Formulary enforcement
GP	Generic product selection
MA	Medication administration
MØ	Prescriber consulted
MR	Medication review
PE	Patient education/instruction
PH	Patient medication history
PM	Patient monitoring
PØ	Patient consulted
PT	Perform laboratory test
RØ	Pharmacist consulted other source
RT	Recommend laboratory test
SC	Self-care consultation
SW	Literature search/review
TC	Payer/processor consulted
TH	Therapeutic product interchange

441-E6 (Result of Service Code) for the Output Codes

Code 441-E6	Description
ØØ	Not Specified
1A	Filled As Is, False Positive
1B	Filled Prescription As Is
1C	Filled, With Different Dose
1D	Filled, With Different Directions
1E	Filled, With Different Drug
1F	Filled, With Different Quantity
1G	Filled, With Prescriber Approval
1H	Brand-to-Generic Change
1J	Rx-to-OTC Change
1K	Filled with Different Dosage Form
2A	Prescription Not Filled
2B	Not Filled, Directions Clarified
3A	Recommendation Accepted
3B	Recommendation Not Accepted
3C	Discontinued Drug
3D	Regimen Changed
3E	Therapy Changed
3F	Therapy Changed-cost increased acknowledged
3G	Drug Therapy Unchanged
3H	Follow-Up/Report
3J	Patient Referral
3K	Instructions Understood
3M	Compliance Aid Provided
3N	Medication Administered

FILE-ENCODING-SPECIFICATION

Code	Description
FLF	The file follows a fixed length format.
PSV	The file follows a pipe-delimited format.

FILE-NAME

Code	Description
CLAIM-IP	Inpatient Claim/Encounters File - Claims/encounters with TYPE-OF-SERVICE = 001, 058, 060, 084, 086, 090, 091, 092, 093, 123, 132, or 135. (Note: In CLAIMIP, TYPE-OF-SERVICE 086 and 084 refer only to services received on an inpatient basis.)
CLAIM-LT	Long Term Care Claims/Encounters File - Claims/encounters with TYPE-OF-SERVICE = 009, 044, 045, 046, 047, 048, 059, or 133 (all mental hospital, and NF services). (Note: Individual services billed by a long-term care facility belong in this file regardless of service type.)
CLAIM-OT	Other Claims/Encounters File - Claims/encounters with TYPE-OF-SERVICE= 002, 003, 004, 005, 006, 007, 008, 010, 011, 012, 013, 014, 015, 016, 017, 018, 019, 020, 021, 022, 023, 024, 025, 026, 027, 028, 029, 030, 031, 032, 035, 036, 037, 038, 039, 040, 041, 042, 043, 049, 050, 051, 052, 053, 054, 055, 056, 057, 060, 061, 062, 063, 064, 065, 066, 067, 068, 069, 070, 071, 072, 073, 074, 075, 076, 077, 078, 079, 080, 081, 082, 083, 084, 085, 086, 087, 088, 089, 115, 119, 120, 121, 122, 123, 127, 131, 134, or 135.
CLAIM-RX	Pharmacy Claims/Encounters File - Claims/encounters with TYPE-OF-SERVICE= 011, 018, 033, 034, 036, 085, 089, 127, or 131.

FILE-STATUS-INDICATOR

Code	Description
P	Production File
T	Test File

FIXED-PAYMENT-IND

Code	Description
0	Not Fixed Payment
1	FFS Fixed Payment

FORCED-CLAIM-IND

Code	Description
0	No
1	Yes

FUNDING-CODE

Code	Description
A	Medicaid Agency
B	CHIP Agency
C	Mental Health Service Agency
D	Education Agency
E	Child and Family Services Agency
F	County
G	City
H	Providers
I	Other

FUNDING-SOURCE-NONFEDERAL-SHARE

Code	Description
01	State appropriations to the Medicaid agency
02	Intergovernmental transfers (IGT)
03	Certified public expenditures (CPE)
04	Provider taxes
05	Donations
06	State appropriations to the CHIP agency

HCBS-SERVICE-CODE

Code	Description
1	The HCBS service was provided under 1915(i)
2	The HCBS service was provided under 1915(j)
3	The HCBS service was provided under 1915(k)
4	The HCBS service was provided under a 1915(c) HCBS Waiver
5	The HCBS service was provided under an 1115 waiver
6	The HCBS service was not provided under the statutes identified above and was of an acute care nature
7	The HCBS service was not provided under the statutes identified above and was of a long term care nature

HCBS-TAXONOMY

Code	Description
01010	Case Management
02011	Group Living, Residential Habilitation
02012	Group Living, Mental Health Services
02013	Group Living, Other
02021	Shared Living, Residential Habilitation
02022	Shared Living, Mental Health Services
02023	Shared Living, Other
02031	In-e Residential Habilitation
02032	In-Home Round-The-Clock Mental Health Services
02033	In-Home Round-The-Clock Services, Other
03010	Job Development
03021	Ongoing Supported Employment, Individual
03022	Ongoing Supported Employment, Group
03030	Career Planning
04010	Prevocational Services
04020	Day Habilitation
04030	Education Services
04040	Day Treatment/Partial Hospitalization
04050	Adult Day Health
04060	Adult Day Services (Social Model)
04070	Community Integration
04080	Medical Day Care for Children
05010	Private Duty Nursing
05020	Skilled Nursing
06010	Home Delivered Meals
07010	Rent and Food Expenses For Live-In Caregiver
08010	Home-Based Habilitation
08020	Home Health Aide
08030	Personal Care
08040	Companion
08050	Homemaker
08060	Chore
09011	Respite, Out-Of-Home
09012	Respite, In-Home
09020	Caregiver Counseling and/or Training
10010	Mental Health Assessment
10020	Assertive Community Treatment
10030	Crisis Intervention
10040	Behavior Support
10050	Peer Specialist
10060	Counseling
10070	Psychosocial Rehabilitation
10080	Clinic Services
10090	Other Mental Health and Behavioral Services

11010	Health Monitoring
Code	Description
11020	Health Assessment
11030	Medication Assessment and/or Management
11040	Nutrition Consultation
11050	Physician Services
11060	Prescription Drugs
11070	Dental Services
11080	Occupational Therapy
11090	Physical Therapy
11100	Speech, Hearing, And Language Therapy
11110	Respiratory Therapy
11120	Cognitive Rehabilitative Therapy
11130	Other Therapies
12010	Financial Management Services In Support Of Participant Direction
12020	Information and Assistance In Support Of Participant Direction
13010	Participant Training
14010	Personal Emergency Response System (Pers)
14020	Home and/or Vehicle Accessibility Adaptations
14031	Equipment and Technology
14032	Supplies
15010	Non-Medical Transportation
16010	Community Transition Services
17010	Goods and Services
17020	Interpreter
17030	Housing Consultation
17990	Other

HCPCS-RATE
http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html?redirect=/medhcpcsgeninfo/

HEALTH-CARE-ACQUIRED-CONDITION-IND

Code	Description
0	No
1	Yes

HEALTH-HOME-ENTITY-NAME

The field can contain any alphanumeric characters, digits or symbols except the "pipe" (|).

HEALTH-HOME-PROVIDER-NPI
https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/

HEALTH-HOME-PROV-IND

Code	Description
0	No
1	Yes

IMMUNIZATION-TYPE

Code	Description
00	None
01	Anthrax
02	Cervical Cancer)
03	Diphtheria
04	Hepatitis A
05	Hepatitis B
06	Haemophilus influenza type b (Hib)
07	Human Papillomavirus (HPV)
08	H1N1 Flu
09	Seasonal Flu
10	Japanese Encephalitis
11	Lyme Disease
12	Measles
13	Meningococcal
14	Monkey pox
15	Mumps
16	Pertussis
17	Pneumococcal
18	Poliomyelitis
19	Rabies
20	Rotavirus
21	Rubella
22	Shingles
23	Smallpox
24	Tetanus
25	Tuberculosis
26	Typhoid Fever
27	Varicella
28	Yellow Fever
29	Other

LINE-ADJUSTMENT-IND

Code	Description of Use
0	Original Claim/Encounter/Payment – Indicates that this is the first (and, when applicable, only) fully adjudicated transaction in a claim family (one or more claims with the related ICN-ORIG and/or ICN-ADJ and typically the same MSIS ID and provider ID(s) also).
1	Void/Reversal/Cancel of a prior submission – Use this code to convey that the purpose of the transaction is to void/reverse/cancel a previously paid/approved claim/encounter/payment where the claim/encounter/payment is not being replaced by a new paid/approved version of the claim/encounter/payment. Typically this would be the last claim/encounter/payment that would ever be associated with a given claim family. These records must have the same ICN-ORIG or ICN-ADJ as the claim/encounter being voided. CMS expects a void transaction to also have the same MSIS ID and provider ID(s) as the claim/encounter/payment being voided/reversed/canceled.
4	Replacement/Resubmission of a previously paid/approved claim/encounter/payment – Use when the purpose of the transaction is to replace a previously paid/approved claim/encounter/payment with a new paid/approved version of the claim/encounter/payment. These records must have the same ICN-ORIG or ICN-ADJ as the claim/encounter being replaced. CMS expects a replacement transaction to also have the same MSIS ID and provider ID(s) as the claim/encounter/payment being replaced/resubmitted.
5	Credit Gross Adjustment – Use this code to indicate an aggregate provider-level recoupment of payments (e.g., not attributable to a single beneficiary). Amounts on these claims should be expressed as negative numbers. If a credit gross adjustment is reported with an ICN that is related to an ICN(s) of another gross adjustment (credit or debit) then CMS will interpret this to mean that the credit gross adjustment with the more recent adjudication date should completely replace the preceding related gross adjustment. If the ICNs of a credit gross adjustment are not related to any other gross adjustments (credit or debit) then the credit gross adjustment will always be treated as a distinct financial transaction.
6	Debit Gross Adjustment – Use this code to indicate an aggregate provider-level payment to a provider (e.g., not attributable to a single beneficiary). Amounts on these claims should be expressed as positive numbers. If a debit gross adjustment is reported with an ICN that is related to an ICN(s) of another gross adjustment (credit or debit) then CMS will interpret this to mean that the credit gross adjustment with the more recent adjudication date should completely replace the preceding related gross adjustment. If the ICNs of a debit gross adjustment are not related to any other gross adjustments (credit or debit) then the debit gross adjustment will always be treated as a distinct financial transaction.

LINE-ADJUSTMENT-REASON-CODE
http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/

MEDICARE-COMB-DED-IND

Code	Description
0	Amount not combined with coinsurance amount
1	Amount combined with coinsurance amount

MEDICARE-REIM-TYPE

Code	Description
01	IPPS - Acute Inpatient PPS
02	LTCHPPS - Long-term Care Hospital PPS
03	SNFPPS - Skilled Nursing Facility PPS
04	HHPPS - Home Health PPS
05	IRFPPS - Inpatient Rehabilitation Facility PPS
06	IPFPPS - Inpatient Psychiatric Facility PPS
07	OPPS - Outpatient PPS
08	Fee Schedules (for physicians, DME, ambulance, and clinical lab)
09	Part C Hierarchical Condition Category Risk Assessment (CMS-HCC RA) Capitation Payment Model

NEW-REFILL-IND

Code	Description
00	New Prescription
01-98	Number of Refill(s)

NDC-UNIT-OF-MEASURE

Code	Description
F2	International Unit
ML	Milliliter
ME	Milligram
GR	Gram
UN	Unit

OCCURRENCE-CODE-01 to OCCURRENCE-CODE-10

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1104cp.pdf

OPERATING-PROV-NPI-NUM
https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/

OPERATING-PROV-TAXONOMY
http://www.wpc-edi.com/reference/

ORIGINATION-STATE

http://www.census.gov/geo/reference/ansi_statetables.html

OTHER-INSURANCE-IND

Code	Description
0	No
1	Yes

OTHER-TPL-COLLECTION

Code	Description
001	Third Party Resource is Casualty/Tort
002	Third Party Resource is Estate
003	Third Party Resource is Lien (TEFRA)
004	Third Party Resource is Lien (Other)
005	Third Party Resource is Worker's Compensation
006	Third Party Resource is Medical Malpractice
007	Third Party Resource is Other

OUTLIER-CODE

Code	Description
01	Day Outlier
02	Cost Outlier
06	Valid DRG Received from the intermediary
07	CMS Developed DRG
08	CMS Developed DRG Using Patient Status Code
09	Not Group able
10	Composite of cost outliers

PATIENT-STATUS
http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0801.pdf

To order the current edition of the UB-04 Data Specifications Manual go to:
http://www.nubc.org/subscriber/index.dhtml
American Hospital Association
155 North Wacker Drive, Suite 400
Chicago, IL 60606
Phone: 312-422-3000
Fax: 312-422-4500

PAYMENT-LEVEL-IND

Code	Description
1	Claim Header – Sum of Line Item payments
2	Claim Detail – Individual Line Item payments

PLACE-OF-SERVICE
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf

PRESCRIBING-PROV-SPECIALTY
See Appendix A under PROV-CLASSIFICATION-CODE #2 for a listing of valid values.

PRESCRIBING-PROV-TAXONOMY
http://www.wpc-edi.com/reference/

PRESCRIBING-PROV-TYPE
See Appendix A under PROV-CLASSIFICATION-CODE #3 for a listing of valid values.

PROCEDURE-CODE 1 TO PROCEDURE-CODE-6
http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html

http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/ICD10.html

http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html?redirect=/medhcpcsgeninfo/

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html

http://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx

Additional CPT codes are available for a fee through professional organizations.

PROCEDURE-CODE-FLAG-1 - PROCEDURE-CODE-FLAG-6

Code	Description
01	CPT 4
02	ICD-9 CM
06	HCPCS (Both National and Regional HCPCS)
07	ICD-10 - CM PCS
10-87	Other Systems

PROGRAM-TYPE

Code	Description
01	EPSDT
02	Family Planning
03	Rural Health Clinic
04	Federally Qualified Health Centers (FQHC)
05	Indian Health Services
07	Home and Community Based Care Waiver Services
08	Money Follows the Person (MFP)
10	BIP - Balancing Incentive Payment
11	Community First Choice (1915(k))
12	Medicaid Emergency Psychiatric Demonstration
13	Home and Community Based Services (HCBS) State Plan Option (1915(i))
14	State Plan CHIP
15	Psychiatric Residential Treatment Facilities Demonstration Grant Program (PRTF)
16	1915(j) (Self- directed personal assistance services/personal care under State Plan or 1915(c) waiver)

PROV-FACILITY-TYPE

Source: http://www.wpc-edi.com/reference/

Provider Facility Type Code	Provider Facility Type Description
100000000	Individuals or Groups (of Individuals)
170000000	Non-Individual - Other Service Providers
250000000	Non-Individual - Agencies
260000000	Non-Individual - Ambulatory Health Care Facilities
270000000	Non-Individual - Hospital Units
280000000	Non-Individual - Hospitals
290000000	Non-Individual - Laboratories
300000000	Non-Individual - Managed Care Organizations
310000000	Non-Individual - Nursing & Custodial Care Facilities
320000000	Non-Individual - Residential Treatment Facilities
330000000	Non-Individual - Suppliers
340000000	Non-Individual - Transportation Services
380000000	Non-Individual - Respite Care Facility
(Note: Appendix L takes the WPC taxonomy codes and relates each one to its provider facility type code)	

REBATE-ELIGIBLE-INDICATOR

Code	Description
0	NDC is not eligible for drug rebate program. (Manufacturer does not have a rebate agreement.)
1	NDC is eligible for drug rebate program
2	NDC is exempt from the drug rebate program (biological and medical devices)

RECORD-ID

Code	Description
CIP00001	FILE-HEADER-RECORD-IP
CIP00002	CLAIM-HEADER-RECORD-IP
CIP00003	CLAIM-LINE-RECORD-IP
CLT00001	FILE-HEADER-RECORD-LT
CLT00002	CLAIM-HEADER-RECORD-LT
CLT00003	CLAIM-LINE-RECORD-LT
COT00001	FILE-HEADER-RECORD-OT
COT00002	CLAIM-HEADER-RECORD-OT
COT00003	CLAIM-LINE-RECORD-OT
CRX00001	FILE-HEADER-RECORD-RX
CRX00002	CLAIM-HEADER-RECORD-RX
CRX00003	CLAIM-LINE-RECORD-RX

REFERRING-PROV-NPI-NUMBER
https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/

REFERRING-PROV-SPECIALTY
See Appendix A under PROV-CLASSIFICATION-CODE #2 for a listing of valid values.

REFERRING-PROV-TAXONOMY
http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/TaxonomyCrosswalk.pdf

http://www.wpc-edi.com/reference/

http://www.cms.hhs.gov/medicareprovidersupenroll/downloads/taxonomy.pdf

REFERRING-PROV-TYPE
See Appendix A under PROV-CLASSIFICATION-CODE #3 for a listing of valid values.

SELF-DIRECTION-TYPE

Code	Description
000	Not Applicable
001	Hiring Authority
002	Budget Authority
003	Hiring and Budget Authority

SERVICE-TRACKING-TYPE

Code	Description
00	Not a Service Tracking Claim
01	Drug Rebate
02	DSH Payment
03	Lump Sum Payment
04	Cost Settlement
05	Supplemental
06	Other

SERVICING-PROV-NPI-NUM
https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/

SERVICING-PROV-SPECIALTY
See Appendix A under PROV-CLASSIFICATION-CODE #2 for a listing of valid values.

SERVICING-PROV-TAXONOMY
http://www.wpc-edi.com/reference/

SOURCE-LOCATION

Code	Description
01	MMIS
02	Non-MMIS CHIP Payment System
03	Pharmacy Benefits Manager (PBM) Vendor
04	Dental Benefits Manager Vendor
05	Transportation Provider System
06	Mental Health Claims Payment System
07	Financial Transaction/Accounting System
08	Other State Agency Claims Payment System
09	County/Local Government Claims Payment System
10	Other Vendor/Other Claims Payment System
20	Managed Care Organization (MCO)

SPLIT-CLAIM-IND

Code	Description
0	No
1	Yes

SSN-INDICATOR

Code	Description
0	State does not use SSN as MSIS-IDENTIFICATION-NUMBER
1	State uses SSN as MSIS-IDENTIFICATION-NUMBER

SUBMISSION-TRANSACTION-TYPE

Code	Description
C	**Create File—**a file that contains a complete set of transactions/changes processed since the last Create file submission. States may submit only one valid Create file per reporting period and data file type.
R	**Replacement File—**a Replacement submission is a replacement of the month's data. It will completely replace the immediate prior submission. If a later replacement entry is received, it will overwrite the previous replacement, as well as a prior Create or Update submission for the same data type and reporting period.
U	**Update File—**a file that contains T-MSIS record segments created in response to business rule rejects. Note: ***The records in an Update file are not generated as a result of a change processed in the state's Medicaid or Medicaid-related systems during the current reporting month.*** These Update file record segments may be unchanged from the ones submitted previously for various reasons (for example, the state may be unable to process a change record in their Medicaid / Medicaid-related systems to correct the issue because the state is simply passing through to T-MSIS data that originated outside of the state's systems).[1] Conversely, the records may be different from those previously submitted, but the change is the result of a fix whose root cause problem was an issue in the T-MSIS file-creation or replacement process at CMS. Regardless, the record was not generated from a change that occurred in the state's source data.

SUBMITTING-STATE

[1][1] CMS will provide direction at a later date concerning resubmission of records that states are unable to correct.

http://www.census.gov/geo/reference/ansi_statetables.html

TOOTH-DESIGNATION-SYSTEM

Code	Description
JO	ANSI/ADA/ISO Specification No. 3950
JP	ADA's Universal/National Tooth Designation system

TOOTH-NUM

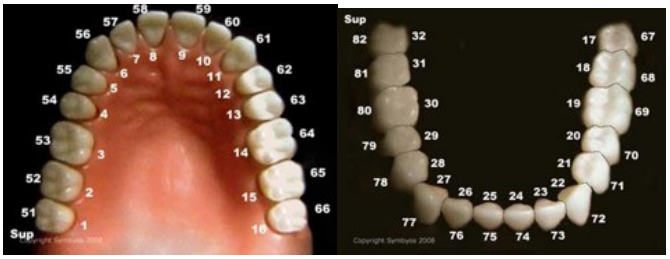
Tooth Number Table

Upper Arch (commencing in the upper right quadrant and rotating counterclockwise)

Tooth #	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
"Super"#	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66

Lower Arch

Tooth #	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
"Super"#	82	81	80	79	78	77	76	75	74	73	72	71	70	69	68	67



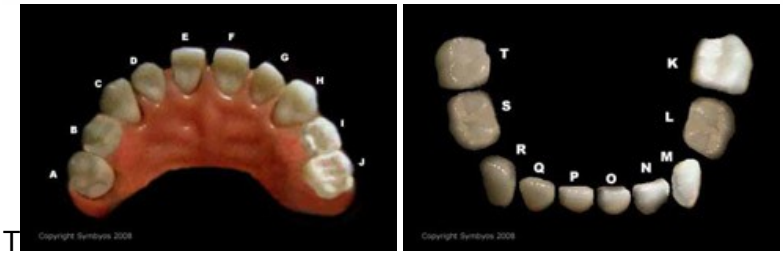
Primary Dentition:

Upper Arch (commencing in the upper right quadrant and rotating counterclockwise)

Tooth #	A	B	C	D	E	F	G	H	I	J
"Super"#	AS	BS	CS	DS	ES	FS	GS	HS	IS	JS

Lower Arch

Tooth #	T	S	R	Q	P	O	N	M	L	K
"Super"#	TS	SS	RS	QS	PS	OS	NS	MS	LS	KS



T

TOOTH-QUAD-CODE

Code	Description
00	Entire Oral Cavity
01	Maxillary Area
02	Mandibular Area
03	Upper Right Sextant
04	Upper Anterior Sextant
05	Upper Left Sextant
06	Lower Left Sextant
07	Lower Anterior Sextant
08	Lower Right Sextant
09	Other Area of Oral Cavity (An area specified in an annexed document or further explanation available.)
10	Upper Right Quadrant (Right Refers to the oral and skeletal structures on the right side.)
20	Upper Left Quadrant (Left Refers to the oral and skeletal structures on the left side.)
30	Lower Left Quadrant
40	Lower Right Quadrant

TOOTH-SURFACE-CODE

Code	**Description**
B	**Buccal** – The surface of the tooth which is closest to the cheek.
D	**Distal** – The surface of the tooth facing away from an invisible line drawn vertically through the center of the face.
F	**Facial** – The surface of a tooth that is directed towards the face.
I	**Incisal** – The cutting edges of the anterior teeth.
L	**Lingual** – The surface of the tooth that is directed towards the tongue.
M	**Mesial** – The surface of a tooth which faces toward an invisible line drawn vertically through the center of the face.
O	**Occlusa** – The surfaces of the posterior (back) teeth which provides the chewing function.

TYPE-OF-BILL

2nd Digit-Type of Facility

Code	Description
1	Hospital
2	Skilled Nursing
3	Home Health
4	Religious Nonmedical (Hospital)
5	Reserved for national assignment (discontinued effective 10/1/05).
6	Intermediate Care
7	Clinic or Hospital Based Renal Dialysis Facility (requires special information in second digit below).
8	Special facility or hospital ASC surgery (requires special information in second digit below).
9	Reserved for National Assignment

3rd Digit-Bill Classification (Except Clinics and Special Facilities)

Code	Description
1	Inpatient
2	Inpatient
3	Outpatient
4	Other
5	Intermediate Care - Level I
6	Intermediate Care - Level II
7	Reserved for national assignment (discontinued effective 10/1/05).
8	Swing Bed (may be used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement).
9	Reserved for National Assignment

3rd Digit-Classification (Clinics Only)

Code	Description
1	Rural Health Clinic (RHC)
2	Hospital Based or Independent Renal Dialysis Facility
3	Free Standing Provider-Based Federally Qualified Health Center (FQHC)
4	Other Rehabilitation Facility (ORF)
5	Comprehensive Outpatient Rehabilitation Facility (CORF)
6	Community Mental Health Center (CMHC)
7-8	Reserved for National Assignment
9	OTHER

3rd Digit-Classification (Special Facilities Only)

Code	Description
1	Hospice (Nonhospital Based)
2	Hospice (Hospital Based)
3	Ambulatory Surgical Center Services to Hospital Outpatients
4	Free Standing Birthing Center
5	Critical Access Hospital
6-8	Reserved for National Assignment
9	OTHER

4th Digit-Frequency

Code	Description
A	Admission/Election Notice
B	Hospice/Medicare Coordinated Care Demonstration/Religious Nonmedical Health Care Institution Termination/Revocation Notice
C	Hospice Change of Provider Notice
D	Hospice/Medicare Coordinated Care Demonstration/Religious Nonmedical Health Care Institution Void/Cancel
E	Hospice Change of Ownership
F	Beneficiary Initiated Adjustment Claim
G	CWF Initiated Adjustment Claim
H	CMS Initiated Adjustment Claim
I	FI Adjustment Claim (Other than QIO or Provider
J	Initiated Adjustment Claim-Other
K	OIG Initiated Adjustment Claim
M	MSP Initiated Adjustment Claim
P	QIO Adjustment Claim
0	Nonpayment/Zero Claims
1	Admit Through Discharge Claim
2	Interim-First Claim
3	Interim-Continuing Claims (Not valid for PPS Bills)
4	Interim-Last Claim (Not valid for PPS Bills)
5	Late Charge Only
7	Replacement of Prior Claim
8	Void/Cancel of a Prior Claim
9	Final Claim for a Home Health PPS Episode

TYPE-OF-CLAIM

Code	Description
1	A Fee-For-Service Medicaid or Medicaid-expansion Claim
2	Medicaid or Medicaid-expansion Capitated Payment
3	Medicaid or Medicaid-expansion Managed Care Encounter (a.k.a. “Dummy”) record that simulates a bill for a service rendered to a patient covered under some form of Capitation Plan. This includes billing records submitted by providers to non-state entities (e.g., MCOs, health plans) for which the State has no financial liability since the risk entity has already received a capitated payment from the State.
4	Medicaid or Medicaid-expansion Service Tracking Claim
5	Medicaid or Medicaid-expansion Supplemental Payment (above capitation fee or above negotiated rate) (e.g., FQHC additional reimbursement)
A	Separate CHIP (Title XXI) claim: A Fee-for-Service Claim
B	Separate CHIP (Title XXI) claim: Capitated Payment
C	Separate CHIP (Title XXI) encounter record that simulates a bill for a service or items rendered to a patient covered under some form of Capitation Plan. This includes billing records submitted by providers to non-State entities (e.g., MCO’s, health plans) for which a state has no financial liability as the at-risk entity has already received a capitated payment from the state
D	Separate CHIP (Title XXI) Service Tracking Claim
E	Separate CHIP (Title XXI) claim for a supplemental payment (above capitation fee or above negotiated rate) (e.g., FQHC additional reimbursement)
U	Other FFS claim
V	Other Capitated Payment
W	Other Managed Care Encounter
X	Non-Medicaid/CHIP service tracking claims
Y	Other Supplemental Payment
Z	Denied claims

TYPE-OF-HOSPITAL

Code	Description
00	Not a hospital
01	Inpatient Hospital
02	Outpatient Hospital
03	Critical Access Hospital
04	Swing Bed Hospital
05	Inpatient Psychiatric Hospital
06	IHS Hospital
07	Children's Hospital
08	Other

TYPE-OF-SERVICE

See **Appendix D: Types of Service (TOS) Reference**

TOS Code	TOS Description	FILE-NAME
001	Inpatient hospital services, other than services in an institution for mental diseases	CLAIMIP
002	Outpatient hospital services	CLAIMOT
003	Rural health clinic services	CLAIMOT
004	Other ambulatory services furnished by a rural health clinic	CLAIMOT
005	Professional laboratory services, Technical laboratory services	CLAIMOT
006	Technical laboratory services	CLAIMOT
007	Professional radiological services	CLAIMOT
008	Technical radiological services	CLAIMOT
009	Nursing facility services for individuals age 21 or older (other than services in an institution for mental disease)	CLAIMLT
010	Early and periodic screening and diagnosis and treatment (EPSDT) services	CLAIMOT
011	Family planning services and supplies for individuals of child-bearing age	CLAIMOT CLAIMRX
012	Physicians' services	CLAIMOT
013	Medical and surgical services of a dentist	CLAIMOT
014	Outpatient substance abuse treatment services.	CLAIMOT
015	Medical or other remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under State law	CLAIMOT
016	Home health services - Nursing services	CLAIMOT
017	Home health services - Home health aide services	CLAIMOT
018	Home health services - Medical supplies, equipment, and appliances suitable for use in the home	CLAIMOT CLAIMRX
019	Home health services - Physical therapy provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services	CLAIMOT

TOS Code	TOS Description	FILE-NAME
020	Home health services - Occupational therapy provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services	CLAIMOT
021	Home health services - Speech pathology and audiology services provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services	CLAIMOT
022	Private duty nursing services	CLAIMOT
023	Advanced practice nurse services	CLAIMOT
024	Pediatric nurse	CLAIMOT
025	Nurse-midwife service	CLAIMOT
026	Nurse practitioner services	CLAIMOT
027	Respiratory care for ventilator-dependent individuals	CLAIMOT
028	Clinic services	CLAIMOT
029	Dental services	CLAIMOT
030	Physical therapy services (when not provided under home health services)	CLAIMOT
031	Occupational therapy services (when not provided under home health services)	CLAIMOT
032	Speech, hearing, and language disorders services (when not provided under home health services)	CLAIMOT
033	Prescribed drugs	CLAIMRX
034	Over-the-counter medications.	CLAIMRX
035	Dentures	CLAIMOT
036	Medical equipment/prosthetic devices	CLAIMOT CLAIMRX
037	Eyeglasses	CLAIMOT
038	Hearing Aids	CLAIMOT
039	Diagnostic services	CLAIMOT
040	Screening services	CLAIMOT
041	Preventive services	CLAIMOT
042	Well-baby and well-child care services as defined by the State.	CLAIMOT

TOS Code	TOS Description	FILE-NAME
043	Rehabilitative services	CLAIMOT
044	Inpatient hospital services for individuals age 65 or older in institutions for mental diseases	CLAIMLT
045	Nursing facility services for individuals age 65 or older in institutions for mental diseases	CLAIMLT
046	Intermediate care facility (ICF/IIDICF/IID) services	CLAIMLT
047	Nursing facility services, other than in institutions for mental diseases	CLAIMLT
048	Inpatient psychiatric services for individuals under age 21	CLAIMLT
049	Outpatient mental health services, other than Outpatient substance abuse treatment services. This TOS includes services furnished in a State-operated mental hospital and including community-based services.	CLAIMOT
050	Inpatient substance abuse treatment services and residential substance abuse treatment services.	CLAIMLT CLAIMOT
051	Personal care services	CLAIMOT
052	Primary care case management services	CLAIMOT
053	Targeted case management services	CLAIMOT
054	Case Management services other than those that meet the definition of primary care case management services or targeted case management services	CLAIMOT
055	Care coordination services	CLAIMOT
056	Transportation services	CLAIMOT
057	Enabling services	CLAIMOT
058	Services furnished in a religious nonmedical health care institution	CLAIMIP
059	Skilled nursing facility services for individuals under age 21	CLAIMLT
060	Emergency hospital services	CLAIMIP CLAIMOT
061	Critical access hospital services – OT	CLAIMOT
062	HCBS - Case management services	CLAIMOT
063	HCBS - Homemaker services	CLAIMOT
064	HCBS - Home health aide services	CLAIMOT

TOS Code	TOS Description	FILE-NAME
065	HCBS - Personal care services	CLAIMOT
066	HCBS - Adult day health services	CLAIMOT
067	HCBS - Habilitation services	CLAIMOT
068	HCBS - Respite care services	CLAIMOT
069	HCBS - Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness	CLAIMOT
070	HCBS - Day Care	CLAIMOT
071	HCBS - Training for family members	CLAIMOT
072	HCBS - Minor modification to the home	CLAIMOT
073	HCBS - Other services requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization	CLAIMOT
074	HCBS - Expanded habilitation services - Prevocational services	CLAIMOT
075	HCBS - Expanded habilitation services - Educational services	CLAIMOT
076	HCBS - Expanded habilitation services - Supported employment services, which facilitate paid employment	CLAIMOT
077	HCBS-65-plus - Case management services	CLAIMOT
078	HCBS-65-plus - Homemaker services	CLAIMOT
079	HCBS-65-plus - Home health aide services	CLAIMOT
080	HCBS-65-plus - Personal care services	CLAIMOT
081	HCBS-65-plus - Adult day health services	CLAIMOT
082	HCBS-65-plus - Respite care services	CLAIMOT
083	HCBS-65-plus - Other medical and social services	CLAIMOT
084	Sterilizations	CLAIMIP CLAIMOT
085	Prenatal care and pre-pregnancy family planning services and supplies.	CLAIMOT CLAIMRX
086	Other Pregnancy-related Procedures	CLAIMIP CLAIMOT

TOS Code	TOS Description	FILE-NAME
087	Hospice services	CLAIMOT
088	Any other health care services or items specified by the Secretary and not excluded under regulations.	CLAIMOT
089	Disposable medical supplies.	CLAIMOT CLAIMRX
090	Critical access hospital services – IP	CLAIMIP
091	Skilled care – hospital residing	CLAIMIP
092	Exceptional care – hospital residing	CLAIMIP
093	Non-acute care – hospital residing	CLAIMIP
115	Residential care	CLAIMOT
119	Capitated payments to HMOs, HIOs, or PACE plans	CLAIMOT
120	Capitated payments for primary care case management (PCCM)	CLAIMOT
121	Premium payments for private health insurance	CLAIMOT
122	Capitated payments to prepaid health plans (PHPs)	CLAIMOT
123	Disproportionate share hospital (DSH) payments	CLAIMIP CLAIMOT
127	Indian Health Service (IHS) - Family Plan	CLAIMOT CLAIMRX
131	Drug Rebates	CLAIMOT CLAIMRX
132	Supplemental payment – inpatient	CLAIMIP
133	Supplemental payment – nursing	CLAIMLT
134	Supplemental payment – outpatient	CLAIMOT
135	EHR payments to provider	CLAIMIP CLAIMOT

UNDER-DIRECTION-OF-PROV-NPI

https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/

UNDER-DIRECTION-OF-PROV-TAXONOMY
http://www.wpc-edi.com/reference/

UNDER-SUPERVISION-OF-PROV-NPI
https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/

UNDER-SUPERVISION-OF-PROV-TAXONOMY
http://www.wpc-edi.com/reference/

UNIT-OF-MEASURE

Code	Description
F2	International Unit
ML	Milliliter
GR	Gram
UN	Unit

WAIVER-TYPE

Code	Description
01	1115 other demonstration – Such waivers may also be called a research, experimental, demonstration or pilot waiver, or refer to consumer-directed care or expanded eligibility. It may cover the entire state or just a geographic entity or specific population.
02	1915(b)(1) – These waivers permit freedom-of-choice or mandatory managed care with some voluntary managed care.
03	1915(b)(2) – These waivers allow states to use enrollment brokers.
04	1915(b)(3) – These waivers allow states to use savings to provide additional services that are not in the State Plan. .
05	1915(b)(4) – These waivers allow fee for service selective contracting.
06	1915(c) – Aged and Disabled
07	1915(c) – Aged
08	1915(c) – Physical Disabilities
09	1915(c) – Intellectual Disabilities
10	1915(c) – Intellectual and Developmental Disabilities
11	1915(c) – Brain Injury
12	1915(c) – HIV/AIDS
13	1915(c) – Technology Dependent or Medically Fragile
14	1915(c) –Disabled (other)
15	1915(c) - Enrolled in 1915(c) waiver for unspecified or unknown populations
16	1915(c) - Autism/Autism spectrum disorder
17	1915(c) – Developmental Disabilities
18	1915(c) – Mental Illness - Age 18 or Older
19	1915(c) – Mental Illness - Under Age 18
20	Concurrent 1915(b)(c) – A concurrent HCBS/1915(c) waiver is one where the approved waiver services are delivered through a managed care authority – e.g., 1115(a), 1915(a), 1915(b), or 1932(a)
21	1115 HIFA Waiver – The associated Waiver-ID is for a HIFA (Health Insurance and Flexibility and Accountability) waiver. May also be called demonstration waiver or refer to the eligibility expansion.
22	1115 Pharmacy Plus Waiver – The associated Waiver-ID is for Pharmacy waiver coverage. Includes waivers under 1115 demonstration authority which are primarily intended to increase coverage or expand eligibility for pharmacy benefits. The associated Waiver-ID is for another type of waiver.
23	1115 Disaster-Related Waiver – The associated Waiver-ID is for a disaster-related waiver that allows for coverage related to a hurricane or other disaster.
24	1115 Family Planning-ONLY waiver – The associated Waiver-ID-Number is for a Family Planning-ONLY waiver. In these waivers, the beneficiary's Medicaid-covered benefits are restricted to Family Planning Services.

XIX-MBESCBES-CATEGORY-OF-SERVICE

See Appendix I: MBES CBES Category of Service Line Definitions for the 64.9 Base Form for listing of valid values.

XXI-MBESCBES-CATEGORY-OF-SERVICE

See **Appendix J: MBES CBES Category of Service Line Definitions for the 21 Form** for listing of valid values.

Appendix B: Home and Community-Based Services (HCBS) Taxonomy

The following table defines categories and services in the HCBS Taxonomy. It was approved by CMS in August 2012.

To acknowledge state variation, services and categories are defined based on the minimum definition necessary to establish mutually distinct categories and services. Some services are defined in part by characteristics that are NOT in that service. For example, the difference between companion services and personal care is that companion services do not include assistance with activities of daily living (ADLs) such as bathing, dressing, eating, and toileting.

Some of the services reflected below, including, but not limited to personal care, case management, home health aide, and physician services, may (and in some case, must) also be covered under the Medicaid State Plan. The definitions below only define these services for purposes of Section 1915(c) Waivers and the State Plan Home and Community-Based Services benefit authorized by Section 1915(i). States interested in reflecting services as "extended state plan" services must offer them in accordance with state plan service definitions. Consult with the CMS Division of Benefits and Coverage in those instances to ensure definition alignment.

The services and categories are arranged in order of consideration for placing a particular state service in the taxonomy. If one is not sure how to map a state's service to the taxonomy, one should first consider Case Management, then Round-the-Clock Services, then Supported Employment, etc.

HCBS Service Taxonomy Values:

Category	Sub-Category (where applicable)	Service	Common Names (where applicable)	Definition
01 – Case Management		N/A		The development of a comprehensive, written individualized support plan. In addition, case management often includes assisting people in gaining access to necessary services, assessment of a person's needs, ongoing monitoring of service provision and/or a person's health and welfare, assistance in accessing supports to transition from an institutional setting (but not the transition services themselves); and development of a 24-hour individual back-up plan with formal and informal supports
	01010 case		care management	Same definition as category 01.

Category	Sub-Category (where applicable)	Service	Common Names (where applicable)	Definition
	management		supports coordination	
02 Round-the-Clock Services	N/A	N/A	N/A	Services by a provider that has round-the-clock responsibility for the health and welfare of residents, except during the time other services (e.g., day services) are furnished. If these services are provided in a 1915(c) waiver, the state must complete Appendix G-3 of the 1915(c) waiver application regarding medication management and administration.
N/A	0201 group living	N/A	assisted living group home services	Round-the-clock services provided in a residence that is NOT a person's home or apartment or a single family residence where one or more people with a disability live with a person or family who furnishes services
N/A	N/A	02011 group living, residential habilitation	N/A	Assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills by a provider with round-the-clock responsibility for the residents' health and welfare in a residence that is NOT a person's own home or apartment or a single family residence where one or more people with a disability live with a person or family who furnishes services.
N/A	N/A	02012 group living, mental health services	N/A	Mental health services by a provider with round-the-clock responsibility for the residents' health and welfare in a residence that is NOT a person's own home or apartment or a single family residence where one or more people with a disability live with a person or family who furnishes services.

Category	Sub-Category (where applicable)	Service	Common Names (where applicable)	Definition
N/A	N/A	02013 group living, other	N/A	Health and social services not identified elsewhere in subcategory 0201 by a provider with round-the-clock responsibility for the residents' health and welfare in a residence that is NOT a person's own home or apartment or a single family residence where one or more people with a disability live with a person or family who furnishes services.
N/A	0202 shared living	N/A	adult foster care family living host homes	Round-the-clock services provided in a single family residence where one or more people with a disability live with a person or family who furnishes services.
N/A	N/A	02021 shared living, residential habilitation	N/A	Assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills provided in a single family residence where one or more people with a disability live with a person or family who furnishes services and has round-the-clock responsibility for the residents' health and welfare.
N/A	N/A	02022 shared living, mental health services	N/A	Mental health services provided in a single family residence where one or more people with a disability live with a person or family who furnishes services and has round-the-clock responsibility for the residents' health and welfare.
N/A	N/A	02023 shared living, other	N/A	Health and social services not identified elsewhere in subcategory 0202 provided in a single family residence where one or more people with a disability live with a person or family who furnishes services and has round-the-clock responsibility for the residents' health and welfare.

Category	Sub-Category (where applicable)	Service	Common Names (where applicable)	Definition
N/A	0203 in-home round-the-clock services	N/A	supported living	Round-the-clock services provided in a person's home or apartment where a provider has round-the-clock responsibility for the person's health and welfare.
N/A	N/A	02031 in-home residential habilitation	N/A	Assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills provided in a person's home or apartment where a provider has round-the-clock responsibility for the person's health and welfare.
N/A	N/A	02032 in-home round-the-clock mental health services	N/A	Mental health services provided in a person's home or apartment where a provider has round-the-clock responsibility for the person's health and welfare.
N/A	N/A	02033 in-home round-the-clock services, other	N/A	Health and social services not identified elsewhere in subcategory 0203 provided in a person's home or apartment where a provider has round-the-clock responsibility for the person's health and welfare.
03 Supported Employment	N/A	N/A	N/A	Assistance to help a person obtain or maintain paid employment or self-employment.
N/A	0301 job development	03010 job development	N/A	Assistance to locate and obtain paid employment or self-employment.
N/A	0302 ongoing supported employment	N/A	N/A	Assistance to maintain paid employment or self-employment.
N/A	N/A	03021 ongoing supported employment, individual	N/A	Assistance to maintain self-employment or paid employment in an individual job placement (i.e., person is working with people without disabilities).
N/A	N/A	03022	N/A	Assistance to maintain paid

Category	Sub-Category (where applicable)	Service	Common Names (where applicable)	Definition
		ongoing supported employment, group		employment in a group placement (i.e., person is working on a team of people with disabilities).
N/A	0303 career planning	03030 career planning	N/A	Focused, time-limited assistance to identify a career direction and develop a plan to achieve employment.
04 Day Services	N/A	N/A	N/A	Services other than supported employment typically provided outside the person's home during the working day (i.e., Monday through Friday between 8 a.m. and 5 p.m.). These services provide a range of supports and are often, but not always, provided on a regularly scheduled basis at a site specifically established to provide day services.
N/A	N/A	04010 prevocational services	N/A	Time-limited services to provide learning and work experiences, including volunteer work, to acquire general skills that help a person obtain paid employment in integrated community settings.
N/A	N/A	04020 day habilitation	N/A	Regularly scheduled activities in settings separate from the participant's residence, including assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills. This service includes community-based volunteer activities that include acquiring, retaining, and improving self-help, socialization, and adaptive skills. This service can include the supports offered in adult day health, adult day services (social model), and community integration if these supports are provided along with assistance in acquiring, retraining, and

Category	Sub-Category (where applicable)	Service	Common Names (where applicable)	Definition
				improving self-help, socialization, and/or adaptive skills.
N/A	N/A	04030 education services	N/A	Services to help a person access post-secondary education.
N/A	N/A	04040 day treatment/ partial hospitalization	N/A	Services necessary for the diagnosis or treatment of the person's mental illness provided in a fixed site facility during the working day.
N/A	N/A	04050 adult day health	N/A	Skilled health services and other support services, NOT including habilitation (i.e., assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills), provided to adults in a fixed site facility during the working day. This service can include the supports offered in adult day services (social model) if these supports are provided along with skilled health services.
N/A	N/A	04060 adult day services (social model)	N/A	Support services, NOT including skilled health services and not including habilitation (i.e., assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills), provided to adults in a fixed site facility during the working day.
N/A	N/A	04070 community integration	escort	Assistance in participating in community activities, NOT including assistance with activities of daily living or assistance in acquiring, retraining, and improving self-help, socialization, and/or adaptive skills. This service can include supports furnished in the person’s residence related to community participation.
N/A	N/A	04080 medical day care for	N/A	Medical services beyond typical day care responsibilities provided

Category	Sub-Category (where applicable)	Service	Common Names (where applicable)	Definition
		children		during the working day for infants, toddlers, and pre-school age children.
05 Nursing	N/A	N/A	N/A	Services within the scope of the state's nurse practices act provided by a licensed nurse.
N/A	N/A	05010 private duty nursing	N/A	Licensed nursing services provided on a continuous or full-time basis (e.g., for more than 4 consecutive hours per day and for more than 60 days). This service can include the supports offered in health assessment, health monitoring, and medication assessment if the service also includes other services within the scope of the state's nurse practices act.
N/A	N/A	05020 skilled nursing	N/A	Licensed nursing services provided on a part-time or intermittent basis. This service can include the supports offered in health assessment, health monitoring, and medication assessment if the service also includes other services within the scope of the state's nurse practices act.
06 Home delivered meals	N/A	N/A	N/A	Prepared meals sent to a person's home, which may not comprise a full nutritional regimen.
N/A	N/A	06010 home delivered meals	N/A	Same definition as category 06.
07 Rent and Food Expenses for Live-In Caregiver	N/A	N/A	N/A	Payment for the additional costs of rent and food that can be attributed to an unrelated direct support worker living with the person. This service does not include payment for the direct support worker's services, which may be covered as part of other services such as personal care.

Category	Sub-Category (where applicable)	Service	Common Names (where applicable)	Definition
N/A	N/A	07010 rent and food expenses for live-in caregiver	N/A	Same definition as category 07.
08 Home-Based Services	N/A	N/A	N/A	Services that support a person in his or her home or apartment, when the provider does not have round-the-clock responsibility for the person's health and welfare. These services can be provided in other community settings, but are primarily furnished in a person's home or apartment.
N/A	N/A	08010 home-based habilitation	supported living (provided on an hourly basis)	Assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills provided in the person's home when the provider does NOT have round-the-clock responsibility for the person's health and welfare. This service can include the supports offered in community integration, home health aide, personal care, companion, and homemaker if these supports are provided along with assistance in acquiring, retraining, and improving self-help, socialization, and/or adaptive skills.
N/A	N/A	08020 home health aide	N/A	Assistance with activities of daily living (ADLs) and/or health-related tasks provided in a person's home and possibly other community settings that are supervised by a registered nurse or licensed therapist and provided by a licensed home health agency. Home health aide may include assistance with instrumental activities of daily living (IADLs). Home health aide may include the supports offered in companion and

Category	Sub-Category (where applicable)	Service	Common Names (where applicable)	Definition
				homemaker if these supports are provided along with assistance with ADLs and/or health-related tasks. Home health aide does NOT include habilitation (assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills).
N/A	N/A	08030 personal care	attendant care personal assistance personal attendant services	Assistance with ADLs and/or health-related tasks provided in a person's home and possibly other community settings, NOT including both provision by a licensed home health agency and a requirement for supervision by a licensed nurse or therapist. Personal care may include assistance with IADLs. Personal care may include the supports offered in companion and homemaker if these supports are provided along with assistance with ADLs and/or health-related tasks. Personal care does NOT include habilitation (assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills).
N/A	N/A	08040 companion	adult companion night supervision	Supervision and/or social support provided in a person's home and possibly other community settings. Companion may also include performance of light housekeeping tasks (the supports offered in homemaker). Companion does NOT include assistance with ADLs or habilitation (assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills).
N/A	N/A	08050 homemaker	N/A	Performance of light housekeeping tasks provided in a person's home and possibly other community settings NOT including supervision

Category	Sub-Category (where applicable)	Service	Common Names (where applicable)	Definition
				and social support, assistance with ADLs, or habilitation (assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills).
N/A	N/A	08060 chore	N/A	Performance of heavy household chores provided in a person's home and possibly other community settings NOT including supervision and social support, assistance with ADLs, or habilitation (assistance in acquiring, retaining, and improving self-help, socialization, and/or adaptive skills).
09 Caregiver Support	N/A	N/A	N/A	Assistance to people who provide ongoing support to the person with a disability when assisting the support person is the primary purpose of the service. In most cases, the support person is unpaid. However, respite can be provided to relieve providers who furnish shared living.
N/A	0901 respite	N/A	N/A	Short-term services provided because a support person is absent or needs relief when relieving the support person is the primary purpose of the service.
N/A	N/A	09011 respite, out-of-home	N/A	Short-term services provided because a support person is absent or needs relief NOT provided in a person's home or apartment when relieving the support person is the primary purpose of the service.
N/A	N/A	09012 respite, in-home	N/A	Short-term services provided because a support person is absent or needs relief provided in a person's home or apartment when relieving the support person is the primary purpose of the service.

Category	Sub-Category (where applicable)	Service	Common Names (where applicable)	Definition
N/A	0902 caregiver counseling and/or training	09020 caregiver counseling and/or training	N/A	Counseling, emotional support, and/or training provided to a family member or friend providing support when providing counseling or training to the support person is the primary purpose of the service. Examples of training topics include a) skills to provide specific treatment regimens or help the person improve function, b) information about the person's disability or conditions, and c) navigation of the service system.
10 Other Mental Health and Behavioral Services	N/A	N/A	N/A	Services NOT identified in previous categories that support people in improving or maintaining mental or behavioral health.
N/A	N/A	10010 mental health assessment	N/A	Assessment or evaluation of mental health status when the assessment is the primary purpose of the service. This service can include medication assessment if the assessment includes other mental health information.
N/A	N/A	10020 assertive community treatment	N/A	A range of mental health supports characterized by assertive engagement of the person, availability 24 hours a day, and support by an interdisciplinary team.
N/A	N/A	10030 crisis intervention	crisis support	Response to stabilize a person exhibiting behavior that puts the person at risk of hospitalization or institutionalization.
N/A	N/A	10040 behavior support	behavior analysis behavior therapy	Services specifically to encourage positive behaviors and to decrease challenging behaviors, including a) assessment to identify antecedents to behaviors and b) development of a plan to improve behaviors.

Category	Sub-Category (where applicable)	Service	Common Names (where applicable)	Definition
N/A	N/A	10050 peer specialist	peer support	Mental health support services provided by a trained and credentialed person with a mental illness.
N/A	N/A	10060 counseling	N/A	Individual or group therapy to develop coping skills or improve mental health function.
N/A	N/A	10070 psychosocial rehabilitation	N/A	Assistance to improve or restore function in ADLs, IADLs, and social or adaptive skills NOT identified in previous categories or services.
N/A	N/A	10080 clinic services	N/A	Services for individuals with chronic mental illness furnished in a clinic or based in a clinic NOT identified in previous categories or services.
N/A	N/A	10090 other mental health and behavioral services	N/A	Services NOT identified elsewhere in category 10 that support people in improving or maintaining mental or behavioral health.
11 Other Health and Therapeutic Services	N/A	N/A	N/A	Services NOT identified in previous categories that support people in improving or maintaining health or functional capacity.
N/A	N/A	11010 health monitoring	N/A	Ongoing monitoring of physical health status when monitoring is the primary purpose of the service. This service can include medication monitoring if other aspects of a person's health also are monitored.
N/A	N/A	11020 health assessment	N/A	Assessment or evaluation of physical health status when the assessment is the primary purpose of the service. This service can include medication assessment if the assessment includes other health information.

Category	Sub-Category (where applicable)	Service	Common Names (where applicable)	Definition
N/A	N/A	11030 medication assessment and/or management	N/A	Assessment of medication administration and/or possible drug interactions—and/or oversight of ongoing medication administration—when the management of medications is the primary purpose of the service.
N/A	N/A	11040 nutrition consultation	N/A	Assistance to a person to help him or her plan and implement changes to nutritional intake.
N/A	N/A	11050 physician services	N/A	Services by a licensed physician. This service can include health assessment, medication assessment, and/or mental health assessment if other physician services are also provided.
N/A	N/A	11060 prescription drugs	N/A	Prescription drugs.
N/A	N/A	11070 dental services	N/A	Services by a licensed dentist.
N/A	N/A	11080 occupational therapy	N/A	Services by a licensed occupational therapist.
N/A	N/A	11090 physical therapy	N/A	Services by a licensed physical therapist.
N/A	N/A	11100 speech, hearing, and language therapy	N/A	Services by a licensed speech, hearing, and language therapist. This service includes services by a speech pathologist or a qualified audiologist.
N/A	N/A	11110 respiratory therapy	N/A	Services by a licensed respiratory therapist.
N/A	N/A	11120 cognitive rehabilitative therapy	N/A	Assistance to manage or restore cognitive function.
N/A	N/A	11130 other	N/A	Therapeutic interventions to

Category	Sub-Category (where applicable)	Service	Common Names (where applicable)	Definition
		therapies		maintain or improve function NOT identified in previous categories or services. This service includes specialized interventions such as those using art, music, dance, or trained animals.
12 Services Supporting Participant Direction	N/A	N/A	N/A	Services that assist a person and/or his or her representative in managing participant-directed services, as identified in the Participant Direction of Services section of the 1915(c) waiver or 1915(i) State Plan Amendment application.
N/A	N/A	12010 financial management services in support of participant direction	N/A	Assistance to help a person and/or representative manage participant-directed services by a) performing financial tasks to facilitate the employment of staff; b) managing the disbursement of funds in a participant-directed budget; and/or c) performing fiscal accounting and making expenditure reports to the person, representative, and/or state authorities.
N/A	N/A	12020 information and assistance in support of participant direction	N/A	Training the person and/or representative in directing or managing services. Topics include: a) the person's rights and responsibilities in participant direction; b) recruiting and hiring staff; c) managing staff and solving problems regarding services; and d) managing a participant-directed budget.
13 Participant Training	N/A	N/A	N/A	Training provided to a participant when training the participant is the primary purpose of the service. Topics may include: a) specific treatment regimens, b) the person's disability or condition, and c) navigation of the service system.

Category	Sub-Category (where applicable)	Service	Common Names (where applicable)	Definition
N/A	N/A	13010 participant training	N/A	The same definition as category 13.
14 Equipment, Technology, and Modifications	N/A	N/A	N/A	Material goods to help a person improve or maintain function.
N/A	1401 personal emergency response system (PERS)	14010 personal emergency response system (PERS)	N/A	Devices that enable participants to signal a response center to secure help in an emergency. This service can include installation, maintenance, and monthly response center fees.
N/A	1402 home and/or vehicle accessibility adaptations	14020 home and/or vehicle accessibility adaptations	home and/or vehicle modifications	Physical changes to a private residence, automobile, or van, to accommodate the participant or improve his or her function.
N/A	1403 equipment, technology, and supplies	N/A	N/A	The purchase or rent of items, devices, product systems, and/or disposable medical supplies.
N/A	N/A	14031 equipment and technology	assistive technologyspecialized medical equipment	The purchase or rent of items, devices, or product systems to increase or maintain a person's functional status. This service can include designing, fitting, adapting, and maintaining equipment, as well as training or technical assistance to use equipment.
N/A	N/A	14032 supplies	N/A	The purchase of disposable medical supplies, including nutritional supplements.

Category	Sub-Category (where applicable)	Service	Common Names (where applicable)	Definition
15 Non-Medical Transportation	N/A	N/A	N/A	Transportation not provided as part of another service such as a round-the-clock service or a day service. This service may include: a) transportation to and from other HCBS services; b) transportation to community activities where HCBS services are not provided; and/or c) the purchase of public transit tokens or passes.
N/A	N/A	15010 non-medical transportation	N/A	Same definition as category 15.
16 Community Transition Services	N/A	N/A	N/A	Non-recurring set-up expenses for moving to a residence where the person is responsible for living expenses.
N/A	N/A	16010 community transition services	N/A	Same definition as category 16.
17 Other Services	N/A	N/A	N/A	Services NOT identified in previous categories.
N/A	N/A	17010 goods and services	Individually directed goods and services	Services, equipment, or supplies in the person's support plan NOT otherwise provided in the Medicaid program.
N/A	N/A	17020 interpreter	N/A	Services provided by an individual to support communication by someone who has limited English proficiency or verbal skills, such as a sign language interpreter or communicator.
N/A	N/A	17030 housing consultation	N/A	Information and assistance to help a person identify and select housing.
N/A	N/A	17990 other	N/A	Services NOT identified in previous categories and services.

Appendix B

Appendix C: Comprehensive Eligibility Crosswalk

MAS/BOE - INDIVIDUALS COVERED UNDER SEPARATE CHILDREN'S HEALTH INSURANCE PROGRAMS (Separate-CHIP)

ITEM	DESCRIPTION	CFR/PL CITATIONS
1	Children covered under a Title XXI separate CHIP)	42 CFR 457.310, §2110 (b) of the Act.
2	Legal immigrant children and pregnant women covered under a Title XXI separate CHIP	§2107(e)(1) of the Act, P.L. 111-3.
3	Children receiving dental-only coverage under a separate CHIP	§2102 and 2110 (b) of the Act, PL 111-3.
4	Targeted low-income pregnant women covered under a Title XXI separate CHIP	§2112 of the Act, PL 111-3
5	Infants under age 1 born to targeted low-income pregnant women made eligible under a Title XXI separate CHIP	§2112 of the Act, PL 111-3.
6	Children who have been granted presumptive eligibility under a Title XXI separate CHIP	42 CFR 457.355, §2105 of the Act.
7	Pregnant women who have been granted presumptive eligibility under a Title XXI separate CHIP	§2112 of the Act, PL 111-3.
8	Caretaker relatives and children covered under the authority of an 1115 waiver and a Title XXI separate CHIP	§2107(e) of the Act.

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	1 Pregnant women who have no other eligible children. 2 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
MSIS Coding (MAS-1, BOE-6) - (OPTIONAL)

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
MSIS Coding (MAS-1, BOE-7) - (OPTIONAL)

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	3 Pregnant women who have no other eligible children. 4 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 S 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 Child Health Insurance Program (CHIP)	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 Child Health Insurance Program (CHIP).	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.
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); 50 PL 100-13.
12	Aged individuals who elect to receive hospice care	§1902(a)(10)(A)(ii),

	who would be eligible if in a medical institution.	(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.
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

ITEM	DESCRIPTION	CFR/PL CITATIONS
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 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 435.231. §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.

ITEM	DESCRIPTION	CFR/PL CITATIONS
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, 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	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.

ITEM	DESCRIPTION	CFR/PL CITATIONS
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 medical institution.	42 CFR 435.211, §§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.

ITEM	DESCRIPTION	CFR/PL CITATIONS
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, §1902(a)(10), and §1903(m) 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).

Appendix D: Types of Service (TOS) Reference

Definitions of Types of Service

The following definitions are adaptations of those given in the Code of Federal Regulations. 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 Code of Federal Regulations (CFR).

Effective FY 1999, services provided under Family Planning, EPSDT, Rural Health Clinics, FQHC's, and Home-and-Community-Based Waiver programs will be coded according to the types of services listed below. Specific programs with which these services are associated will be identified using the program type coding as defined in Attachment 5.

1. **Unduplicated Total**.--Report the unduplicated total of recipients by maintenance assistance status (MAS) and by basis of eligibility (BOE). A recipient receiving more than one type of service is reported only once in the unduplicated total.

Facilities

2. Inpatient Hospital Services (TOS Code=001)(See 42 CFR 440.10; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--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 health conditions;

- 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 meets the requirements in 42 CFR 482.30 unless a waiver has been granted by the Secretary of Health and Human Services.

Inpatient hospital services do 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.

3. Mental Health Facility Services (See 42 CFR 440.140, 440.160, and 435.1009).--An institution for mental health conditions is a hospital, nursing facility, or other institution that is primarily engaged in providing diagnosis, treatment or care of individuals with mental health conditions, including medical care, nursing care, and related services. Report totals for services defined under 3a and 3b.

3a. Inpatient Psychiatric Facility Services for Individuals Age 21 and Under (TOS Code=048)(See 42 CFR 440.160; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450). --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 age 21 and under in psychiatric facilities or programs).

3b. Other Mental Health Facility Services (Individuals Age 65 or Older) (TOS Code= 044 and 045)(See 42 CFR 440.140).--These are services provided under the direction of a physician for the care and treatment of recipients in an institution for mental health conditions that meets the requirements specified in 42 CFR 440.140.

4. Nursing Facilities (NF) Services (TOS Code=009 and 047) (See 42 CFR 440.40 and 440.155).--These are services provided in an institution (or a distinct part of an institution) which:

- 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 health conditions; 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.

NOTE: ICF Services - All Other.--This is combined with nursing facility services.

5. **ICF Services for the Intellectually Disabled (TOS Code=046)** (See 42 CFR 440.150).--These are services provided in an institution for individuals with intellectual disabilities 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 in 42 CFR 442, Subpart C (certification of ICF/IID); and

   - The individuals with intellectual disabilities recipients for whom payment is requested are receiving active treatment as defined in 42 CFR 483.440(a).

Services

6. **Physicians' Services (TOS Code=012)**(See 42 CFR 440.50; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--Whether furnished in a physician's office, a recipient's home, a hospital, a NF, or elsewhere, these are 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 dental medicine or dental surgery if State law allows such services to be provided by either a physician or dentist.

7. **Outpatient Hospital Services (TOS Codes=002)**(See 42 CFR 440.20; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--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.

8. **Prescribed Drugs (TOS Code=033)** (See 42 CFR 440.120; 42 CFR § 457.402; 42 CFR § 457.410; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--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.

9. **Dental Services (TOS Code=029)** (See 42 CFR 440.100; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--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 recipient.

   A dentist is an individual licensed to practice dentistry or dental surgery. Dental services include dental screening and dental clinic services.

   NOTE: Include services related to providing and fitting dentures as dental services. Dentures mean artificial structures made by, or under the direction of, a dentist to replace a full or partial set of teeth.

   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 which 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).

Other Services

10. **Other Licensed Practitioners' Services (TOS Code=015)** (See 42 CFR 440.60; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--These are medical or remedial care or services, other than physician services or services of a dentist, provided by licensed practitioners within the scope of practice as defined under State law. The category "Other Licensed Practitioners' Services" is different than the "Other Care" category. Examples of other practitioners (if covered under State law) are:

- Chiropractors;
- Podiatrists;
- Psychologists; and
- Optometrists.

Other Licensed Practitioners' Services include hearing aids and 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 prosthetic devices billed by physicians, laboratory or X-ray services provided by other practitioners, or services of other practitioners that are included in inpatient or outpatient hospital bills. These services are counted under the related type of service as appropriate. Devices billed by providers not included under the listed types of service are counted under Other Care.

Report Other Licensed Practitioners' Services that are billed by a hospital as inpatient or outpatient services, as appropriate.

Speech therapists, audiologists, opticians, physical therapists, and occupational therapists are not included within Other Licensed Practitioners' Services.

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.

11. **Clinic Services (TOS Code=028**(See 42 CRF 440.90; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--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. For reporting purposes, 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; and
    - 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.

12. **Laboratory and X-Ray Services (TOS Code=005, 006, 007, and 008)**(See 42 CFR 440.30; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--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;

- Provided in an office or similar facility other than a hospital inpatient or outpatient department or clinic; and

- Provided by a laboratory that meets the requirements for participation in Medicare.

X-ray services provided by dentists are reported under dental services.

13. **Sterilizations (TOS Code=084)(See 42 CFR 441, Subpart F)**.--These are medical procedures, treatment or operations for the purpose of rendering an individual permanently incapable of reproducing.

14. **Home Health Services (TOS Code=016,017, 018, 019, 020, and 021)** (See 42 CFR 440.70; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450) .--These are services provided at the patient's place of residence, in compliance with a physician's written plan of care that is reviewed every 62 days. The following items and services are mandatory.

    - Nursing services, as defined in the State Nurse Practice Act that 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; and

        - 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.

    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. Services received in a NF that are different from those normally provided as part of the institution's care may qualify as home health services. 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.

Personal Services

15. Personal Support Services.--Report total unduplicated recipients and payments for services defined in 15a through 15i.

15a. Personal Care Services (TOS Code=051) (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 individuals with intellectual disabilities, or institution for mental health conditions 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.

15b. Targeted Case Management Services (TOS Code=053) (See 42 CFR § 440.169; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--These are services that are furnished to individuals eligible under the plan to gain access to needed medical, social, educational, and other services. The agency may make available case management services 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.

15c. Rehabilitative Services (TOS Code=043) (See 42 CFR 440.130).--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 health condition and restoration of a recipient to his/her best possible functional level.

15d. Physical Therapy, Occupational Therapy, and Services For Individuals With Speech, Hearing, and Language Disorders (TOS Codes=030, 031, and 032)(See 42 CFR 440.110; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--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 recipient by, or under the direction of, a qualified physical therapist, occupational therapist, speech pathologist, or audiologist. It includes any necessary supplies and equipment.

15e. Hospice Services (TOS Code=087) (See 42 CFR 418.202; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--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.

15f. Nurse Midwife (TOS Code=025) (See 42 CFR 440.165; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--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.

15g. Nurse Practitioner (TOS Code=026) (See 42 CFR 440.166; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--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.

15h. Private Duty Nursing (TOS Code=022) (See 42 CFR 440.80; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--When covered in the State plan, 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).

15i. Religious Non-Medical Health Care Institutions (TOS Code=058) (See 42 CFR 440.170).--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 Section 1861(ss)(1) of the Act.

Other Care

16. Other Care (See 42 CFR 440.120(b), (c), and (d), and 440.170(a)).--Report total unduplicated recipients and payments for services in sections 16a, 16b, and 16c. Such services do not meet the definition of, and are not classified under, any of the previously described categories.

16a. Transportation (TOS Code=056) (See 42 CFR 440.170; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--Report totals for services provided under this title to include transportation and other related travel services determined necessary by you to secure medical examinations and treatment for a recipient.

NOTE: Transportation, as defined above, is furnished only by a provider to whom a direct vendor payment can appropriately be made. If other arrangements are made to assure transportation under 42 CFR 431.53, FFP is available as an administrative cost.

16b. Other Pregnancy-related Procedures (TOS Code=086) (See 42 CFR 441, Subpart E; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450).--In accordance with the terms of the DHHS Appropriations Bill and 42 CFR 441, Subpart E, FFP is available for other pregnancy-related procedures:

- When a physician has certified in writing to the Medicaid agency that, on the basis of his or her professional judgment, the life of the mother would be endangered if the fetus were carried to term; or

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

16c. Other Services (TOS Code= 035, 036, 037, 062, 063, 064, 065, 066, 067, 068, 069, 073, 074, 075, 076, 077, 078, 079, 080, 081, 082, 083).--These services do not meet the definitions of any of the previously described service categories. They may include, but are not limited to:

- Prosthetic devices (see 42 CFR 440.120; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450) 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.

- Eyeglasses (see 42 CFR 440.120; 42 CFR § 457.402; 42 CFR § 457.420; 42 CFR § 457.430; 42 CFR § 457.431; 457.440; 42 CFR § 457.450). Eyeglasses mean lenses, including frames, and other aids to vision prescribed by a physician skilled in diseases of the eye or an optician. It includes optician fees for services.

- Home and Community-Based Waiver services (See §1915(c) of the Act and 42 CFR 440.180) that cannot be associated with other TYPE-OF-SERVICE codes (e.g., community homes for the disabled and adult day care.)

17. Capitated Care (See 42 CFR Part 434).--This includes enrollees and capitated payments for the plan types defined in 17 a and b below. Report unduplicated enrolled eligibles and payments for 17 a and b.

17a. Health Maintenance Organization (HMO) and Health Insuring Organization (HIO) (TOS Code=119).--These include 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.

17b. Prepaid Health Plans (PHP) (TOS Code=122).--These include 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.

18. Primary Care Case Management (PCCM) (TOS Code=120) (See §1915(b)(1) of the Act).--The State contracts directly with primary care providers who agree to be responsible for the provision and/or coordination of medical services to Medicaid recipients under their care. Currently, most PCCM programs pay the primary care physician a monthly case management fee. Report these recipients and associated PCCM fees in this section.

NOTE: Where the fee includes services beyond case management, report the enrollees and fees under prepaid health plans (17b).

Appendix E: Program Type Reference

Definitions of Program Type Reference

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

Program Type 1-3

Program Type 01. 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); and
    - 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 02. 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: CMS'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 03. Rural Health Clinics (RHC)(See 42 CFR 440.20(b)).--These include services (as allowed by State law) furnished by a rural health clinic which 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 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 4-5

Program Type 04. Federally Qualified Health Center (FQHC) (See §1905(a)(2) 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 the same as the 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 05. Indian Health Services (See §1911 of the Act) (See 42 CFR 431.110).—

Indian Health Services (See §1911 of the Act) (See 42 CFR 431.110).--These are services provided by a program of the Indian Health Services (IHS), tribe or tribal organization under the Indian Self-Determination and Education Assistance Act, and an urban Indian organization under title V of the Indian Health Care Improvement Act. A State plan must provide that an IHS, tribal or urban 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 6-10

Program Type 06. Home and Community-Based Services for Disabled and Elderly (See §1929 of the Act) and for Individuals Age 65 and Older (MSIS) (See 42 CFR 441, Subpart H).--This program is for §1915(d) recipients of home and community-based services for individuals age 65 or older. This is 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.

Program Type 07. Home and Community Based Waivers (See §1915(c) of the Act and 42 CFR 440.180).--This program includes services furnished under a waiver approved under the provisions in 42 CFR Part 441, Subpart G (home and community-based services; waiver requirements).

Program Type 08. Money Follows Patient (MFP) service package (established by Section 6071 of Deficit Reduction Act of 2005 [Public Law 109-171] and extended by Section 2403 off the Patient Protection and Affordable Care Act of 2010 [Public Law 111-148]) helps States rebalance their long-term care systems through the development of transition programs that move people with Medicaid from institutional-based long-term care to community-based long-term care. To qualify for MFP, Medicaid recipients need to have been in institutional care for at least 90 days, exclusive of Medicare-paid rehabilitation days. Upon the initial transition to community-based long-term care, MFP participants are eligible for MFP benefits for up to 365 days. At the conclusion of MFP eligibility, the person continues as a typical Medicaid beneficiary. While eligible for MFP benefits, the restricted benefits flag in the eligibility file should be set to value 08 whenever the beneficiary has a single day of MFP eligibility during the month.

Any service financed with MFP grant funds is considered an MFP service. MFP services are home- and community-based services (HCBS) financed with MFP grant funds. They can be 1915(c) waiver services or HCBS state plan services. The program has three classes of HCBS, including qualified HCBS (HCBS that the person would have been eligible for regardless of participation in MFP), demonstration HCBS (HCBS that are above and beyond what they would have qualified for as a regular Medicaid beneficiary), and supplemental services (which are typically one-time services someone needs to make the transition to community-based long-term care). States received enhanced matching funds for the qualified and demonstration services, and their regular mating rate for the supplemental services. Examples of MFP-financed services include, but are not limited to:

- 1915(c) waiver services
- Personal care assistance services provided through the state plan
- Behavioral health services, including psychosocial rehabilitation

Program Type 10. Balancing Incentive Payments (BIP). The Balancing Incentive Program authorizes grants to States to increase access to non-institutional long-term services and supports (LTSS) as of October 1, 2011.

The Balancing Incentive Program will help States transform their long-term care systems by:

- Lowering costs through improved systems performance & efficiency
- Creating tools to help consumers with care planning & assessment
- Improving quality measurement & oversight

The Balancing Incentive Program also provides new ways to serve more people in home and community-based settings, in keeping with the integration mandate of the Americans with Disabilities Act (ADA), as required by the Olmstead decision. The Balancing Incentive Program was created by the Affordable Care Act of 2010 (Section 10202).

Program Type 11-13

Program Type 11. Community First Choice (1915(k). The "Community First Choice Option" lets States provide home and community-based attendant services to Medicaid enrollees with disabilities under their State Plan.

This option became available on October 1, 2011 and provides a 6 % increase in Federal matching payments to States for expenditures related to this option.

Program Type 12. Psychiatric Rehab Facility For Children. Under the authority of section 2707 of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), the Centers for Medicare & Medicaid Services (CMS) is funding the Medicaid Emergency Psychiatric Demonstration, which will be conducted by participating States. This is a 3-year Demonstration that permits participating States to provide payment under the State Medicaid plan to certain non-government psychiatric hospitals for inpatient emergency psychiatric care to Medicaid recipients aged 21 to 64 who have expressed suicidal or homicidal thoughts or gestures, and are determined to be dangerous to themselves or others.

Program Type 13. Home and Community-Based Services (HCBS) State Plan Option (1915(i)). States can offer a variety of services under a State Plan Home and Community-Based Services (HCBS) benefit. People must meet State-defined criteria based on need and typically get a combination of acute-care medical services (like dental services, skilled nursing services) and long-term services (like respite, case management, supported employment and environmental modifications).

1915(i) State plan HCBS: State Options

- Target the HCBS benefit to one or more specific populations
- Establish separate additional needs-based criteria for individual HCBS
- Establish a new Medicaid eligibility group for people who get State plan HCBS
- Define the HCBS included in the benefit, including State- defined and CMS-approved "other services" applicable to the population
- Option to allow any or all HCBS to be self-directed

Program Type 14

Program Type 14 (a)–(m)

Program Type 14. State Plan CHIP (See 42 CRF 457) 'This program is for Title XXI recipients (children age 0 through 18, children receiving prenatal care through the conception to birth option, pregnant women), "Child health assistance" services (as allowed by State law and defined at § 457.402) means payment for part or all of the cost of health benefits coverage provided to targeted low-income children for the following services:

(a) Inpatient hospital services.

(b) Outpatient hospital services.

(c) Physician services.

(d) Surgical services.

(e) Clinic services (including health center services) and other ambulatory health care

services.

(f) Prescription drugs and biologicals and the administration of these drugs and biologicals, only if these drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.

(g) Over-the-counter medications.

(h) Laboratory and radiological services.

(i) Prenatal care and pre-pregnancy family planning services and supplies.
(j) Inpatient mental health services, other than services described in paragraph (r) of this section but including services furnished in a state-operated mental health hospital and including residential or other 24-hour therapeutically planned structured services.

(k) Outpatient mental health services, other than services described in paragraph (s) of this section but including services furnished in a State-operated mental health hospital and including community-based services.

(l) Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices and adaptive devices).

(m) Disposable medical supplies.

Program Type 14 **(n)–(bb)**

(n) Home and community-based health care services and related supportive services (such as home health nursing services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members and minor modification to the home.)

(o) Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing, pediatric nurse services and respiratory care services) in a home, school, or other setting.

(p) Other pregnancy-related procedure only if necessary to save the life of the mother or if the pregnancy is the result of rape or incest.

(q) Dental services.

(r) Inpatient substance abuse treatment services and residential substance abuse treatment services.

(s) Outpatient substance abuse treatment services.

(t) Case management services.

(u) Care coordination services.

(v) Physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders.

(w) Hospice care.

(x) Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is—

(1) Prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law;

(2) Performed under the general supervision or at the direction of a physician; or

(3) Furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

(y) Premiums for private health care insurance coverage.

(z) Medical transportation.

(aa) Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

(bb) Any other health care services or items specified by the Secretary and not excluded under this subchapter.

Program Type 15-16

Program Type 15. Psychiatric Residential Treatment Facilities Demonstration Grant Program. The Community Alternatives to Psychiatric Residential Treatment Facilities (PRTF) Demonstration Grant Program was authorized by Section 6063 of the Deficit Reduction Act of 2005 to provide up to $218 million to up to 10 states to develop 5-year demonstration programs that provide home and community-based services to children as alternatives to PRTF's. Nine states implemented demonstration grants. These projects were designed to test the cost-effectiveness of providing services in a child's home or community rather than in a PRTF and whether the services improve or maintain the child's functioning.

Program Type 16. 1915(j) (Self-directed personal assistance services/personal care under State Plan or 1915(c) waiver). Self-directed personal assistance services (PAS) are personal care and related services provided under the Medicaid State plan and/or section 1915(c) waivers the State already has in place.

- Participation in self-directed PAS is voluntary
- Participants set their own provider qualifications and train their PAS providers Participants determine how much they pay for a service, support or item

Appendix F: Eligibility Group Table

Code	Eligibility Group	Short Description	Citation	Type	Category
MEDICAID MANDATORY COVERAGE					
01	Parents and Other Caretaker Relatives	Parents and other caretaker relatives of dependent children with household income at or below a standard established by the state.	42 CFR 435.110; 1902(a)(10)(A)(i)(I); 1931(b) and (d)	Family/Adult	Mandatory Coverage
02	Transitional Medical Assistance	Families with Medicaid eligibility extended for up to 12 months because of earnings.	408(a)(11)(A); 1902(a)(52); 1902(e)(1)(B); 1925; 1931(c)(2)	Family/Adult	Mandatory Coverage
03	Extended Medicaid due to Earnings	Families with Medicaid eligibility extended for 4 months because of increased earnings.	42 CFR 435.112; 408(a)(11)(A); 1902 (e)(1)(A); 1931 (c)(2)	Family/Adult	Mandatory Coverage
04	Extended Medicaid due to Spousal Support Collections	Families with Medicaid eligibility extended for 4 months as the result of the collection of spousal support.	42 CFR 435.115; 408(a)(11)(B); 1931 (c)(1)	Family/Adult	Mandatory Coverage
05	Pregnant Women	Women who are pregnant or post-partum, with household income at or below a standard established by the state.	42 CFR 435.116; 1902(a)(10)(A)(i)(III) and (IV); 1902(a)(10)(A)(ii)(I), (IV) and (IX); 1931(b) and (d);	Family/Adult	Mandatory Coverage
06	Deemed Newborns	Children born to women covered under Medicaid or a separate CHIP for the date of the child's birth, who are deemed eligible for Medicaid until the child turns age 1	42 CFR 435.117; 1902(e)(4) and 2112€	Family/Adult	Mandatory Coverage
07	Infants and Children under Age 19	Infants and children under age 19 with household income at or	42 CFR 435.118 1902(a)(10)(A)	Family/Adult	Mandatory Coverage

Code	Eligibility Group	Short Description	Citation	Type	Category
		below standards established by the state based on age group.	(i)(III), (IV), (VI) and (VII); 1902(a)(10)(A)(ii)(IV) and (IX); 1931(b) and (d)		
08	Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care	Individuals for whom an adoption assistance agreement is in effect or foster care or kinship guardianship assistance maintenance payments are made under Title IV-E of the Act.	42 CFR 435.145; 473(b)(3); 1902(a)(10)(A)(i)(I)	Family/Adult	Mandatory Coverage
09	Former Foster Care Children	Individuals under the age of 26, not otherwise mandatorily eligible, who were in foster care and on Medicaid either when they turned age 18 or aged out of foster care.	42 CFR 435.150; 1902(a)(10)(A)(i)(IX)	Family/Adult	Mandatory Coverage
11	Individuals Receiving SSI	Individuals who are aged, blind or disabled who receive SSI.	42 CFR 435.120; 1902(a)(10)(A)(i)(II)(aa)	ABD	Mandatory Coverage
12	Aged, Blind and Disabled Individuals in 209(b) States	In 209(b) states, aged, blind and disabled individuals who meet more restrictive criteria than used in SSI.	42 CFR 435.121; 1902(f)	ABD	Mandatory Coverage
13	Individuals Receiving Mandatory State Supplements	Individuals receiving mandatory State Supplements to SSI benefits.	42 CFR 435.130	ABD	Mandatory Coverage
14	Individuals Who Are Essential Spouses	Individuals who were eligible as essential spouses in 1973 and who continue be essential to the well-being of a recipient of cash assistance.	42 CFR 435.131; 1905(a)	ABD	Mandatory Coverage
15	Institutionalized Individuals Continuously Eligible Since 1973	Institutionalized individuals who were eligible for Medicaid in 1973 as inpatients of Title XIX medical institutions	42 CFR 435.132	ABD	Mandatory Coverage

Code	Eligibility Group	Short Description	Citation	Type	Category
		or intermediate care facilities, and who continue to meet the 1973 requirements.			
16	Blind or Disabled Individuals Eligible in 1973	Blind or disabled individuals who were eligible for Medicaid in 1973 who meet all current requirements for Medicaid except for the blindness or disability criteria.	42 CFR 435.133	ABD	Mandatory Coverage
17	Individuals Who Lost Eligibility for SSI/SSP Due to an Increase in OASDI Benefits in 1972	Individuals who would be eligible for SSI/SSP except for the increase in OASDI benefits in 1972, who were entitled to and receiving cash assistance in August, 1972.	42 CFR 435.134	ABD	Mandatory Coverage
18	Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA increases since April, 1977	Individuals who are receiving OASDI and became ineligible for SSI/SSP after April, 1977, who would continue to be eligible if the cost of living increases in OASDI since their last month of eligibility for SSI/SSP/OASDI were deducted from income.	42 CFR 435.135;	ABD	Mandatory Coverage
19	Disabled Widows and Widowers Ineligible for SSI due to Increase in OASDI	Disabled widows and widowers who would be eligible for SSI /SSP, except for the increase in OASDI benefits due to the elimination of the reduction factor in P.L. 98-21, who therefore are deemed to be SSI or SSP recipients.	42 CFR 435.137; 1634(b)	ABD	Mandatory Coverage
20	Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security	Disabled widows and widowers who would be eligible for SSI/SSP, except for the early receipt of OASDI benefits, who are not	42 CFR 435.138; 1634(d)	ABD	Mandatory Coverage

Code	Eligibility Group	Short Description	Citation	Type	Category
		entitled to Medicare Part A, who therefore are deemed to be SSI recipients.			
21	Working Disabled under 1619(b)	Blind or disabled individuals who participated in Medicaid as SSI cash recipients or who were considered to be receiving SSI, who would still qualify for SSI except for earnings.	1619(b); 1902(a)(10)(A)(i)(II)(bb); 1905(q)	ABD	Mandatory Coverage
22	Disabled Adult Children	Individuals who lose eligibility for SSI at age 18 or older due to receipt of or increase in Title II OASDI child benefits.	1634(c)	ABD	Mandatory Coverage
23	Qualified Medicare Beneficiaries	Individuals with income equal to or less than 100% of the FPL who are entitled to Medicare Part A, who qualify for Medicare cost-sharing.	1902(a)(10)(E)(i); 1905(p)	ABD	Mandatory Coverage
24	Qualified Disabled and Working Individuals	Working, disabled individuals with income equal to or less than 200% of the FPL, who are entitled to Medicare Part A under section 1818A, who qualify for payment of Medicare Part A premiums.	1902(a)(10)(E)(ii); 1905(p)(3)(A)(i); 1905(s)	ABD	Mandatory Coverage
25	Specified Low Income Medicare Beneficiaries	Individuals with income between 100% and 120% of the FPL who are entitled to Medicare Part A, who qualify for payment of Medicare Part B premiums.	1902(a)(10)(E)(iii); 1905(p)(3)(A)(ii)	ABD	Mandatory Coverage
26	Qualifying Individuals	Individuals with income between 120% and 135% of the FPL who are entitled to Medicare Part A, who qualify for payment of Medicare Part B premiums.	1902(a)(10)(E)(iv); 1905(p)(3)(A)(ii)	ABD	Mandatory Coverage

Code	Eligibility Group	Short Description	Citation	Type	Category
MEDICAID OPTIONS FOR COVERAGE					
27	Optional Coverage of Parents and Other Caretaker Relatives	Individuals qualifying as parents or caretaker relatives who are not mandatorily eligible and who have income at or below a standard established by the State.	42 CFR 435.220; 1902(a)(10)(A)(ii)(I)	Family/Adult	Options for Coverage
28	Reasonable Classifications of Individuals under Age 21	Individuals under age 21 who are not mandatorily eligible and who have income at or below a standard established by the State.	42 CFR 435.222; 1902(a)(10)(A)(ii)(I) and (IV)	Family/Adult	Options for Coverage
29	Children with Non-IV-E Adoption Assistance	Children with special needs for whom there is a non-IV-E adoption assistance agreement in effect with a state, who either were eligible for Medicaid or had income at or below a standard established by the state.	42 CFR 435.227; 1902(a)(10)(A)(ii)(VIII);	Family/Adult	Options for Coverage
30	Independent Foster Care Adolescents	Individuals under an age specified by the State, less than age 21, who were in State-sponsored foster care on their 18th birthday and who meet the income standard established by the State.	42 CFR 435.226; 1902(a)(10)(A)(ii)(XVII)	Family/Adult	Options for Coverage
31	Optional Targeted Low Income Children	Uninsured children who meet the definition of optional targeted low income children at 42 CFR 435.4, who have household income at or below a standard established by the State.	42 CFR 435.229 and 435.4; 1902(a)(10)(A)(ii)(XIV); 1905(u)(2)(B)	Family/Adult	Options for Coverage
32	Individuals Electing COBRA Continuation Coverage	Individuals choosing to continue COBRA benefits with income equal to or less than 100% of the FPL.	1902(a)(10)(F); 1902(u)(1)	Family/Adult	Options for Coverage

Code	Eligibility Group	Short Description	Citation	Type	Category
33	Individuals above 133% FPL under Age 65	Individuals under 65, not otherwise mandatorily or optionally eligible, with income above 133% FPL and at or below a standard established by the State.	CFR 435.218; 1902(hh); 1902(a)(10)(A)(ii)(XX)	Family/Adult	Options for Coverage
34	Certain Individuals Needing Treatment for Breast or Cervical Cancer	Individuals under the age of 65 who have been screened for breast or cervical cancer and need treatment.	42 CFR 435.213; 1902(a)(10)(A)(ii)(XVIII); 1902(aa)	Family/Adult	Options for Coverage
35	Individuals Eligible for Family Planning Services	Individuals who are not pregnant, with income equal to or below the highest standard for pregnant women, as specified by the State, limited to family planning and related services.	42 CFR 435.214; 1902(a)(10)(A)(ii)(XXI)	Family/Adult	Options for Coverage
36	Individuals with Tuberculosis	Individuals infected with tuberculosis whose income does not exceed established standards, limited to tuberculosis-related services.	42 CFR 435.215; 1902(a)(10)(A)(ii)(XII); 1902(z)	Family/Adult	Options for Coverage
37	Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash Assistance	Individuals who meet the requirements of SSI or Optional State Supplement, but who do not receive cash.	42 CFR 435.210 & 230; 1902(a)(10)(A)(ii)(I);	ABD	Options for Coverage
38	Individuals Eligible for Cash Assistance except for Institutionalization	Individuals who meet the requirements of AFDC, SSI or Optional State Supplement, and would be eligible if they were not living in a medical institution.	42 CFR 435.211; 1902(a)(10)(A)(ii)(IV);	ABD	Options for Coverage

Code	Eligibility Group	Short Description	Citation	Type	Category
39	Individuals Receiving Home and Community Based Services under Institutional Rules	Individuals who would be eligible for Medicaid under the State Plan if in a medical institution, who would live in an institution if they did not receive home and community based services.	42 CFR 435.217; 1902(a)(10)(A)(ii)(VI)	ABD	Options for Coverage
40	Optional State Supplement Recipients - 1634 States, and SSI Criteria States with 1616 Agreements	Individuals in 1634 States and in SSI Criteria States with agreements under 1616, who receive a state supplementary payment (but not SSI).	42 CFR 435.232; 1902(a)(10)(A)(ii)(IV)	ABD	Options for Coverage
41	Optional State Supplement Recipients - 209(b) States, and SSI Criteria States without 1616 Agreements	Individuals in 209(b) States and in SSI Criteria States without agreements under 1616, who receive a state supplementary payment (but not SSI).	42 CFR 435.234; 1902(a)(10)(A)(ii)(XI)	ABD	Options for Coverage
42	Institutionalized Individuals Eligible under a Special Income Level	Individuals who are in institutions for at least 30 consecutive days who are eligible under a special income level.	42 CFR 435.236; 1902(a)(10)(A)(ii)(V)	ABD	Options for Coverage
43	Individuals participating in a PACE Program under Institutional Rules	Individuals who would be eligible for Medicaid under the State Plan if in a medical institution, who would require institutionalization if they did not participate in the PACE program.	1934	ABD	Options for Coverage
44	Individuals Receiving Hospice Care	Individuals who would be eligible for Medicaid under the State Plan if they were in a medical institution, who are terminally ill, and who will receive hospice care.	1902(a)(10)(A)(ii)(VII); 1905(o)	ABD	Options for Coverage

Code	Eligibility Group	Short Description	Citation	Type	Category
45	Qualified Disabled Children under Age 19	Certain children under 19 living at home, who are disabled and would be eligible if they were living in a medical institution.	1902(e)(3)	ABD	Options for Coverage
46	Poverty Level Aged or Disabled	Individuals who are aged or disabled with income equal to or less than a percentage of the FPL, established by the state (no higher than 100%).	1902(a)(10)(A)(ii)(X); 1902(m)(1)	ABD	Options for Coverage
47	Work Incentives Eligibility Group	Individuals with a disability with income below 250% of the FPL, who would qualify for SSI except for earned income.	1902(a)(10)(A)(ii)(XIII)	ABD	Options for Coverage
48	Ticket to Work Basic Group	Individuals with earned income between ages 16 and 64 with a disability, with income and resources equal to or below a standard specified by the State.	1902(a)(10)(A)(ii)(XV)	ABD	Options for Coverage
49	Ticket to Work Medical Improvements Group	Individuals with earned income between ages 16 and 64 who are no longer disabled but still have a medical impairment, with income and resources equal to or below a standard specified by the State.	1902(a)(10)(A)(ii)(XVI)	ABD	Options for Coverage
50	Family Opportunity Act Children with Disabilities	Children under 19 who are disabled, with income equal to or less than a standard specified by the State (no higher than 300% of the FPL).	1902(a)(10)(A)(ii)(XIX); 1902(cc)(1)	ABD	Options for Coverage

Code	Eligibility Group	Short Description	Citation	Type	Category
51	Individuals Eligible for Home and Community-Based Services	Individuals with income equal to or below 150% of the FPL, who qualify for home and community based services without a determination that they would otherwise live in an institution.	1902(a)(10)(A)(ii)(XXII); 1915(i)	ABD	Options for Coverage
52	Individuals Eligible for Home and Community-Based Services - Special Income Level	Individuals with income equal to or below 300% of the SSI federal benefit rate, who meet the eligibility requirements for a waiver approved for the State under 1915(c), (d) or (e), or 1115.	1902(a)(10)(A)(ii)(XXII); 1915(i)	ABD	Options for Coverage
72	Adult Group - Individuals at or below 133% FPL Age 19 through 64 - newly eligible for all states	Non-pregnant individuals aged 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL.	42 CFR 435.119; 1902(a)(10)(A)(i)(VIII)	Family/Adult	Mandatory Coverage

Code	Eligibility Group	Short Description	Citation	Type	Category
73	Adult Group - Individuals at or below 133% FPL Age 19 through 64- not newly eligible for non 1905z(3) states	Non-pregnant individuals aged 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL.	42 CFR 435.119; 1902(a)(10)(A)(i)(VIII) 1905z(3)	Family/Adult	Mandatory Coverage
74	Adult Group - Individuals at or below 133% FPL Age 19 through 64 – not newly eligible parent/ caretaker-relative(s) in 1905z(3) states	Non-pregnant individuals aged 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL.	42 CFR 435.119; 1902(a)(10)(A)(i)(VIII) 1905z(3)	Family/Adult	Mandatory Coverage
75	Adult Group - Individuals at or below 133% FPL Age 19 through 64- not newly eligible non-parent/ caretaker-relative(s) in 1905z(3) states	Non-pregnant individuals aged 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL.	42 CFR 435.119; 1902(a)(10)(A)(i)(VIII) 1905z(3)	Family/Adult	Mandatory Coverage
MEDICAID MEDICALLY NEEDY					
53	Medically Needy Pregnant Women	Women who are pregnant, who would qualify as categorically needy, except for income.	42 CFR 435.301(b)(1)(i) and (iv); 1902(a)(10)(C)(ii)(II)	Family/Adult	Medically Needy

Code	Eligibility Group	Short Description	Citation	Type	Category
54	Medically Needy Children under Age 18	Children under 18 who would qualify as categorically needy, except for income.	42 CFR 435.301(b)(1)(ii); 1902(a)(10)(C)(ii)(II)	Family/Adult	Medically Needy
55	Medically Needy Children Age 18 through 20	Children over 18 and under an age established by the State (less than age 21), who would qualify as categorically needy, except for income.	42 CFR 435.308; 1902(a)(10)(C)(ii)(II)	Family/Adult	Medically Needy
56	Medically Needy Parents and Other Caretakers	Parents and other caretaker relatives of dependent children, eligible as categorically needy except for income.	42 CFR 435.310	Family/Adult	Medically Needy
59	Medically Needy Aged, Blind or Disabled	Individuals who are age 65 or older, blind or disabled, who are not eligible as categorically needy, who meet income and resource standards specified by the State, or who meet the income standard using medical and remedial care expenses to offset excess income.	42 CFR 435.320, 435.322, 435.324,and 435.330; 1902(a)(10)(C)	ABD	Medically Needy
60	Medically Needy Blind or Disabled Individuals Eligible in 1973	Blind or disabled individuals who were eligible for Medicaid as Medically Needy in 1973 who meet all current requirements for Medicaid except for the blindness or disability criteria.	42 CFR 435.340	ABD	Medically Needy
CHIP COVERAGE					
61	Targeted Low-Income Children	Uninsured children under age 19 who do not have access to public employee coverage and whose household income is within standards established by the state.	42 CFR 457.310; 2102(b)(1)(B)(v)	Children	Optional

Code	Eligibility Group	Short Description	Citation	Type	Category
62	Deemed Newborn	Children born to targeted low-income pregnant women who are deemed eligible for CHIP or Medicaid for one year.	2112(e)	Children	Optional
63	Children Ineligible for Medicaid Due to Loss of Income Disregards	Children determined to be ineligible for Medicaid as a result of the elimination of income disregards under the MAGI income methodology.	42 CFR 457.340(d) Section 2101(f) of the ACA	Children	Mandatory
CHIP ADDITIONAL OPTIONS FOR COVERAGE					
64	Coverage from Conception to Birth	Uninsured children from conception to birth who do not have access to public employee coverage and whose household income is within standards established by the state.	42 CFR 457.310 2102(b)(1)(B)(v)	Children	Option for Coverage
65	Children with Access to Public Employee Coverage	Uninsured children under age 19 having access to public employee coverage and whose household income is within standards established by the state.	2110(b)(2)(B) and (b)(6)	Children	Option for Coverage
66	Children Eligible for Dental Only Supplemental Coverage	Children who are otherwise eligible for CHIP but for the fact that they are enrolled in a group health plan or health insurance offered through an employer. Coverage is limited to dental services.	2110(b)(5)	Children	Option for Coverage
67	Targeted Low-Income Pregnant Women	Uninsured pregnant women who do not have access to public employee coverage and whose household income is within standards established by the state.	2112	Pregnant Women	Option for Coverage
68	Pregnant Women with Access to	Uninsured pregnant women having access to	2110(b)(2)(B) and (b)(6)	Pregnant Women	Option for Coverage

Code	Eligibility Group	Short Description	Citation	Type	Category
	Public Employee Coverage	public employee coverage and whose household income is within standards established by the state.			
1115 EXPANSION ELIGIBILITY GROUPS					
69	Individuals with Mental Health Conditions (expansion group)	Individuals with mental health conditions who do not qualify for Medicaid due to the severity or duration of their disability or due to other eligibility factors; and/or those who are otherwise eligible but require benefits or services that are not comparable to those provided to other Medicaid beneficiaries.	1115 expansion		
70	Family Planning Participants (expansion group)	Individuals of child bearing age who require family planning services and supplies and for which the state does not choose to, or cannot provide, optional eligibility coverage under the Individuals Eligible for Family Planning Services eligibility group (1902(a)(10)(A)(ii)(XXI)).	1115 expansion		
71	Other expansion group	Individuals who do not qualify for Medicaid or CHIP under a mandatory eligibility or coverage group and for whom the state chooses to provide eligibility and/or benefits in a manner not permitted by title XIX or XXI of the Social Security Act.	1115 expansion		

Appendix G: ISO 639 Language Codes Reference

ISO 639-2 Code	Language	ISO 639-2 Code	Language
abk	Abkhazian	kru	Kurukh
ace	Achinese	kut	Kutenai
ach	Acoli	lad	Ladino
ada	Adangme	lah	Lahnda
ady	Adyghe; Adygei	lam	Lamba
aar	Afar	day	Land Dayak languages
afh	Afrihili	lao	Lao
afr	Afrikaans	lat	Latin
afa	Afro-Asiatic languages	lav	Latvian
ain	Ainu	lez	Lezghian
aka	Akan	lim	Limburgan; Limburger; Limburgish
akk	Akkadian	lin	Lingala
alb	Albanian	lit	Lithuanian
alb	Albanian	jbo	Lojban
ale	Aleut	nds	Low German; Low Saxon; German, Low; Saxon, Low
alg	Algonquian languages	dsb	Lower Sorbian
tut	Altaic languages	loz	Lozi
amh	Amharic	lub	Luba-Katanga
anp	Angika	lua	Luba-Lulua
apa	Apache languages	lui	Luiseno
ara	Arabic	smj	Lule Sami
arg	Aragonese	lun	Lunda
arp	Arapaho	luo	Luo (Kenya and Tanzania)
arw	Arawak	lus	Lushai
arm	Armenian	ltz	Luxembourgish; Letzeburgesch
rup	Aromanian; Arumanian; Macedo-Romanian	mac	Macedonian
art	Artificial languages	mad	Madurese
asm	Assamese	mag	Magahi
ast	Asturian; Bable; Leonese; Asturleonese	mai	Maithili
ath	Athapascan languages	mak	Makasar
aus	Australian languages	mlg	Malagasy

ISO 639-2 Code	Language	ISO 639-2 Code	Language
map	Austronesian languages	may	Malay
ava	Avaric	mal	Malayalam
ave	Avestan	mlt	Maltese
awa	Awadhi	mnc	Manchu
aym	Aymara	mdr	Mandar
aze	Azerbaijani	man	Mandingo
ban	Balinese	mni	Manipuri
bat	Baltic languages	mno	Manobo languages
bal	Baluchi	glv	Manx
bam	Bambara	mao	Maori
bai	Bamileke languages	arn	Mapudungun; Mapuche
bad	Banda languages	mar	Marathi
bnt	Bantu languages	chm	Mari
bas	Basa	mah	Marshallese
bak	Bashkir	mwr	Marwari
baq	Basque	mas	Masai
btk	Batak languages	myn	Mayan languages
bej	Beja; Bedawiyet	men	Mende
bel	Belarusian	mic	Mi'kmaq; Micmac
bem	Bemba	min	Minangkabau
ben	Bengali	mwl	Mirandese
ber	Berber languages	moh	Mohawk
bho	Bhojpuri	mdf	Moksha
bih	Bihari languages	lol	Mongo
bik	Bikol	mon	Mongolian
bin	Bini; Edo	mkh	Mon-Khmer languages
bis	Bislama	mos	Mossi
byn	Blin; Bilin	mul	Multiple languages
zbl	Blissymbols; Blissymbolics; Bliss	mun	Munda languages
nob	Bokmål, Norwegian; Norwegian Bokmål	nah	Nahuatl languages
bos	Bosnian	nau	Nauru
bra	Braj	nav	Navajo; Navaho
bre	Breton	nde	Ndebele, North; North Ndebele
bug	Buginese	nbl	Ndebele, South; South Ndebele
bul	Bulgarian	ndo	Ndonga
bua	Buriat	nap	Neapolitan
bur	Burmese	new	Nepal Bhasa; Newari
cad	Caddo	nep	Nepali
cat	Catalan; Valencian	nia	Nias
cau	Caucasian languages	nic	Niger-Kordofanian languages
ceb	Cebuano	ssa	Nilo-Saharan languages

ISO 639-2 Code	Language	ISO 639-2 Code	Language
cel	Celtic languages	niu	Niuean
cai	Central American Indian languages	nqo	N'Ko
khm	Central Khmer	nog	Nogai
chg	Chagatai	non	Norse, Old
cmc	Chamic languages	nai	North American Indian languages
cha	Chamorro	frr	Northern Frisian
che	Chechen	sme	Northern Sami
chr	Cherokee	nor	Norwegian
chy	Cheyenne	nno	Norwegian Nynorsk; Nynorsk, Norwegian
chb	Chibcha	nub	Nubian languages
nya	Chichewa; Chewa; Nyanja	nym	Nyamwezi
chi	Chinese	nyn	Nyankole
chn	Chinook jargon	nyo	Nyoro
chp	Chipewyan; Dene Suline	nzi	Nzima
cho	Choctaw	oci	Occitan (post 1500)
chu	Church Slavic; Old Slavonic; Church Slavonic; Old Bulgarian; Old Church Slavonic	arc	Official Aramaic (700-300 BCE); Imperial Aramaic (700-300 BCE)
chk	Chuukese	oji	Ojibwa
chv	Chuvash	ori	Oriya
nwc	Classical Newari; Old Newari; Classical Nepal Bhasa	orm	Oromo
syc	Classical Syriac	osa	Osage
cop	Coptic	oss	Ossetian; Ossetic
cor	Cornish	oto	Otomian languages
cos	Corsican	pal	Pahlavi
cre	Cree	pau	Palauan
mus	Creek	pli	Pali
crp	Creoles and pidgins	pam	Pampanga; Kapampangan
cpe	Creoles and pidgins, English based	pag	Pangasinan
cpf	Creoles and pidgins, French-based	pan	Panjabi; Punjabi
cpp	Creoles and pidgins, Portuguese-based	pap	Papiamento
crh	Crimean Tatar; Crimean Turkish	paa	Papuan languages
hrv	Croatian	nso	Pedi; Sepedi; Northern Sotho
cus	Cushitic languages	per	Persian
cze	Czech	peo	Persian, Old (ca.600-400 B.C.)
dak	Dakota	phi	Philippine languages
dan	Danish	phn	Phoenician
dar	Dargwa	pon	Pohnpeian
del	Delaware	pol	Polish

ISO 639-2 Code	Language	ISO 639-2 Code	Language
din	Dinka	por	Portuguese
div	Divehi; Dhivehi; Maldivian	pra	Prakrit languages
doi	Dogri	pro	Provençal, Old (to 1500);Occitan, Old (to 1500)
dgr	Dogrib	pus	Pushto; Pashto
dra	Dravidian languages	que	Quechua
dua	Duala	raj	Rajasthani
dum	Dutch, Middle (ca.1050-1350)	rap	Rapanui
dut	Dutch; Flemish	rar	Rarotongan; Cook Islands Maori
dyu	Dyula	roa	Romance languages
dzo	Dzongkha	rum	Romanian; Moldavian; Moldovan
frs	Eastern Frisian	roh	Romansh
efi	Efik	rom	Romany
egy	Egyptian (Ancient)	run	Rundi
eka	Ekajuk	rus	Russian
elx	Elamite	sal	Salishan languages
eng	English	sam	Samaritan Aramaic
enm	English, Middle (1100-1500)	smi	Sami languages
ang	English, Old (ca.450-1100)	smo	Samoan
myv	Erzya	sad	Sandawe
epo	Esperanto	sag	Sango
est	Estonian	san	Sanskrit
ewe	Ewe	sat	Santali
ewo	Ewondo	srd	Sardinian
fan	Fang	sas	Sasak
fat	Fanti	sco	Scots
fao	Faroese	sel	Selkup
fij	Fijian	sem	Semitic languages
fil	Filipino; Pilipino	srp	Serbian
fin	Finnish	srr	Serer
fiu	Finno-Ugrian languages	shn	Shan
fon	Fon	sna	Shona
fre	French	iii	Sichuan Yi; Nuosu
frm	French, Middle (ca.1400-1600)	scn	Sicilian
fro	French, Old (842-ca.1400)	sid	Sidamo
fur	Friulian	sgn	Sign Languages
ful	Fulah	bla	Siksika
gaa	Ga	snd	Sindhi
gla	Gaelic; Scottish Gaelic	sin	Sinhala; Sinhalese
car	Galibi Carib	sit	Sino-Tibetan languages

ISO 639-2 Code	Language	ISO 639-2 Code	Language
glg	Galician	sio	Siouan languages
lug	Ganda	sms	Skolt Sami
gay	Gayo	den	Slave (Athapascan)
gba	Gbaya	sla	Slavic languages
gez	Geez	slo	Slovak
geo	Georgian	slv	Slovenian
ger	German	sog	Sogdian
gmh	German, Middle High (ca.1050-1500)	som	Somali
goh	German, Old High (ca.750-1050)	son	Songhai languages
gem	Germanic languages	snk	Soninke
gil	Gilbertese	wen	Sorbian languages
gon	Gondi	sot	Sotho, Southern
gor	Gorontalo	sai	South American Indian languages
got	Gothic	alt	Southern Altai
grb	Grebo	sma	Southern Sami
grc	Greek, Ancient (to 1453)	spa	Spanish; Castilian
gre	Greek, Modern (1453-)	srn	Sranan Tongo
grn	Guarani	suk	Sukuma
guj	Gujarati	sux	Sumerian
gwi	Gwich'in	sun	Sundanese
hai	Haida	sus	Susu
hat	Haitian; Haitian Creole	swa	Swahili
hau	Hausa	ssw	Swati
haw	Hawaiian	swe	Swedish
heb	Hebrew	gsw	Swiss German; Alemannic; Alsatian
her	Herero	syr	Syriac
hil	Hiligaynon	tgl	Tagalog
him	Himachali languages; Western Pahari languages	tah	Tahitian
hin	Hindi	tai	Tai languages
hmo	Hiri Motu	tgk	Tajik
hit	Hittite	tmh	Tamashek
hmn	Hmong; Mong	tam	Tamil
hun	Hungarian	tat	Tatar
hup	Hupa	tel	Telugu
iba	Iban	ter	Tereno
ice	Icelandic	tet	Tetum
ido	Ido	tha	Thai
ibo	Igbo	tib	Tibetan

ISO 639-2 Code	Language	ISO 639-2 Code	Language
ijo	Ijo languages	tig	Tigre
ilo	Iloko	tir	Tigrinya
smn	Inari Sami	tem	Timne
inc	Indic languages	tiv	Tiv
ine	Indo-European languages	tli	Tlingit
ind	Indonesian	tpi	Tok Pisin
inh	Ingush	tkl	Tokelau
ina	Interlingua (International Auxiliary Language Association)	tog	Tonga (Nyasa)
ile	Interlingue; Occidental	ton	Tonga (Tonga Islands)
iku	Inuktitut	tsi	Tsimshian
ipk	Inupiaq	tso	Tsonga
ira	Iranian languages	tsn	Tswana
gle	Irish	tum	Tumbuka
mga	Irish, Middle (900-1200)	tup	Tupi languages
sga	Irish, Old (to 900)	tur	Turkish
iro	Iroquoian languages	ota	Turkish, Ottoman (1500-1928)
ita	Italian	tuk	Turkmen
jpn	Japanese	tvl	Tuvalu
jav	Javanese	tyv	Tuvinian
jrb	Judeo-Arabic	twi	Twi
jpr	Judeo-Persian	udm	Udmurt
kbd	Kabardian	uga	Ugaritic
kab	Kabyle	uig	Uighur; Uyghur
kac	Kachin; Jingpho	ukr	Ukrainian
kal	Kalaallisut; Greenlandic	umb	Umbundu
xal	Kalmyk; Oirat	mis	Uncoded languages
kam	Kamba	und	Undetermined
kan	Kannada	hsb	Upper Sorbian
kau	Kanuri	urd	Urdu
krc	Karachay-Balkar	uzb	Uzbek
kaa	Kara-Kalpak	vai	Vai
krl	Karelian	ven	Venda
kar	Karen languages	vie	Vietnamese
kas	Kashmiri	vol	Volapük
csb	Kashubian	vot	Votic
kaw	Kawi	wak	Wakashan languages
kaz	Kazakh	wln	Walloon
kha	Khasi	war	Waray
khi	Khoisan languages	was	Washo
kho	Khotanese; Sakan	wel	Welsh
kik	Kikuyu; Gikuyu	fry	Western Frisian

ISO 639-2 Code	Language	ISO 639-2 Code	Language
kmb	Kimbundu	wal	Wolaitta; Wolaytta
kin	Kinyarwanda	wol	Wolof
kir	Kirghiz; Kyrgyz	xho	Xhosa
tlh	Klingon; tlhIngan-Hol	sah	Yakut
kom	Komi	yao	Yao
kon	Kongo	yap	Yapese
kok	Konkani	yid	Yiddish
kor	Korean	yor	Yoruba
kos	Kosraean	ypk	Yupik languages
kpe	Kpelle	znd	Zande languages
kro	Kru languages	zap	Zapotec
kua	Kuanyama; Kwanyama	zza	Zaza; Dimili; Dimli; Kirdki; Kirmanjki; Zazaki
kum	Kumyk	zen	Zenaga
kur	Kurdish	zha	Zhuang; Chuang
		zul	Zulu
		zun	Zuni

Appendix H: Benefit Types

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
Mandatory Benefits for Categorically Needy (Mandatory and Options for Coverage) Individuals and Optional Benefits for Medically Needy Individuals						
001	Inpatient Hospital Services	Services furnished in a hospital or institution (licensed or formally approved as a hospital), for the care and treatment of inpatients with disorders other than mental health disease.	Mandatory	Institutional	No	1905(a)(1), 440.10, 440.189(g)
002	Outpatient Hospital Services	Preventive, diagnostic, therapeutic, rehabilitative, or palliative services furnished to outpatients by a hospital or institution (licensed or formally approved as a hospital).	Mandatory	Ambulatory	No	1905(a)(2)(A), 440.20(a)
003	Rural Health Clinics	Services and supplies provided by a physician within the scope of his/her practice, a physician assistant (if not prohibited by state law), nurse practitioner (if not prohibited by state law) nurse midwife, or other specialized nurse practitioners, intermittent visiting nurse care and related	Mandatory	Ambulatory	No	1905(a)(2)(B), 440.20(b) and (c), 1910(a)

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
		medical supplies (other than drugs and biologicals), and other ambulatory services when furnished in a certified rural health clinic or away from the clinic if an agreement between the physician and clinic for payment of services by the clinic exists.				
004	Federally Qualified Health Centers	Services and related supplies provided by a physician within the scope of his/her practice, physician assistants, nurse practitioners, nurse midwives, clinical psychologists, clinical social workers, and other ambulatory services when furnished in a federally qualified health center.	Mandatory	Ambulatory	No	1905(a)(2)(C)
005	Other Laboratory and X-Ray Services	Technical and radiological services ordered and provided by or under direction of a physician or other licensed practitioner in an office or similar facility other than a clinic or hospital outpatient department and furnished by an approved laboratory.	Mandatory	Ambulatory	No	1905(a)(3), 440.30
006	Nursing Facility Services for Individuals Age 21 and Older	Services (other than services in an institution for	Mandatory	Institutional	Yes	1905(a)(4)(A), 440.40(a)

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
		mental health conditions), furnished to individuals age 21 and older, which are needed on a daily basis and required to be provided in an inpatient basis provided by a Medicaid-approved facility and ordered by and provided under the direction of a physician.				
007	Early and Periodic Screening, Diagnostic and Treatment Services	Screening and diagnostic services to determine physical or mental health condition; health care treatment and other measures to correct or ameliorate any chronic conditions discovered in recipients under age 21.	Mandatory	Both	No	1905(a)(4)(B), 1902(a)(43), 1905(r)
008	Family Planning Services and Supplies	Family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who desire such services and supplies.	Mandatory	Ambulatory	No	1905(a)(4)(C), 441 Subpart F
009	Cessation of Tobacco Use by Pregnant Women	Counseling and pharmacotherapy services for cessation of tobacco use by pregnant women.	Mandatory	Ambulatory	No	1905(a)(4)(D)
010	Physician Services	Services furnished by a state-licensed	Mandatory	Ambulatory	No	1905(a)(5)(A), 440.50(a)

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
		physician within his or her scope of practice of medicine or osteopathy.				
011	Medical and Surgical Services Furnished by a Dentist	Medical and surgical services furnished by a doctor of dental medicine or dental surgery, or if permitted by state law, by a physician.	Mandatory	Ambulatory	No	1905(a)(5)(B), 440.50(b)
012	Nurse Midwife Services	Services furnished by a licensed nurse midwife within the scope of practice authorized by State law or regulation; Inpatient or outpatient hospital services or clinic services furnished by a licensed nurse midwife under the supervision of, or associated with a physician or other health care provider.	Mandatory	Ambulatory	No	1905(a)(17), 440.165
013	Certified Pediatric or Family Nurse Practitioner Services	Services furnished by a certified pediatric nurse practitioner with a practice limited to providing primary health care to individuals under age 21; or a certified family nurse practitioner with a practice limited to providing primary health care to individuals and families.	Mandatory	Ambulatory	No	1905(a)(21), 440.166
014	Free Standing Birth Center Services	Services furnished to an individual at a freestanding birth center, which include prenatal labor and delivery,	Mandatory	Institutional	No	1905(a)(28)

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
		or postpartum care and other ambulatory services related to the health and safety of the individual.				
015	Home Health Services - Intermittent and Part-time Nursing Services Provided by a Home Health Agency	Nursing service that is provided on a part-time or intermittent basis by a home health agency or in the absence of an agency in the area, by a registered nurse.	Mandatory	Ambulatory	Yes	1905(a)(7), 440.70(b)(1), 441.15
016	Home Health Services - Home Health Aide Services Provided by a Home Health Agency	Home health aide services provided by a home health agency.	Mandatory	Ambulatory	Yes	1905(a)(7), 440.70(b)(2), 441.15
017	Home Health Services - Medical Supplies, Equipment and Appliances Suitable for Use in the Home	Services include medical supplies, equipment and appliances suitable for use in the home.	Mandatory	Ambulatory	Yes	1905(a)(7), 440.70(b)(3), 441.15
Optional Benefits for Categorically Needy (Mandatory and Options for Coverage) and Medically Needy Individuals						
018	Medical Care and Any Type of Remedial Care Recognized Under State Law - Podiatrist Services	Medical or remedial care or services provided by licensed podiatrists within the scope of practice as defined under state law.	Optional	Ambulatory	No	1905(a)(6), 440.60
019	Medical Care and Any Type of Remedial Care Recognized Under State Law - Optometrist Services	Medical or remedial care or services provided by licensed optometrists within the scope of practice as defined under state law	Optional	Ambulatory	No	1905(a)(6), 440.60
020	Medical Care and Any Type of Remedial Care Recognized Under State	Services provided by licensed chiropractors	Optional	Ambulatory	No	1905(a)(6), 440.60

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
	Law - Chiropractors' Services	consisting of treatment by means of manual manipulation of the spine within the scope authorized by the state to perform.				
021	Medical Care and Any Type of Remedial Care Recognized Under State Law - Other Licensed Practitioner Services	Medical or any other remedial care or services provided by a licensed practitioner within the scope of his/her practice as defined by state law.	Optional	Ambulatory	No	1905(a)(6), 440.60
022	Home Health Services - Physical Therapy, Occupational Therapy, Speech Pathology, Audiology Provided by a Home Health Agency	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 medical rehabilitation services.	Optional	Ambulatory	Yes	1905(a)(7), 440.70(b)(4), 441.15
023	Private Duty Nursing Services	Nursing services, provided by RNs or LPNs, in a home, hospital, or skilled nursing facility, to recipients who require more individual and continuous care than is available from a visiting nurse, or routinely provided by hospital or skilled nursing facility staff.	Optional	Ambulatory	Yes	1905(a)(8), 440.80
024	Clinic Services	Preventive, diagnostic, therapeutic, rehabilitative or palliative services furnished by a facility that is not part of a hospital,	Optional	Ambulatory	No	1905(a)(9), 440.90

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
		but is organized and operated to provide medical care; services provided at the clinic or outside the clinic under the direction of a physician or dentist.				
025	Dental Services	Diagnostic, preventive, or corrective procedures provided by or under the supervision of a licensed dentist; treatment of the teeth and associated structures of the oral cavity; treatment of disease, injury, or impairment that my affect general health of recipient.	Optional	Ambulatory	No	1905(a)(10), 440.100
026	Physical Therapy and Related Services-Physical Therapy	Services prescribed by a physician or other licensed practitioner of the healing arts, and provided to a recipient by or under the direction of a qualified physical therapist; includes supplies and equipment.	Optional	Ambulatory	Yes	1905(a)(11), 440.110(a)
027	Physical Therapy and Related Services-Occupational Therapy	Services provided by a qualified occupational therapist, which have been prescribed by a physician or practitioner of the healing arts; includes supplies and equipment.	Optional	Ambulatory	Yes	1905(a)(11), 440.110(b)
028	Physical Therapy and Related Services -	Diagnostic, screening,	Optional	Ambulatory	Yes	1905(a)(11), 440.110(c)

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
	Services for Individuals with Speech, Hearing and Language Disorders	preventive or corrective services for individuals with speech, hearing and language disorders; provided by or under the direction of a certified speech pathologist or audiologist or other licensed practitioner of the healing arts; includes supplies and equipment.				
029	Prescribed Drugs, Dentures, and Prosthetic Devices; and Eyeglasses - Prescribed Drugs	Single or compound substances or mixture of substances prescribed by a physician or licensed practitioner, and dispensed by a licensed pharmacist or authorized practitioner, for the cure, mitigation, or prevention of disease or maintenance of health.	Optional	Ambulatory	No	1905(a)(12), 440.120(a)
030	Prescribed Drugs, Dentures, and Prosthetic Devices; and Eyeglasses - Dentures	Artificial structures made by or under the direction of a dentist to replace a full or partial set of teeth.	Optional	Ambulatory	No	1905(a)(12), 440.120(b)
031	Prescribed Drugs, Dentures, and Prosthetic Devices; and Eyeglasses - Prosthetic Devices	Replacement, corrective or supportive devices prescribed by a physician or licensed practitioner, to artificially replace a missing portion of the body, prevent or correct physical deformity	Optional	Ambulatory	No	1905(a)(12), 440.120(c)

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
		or malfunction, or to support a weak or deformed portion of the body.				
032	Prescribed Drugs, Dentures, and Prosthetic Devices; and Eyeglasses - Eyeglasses	Lenses, including frames and other aids to vision, prescribed by a physician skilled in eye disease, or an optometrist.	Optional	Ambulatory	No	1905(a)(12), 440.120(d)
033	Other Diagnostic, Screening, Preventive, and Rehabilitative Services - Diagnostic Services	Medical procedures or supplies recommended by a physician or licensed practitioner to enable him/her to identify the existence, nature or extent of illness, injury or other health deviation in a recipient.	Optional	Ambulatory	No	1905(a)(13), 440.130(a)
034	Other Diagnostic, Screening, Preventive, and Rehabilitative Services - Screening Services	Use of standardized tests given to a designated population, to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases.	Optional	Ambulatory	No	1905(a)(13), 440.130(b)
035	Other Diagnostic, Screening, Preventive, and Rehabilitative Services - Preventive Services	Services provided by a physician or other licensed practitioner to prevent disease, disability or other health conditions or their progression, to prolong life and to promote physical and mental health efficiency.	Optional	Ambulatory	No	1905(a)(13), 440.130(c)

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
036	Other Diagnostic, Screening, Preventive, and Rehabilitative Services - Rehabilitative Services	Medical or remedial services recommended by a physician or other licensed practitioner for maximum reduction of physical or mental health condition, and restoration of a recipient to his/her best possible functional level.	Optional	Ambulatory	Yes	1905(a)(13), 440.130(d)
037	Services for Individuals Age 65 and Over in IMDs - Inpatient Hospital Services	Services for the care and treatment of recipients, age 65 and older, in an institution for mental health conditions, provided under the direction of a physician.	Optional	Institutional	Yes	1905(a)(14), 440.140(a)
038	Services for Individuals Age 65 and Over in IMDs - Nursing Facility Services	Nursing services needed on a daily basis and required to be provided on an inpatient basis to individuals age 65 and older in an institution for mental health conditions.	Optional	Institutional	Yes	1905(a)(14), 440.140(b)
039	Intermediate Care Facility Services for Individuals with Intellectual Disabilities (ICF-IID)	Items and health rehabilitative services provided to persons with intellectual disabilities or related conditions, receiving active treatment in a licensed ICF/IID.	Optional	Institutional	Yes	1905(a)(15), 440.150
040	Inpatient Psychiatric Services for Individuals Under 21	Inpatient psychiatric services provided to individuals under age 21, under the direction of a physician, furnished in an	Optional	Institutional	Yes	1905(a)(16), 440.160

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
		approved and accredited psychiatric hospital or facility.				
041	Hospice Care Services	Items and services provided to a terminally ill individual, which includes nursing care, physical or occupational therapy, medical social services, homemaker services, medical supplies and appliances, physician services, short-term inpatient care and counseling.	Optional	Both	Yes	1905(a)(18)
042	Case Management and TB-Related Services - Case Management and Targeted Case Management Services	Services to assist eligible individuals who reside in a community setting or are transitioning to a community setting, in gaining access to medical, social, educational, and other services. As specified in a state's plan, may be offered to individuals within targeted groups.	Optional	Ambulatory	Yes	1905(a)(19), 440.169, 1915(g)
043	Case Management Services and TB-Related Services -Special TB Related Services	Services for the treatment of infection with tuberculosis consisting of prescribed drugs, physicians' services, laboratory and x-ray services (including services to confirm the presence of infection), clinic services and federally-qualified health center services, case	Optional	Ambulatory	No	1905(a)(19)

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
		management services, and services (other than room and board) designed to encourage completion of regimens of prescribed drugs by outpatients, including services to observe directly the intake of prescribed drugs.				
044	Respiratory Care Services	Services provided in home, under the direction of a physician, by a respiratory therapist or other health care professional trained in respiratory therapy, to an individual who is medically dependent on a ventilator for life support for 6 hours or more per day, has been dependent on the ventilator for at least 30 consecutive days as an inpatient in a hospital, NF or ICF/IID, has adequate social support, and wishes to be cared for at home.	Optional	Ambulatory	No	1905(a)(20), 1902(e)(9)(A)-(C), 440.185
045	Personal Care Services	Services, furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, or intermediate facility for individuals with intellectual and or developmental	Optional	Ambulatory	Yes	1905(a)(24), 440.167

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
		disabilities, or institution for mental health conditions, that are authorized by a physician in accordance with a plan of treatment, and provided by an individual qualified to provide such services, who is not a legally responsible relative.				
046	Primary Care Case Management Services (Integrated Care Model)	Case management related services which include location, coordination, and monitoring of primary health care services and provider under a contract between the State and either a PCCM who is a physician, or at the State's option, a physician assistant, nurse practitioner, certified nurse midwife, physician group practice, or an entity that employs or arranges with physicians to furnish services.	Optional	Ambulatory	No	1905(a)(25), 440.168
047	Special Sickle-Cell Anemia-Related Services	Primary and secondary medical strategies and treatment and services for individuals who have Sickle Cell Disease.	Optional	Ambulatory	No	1905(a)(27)

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
048	Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary - Transportation	Expenses for transportation and other related travel expenses determined to be necessary by the agency to secure medical examinations and treatment for a beneficiary.	Optional, but states are required to assure that transportation is available to and from Medicaid services, either as a State Plan benefit, an administrative activity or under a waiver	Ambulatory	No	1905(a)(29), 440.170(a)
049	Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary - Services provided in religious non-medical health care facilities	Non-medical services and items, furnished in an institution that is defined in the Internal Revenue Code and is exempt from taxes, to patients who choose to rely solely upon a religious method of healing and for whom the acceptance of medical health services would be inconsistent with their religious beliefs.	Optional	Institutional	Yes	1905(a)(29), 440.170(b) and (c)
050	Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary - Nursing facility services for individuals under age 21	Services (other than services in an Institution for mental health conditions), furnished to individuals under the age of 21, which are needed on a daily basis and required to be provided in an inpatient basis provided by a Medicaid-approved facility	Optional	Institutional	Yes	1905(a)(29), 440.170(d)

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
		and ordered by and provided under the direction of a physician.				
051	Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary - Emergency hospital services	Services that are necessary to prevent death or serious impairment of health of a recipient, and that the threat to life or health necessitates that use of the most accessible hospital available that is equipped to furnish the services, with no regard to conditions of participation under Medicare or definitions of inpatient or outpatient hospital services.	Optional	Ambulatory	No	1905(a)(29), 440.170(e)
052	Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary - Critical Access Hospitals	Services that are furnished by a Medicare participating Critical Access Hospital (CAH) provider and are of a type that would be paid for by Medicare when provided to a Medicare recipient, other than nursing facility services by a CAH with a swing-bed approval.	Optional	Institutional	No	1905(a)(29), 440.170(g)
053	Extended Services for Pregnant Women - Additional Services for Any Other Medical Conditions That May Complicate Pregnancy	Extended services for pregnant women - Additional Services for any other medical conditions that may complicate	Optional	Ambulatory	No	1902(a)(10)(end)(V)

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
		pregnancy, except Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls. (These services will fall into valid value # 71.)				
054	Community First Choice	Home and community-based attendant services and supports to assist eligible beneficiaries in accomplishing activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related tasks through hands-on assistance, supervision or cueing.	Optional	Ambulatory	No	1915(k)

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
055	Health Homes	Comprehensive and timely high-quality services that are provided by a designated provider, a team of health care professionals operating with such a provider, or a health team. Services include care management, care coordination and promotion, comprehensive transitional care, patient and family support, referral to community and social support services, and use of information technology to link services.	Optional	Ambulatory	No	1945
Special Benefit Provisions						
056	Limited Pregnancy-Related Services for Pregnant Women with Income Above the Applicable Income Limit	Potentially limited services for pregnant women with income above a certain limit to pregnancy-related services that are necessary for the health of the pregnant woman and fetus, or have become necessary as a result of the woman having been pregnant, including, but not limited to prenatal care, delivery, postpartum care, and family planning services.	N/A	N/A	No	1902(a)(10)(end)(VII), 440.210(a)(2), 440.250(p)
057	Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period	Ambulatory prenatal care services provided to an eligible pregnant woman during the PE period, which	N/A	N/A	No	1920, 1902(a)(47)

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
		begins on the date a pregnant woman is determined presumptively eligible by a Medicaid qualified provider based on preliminary information, and ends on the day on which a full determination of eligibility is made or at the end of the month following the month in which the PE determination was made if the woman fails to file an application for full benefits.				
058	Benefits for Families Receiving Transitional Medical Assistance	Benefits provided to families who would have lost eligibility because of hours of, or income from employment of the caretaker relative. Benefits may be limited or provided through alternative methods during the second six months of the 12 month period of extended benefits.	N/A	N/A	N/A	1925, 1902(a)(52)
059	Standards for Coverage of Transplant Services	Standards which provide that similarly situated individuals are treated alike and any restriction, on the facilities or practitioners which may provide such procedures, is consistent with accessibility to high quality care.	N/A	N/A	N/A	1903(i)(1), 441.35
060	School-Based Services Payment	Provision of benefits in a	N/A	N/A	N/A	1903(c)

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
	Methodologies	school-based setting or arranged by a school to a child with a disability even if such services are included in the child's individualized education program (IEP), and to an infant or toddler with a disability even if such services are included in the child's individualized family service plan (IFSP).				
061	Indian Health Services and Tribal Health Facilities	Allows for reimbursement of state plan covered services when provided by a facility of the Indian Health Service, including a hospital, nursing facility or any other type of facility which provides covered services under the state plan.	N/A	N/A	N/A	1911, 431.110(b)
062	Methods and Standards to Assure High Quality Care	The plan must include a description of methods and standards used to assure that services are of high quality and that the care and services are available under the plan at least to the extent that such care and services are available to the general populations in the geographic area.	N/A	N/A	N/A	1902(a)(30)(A), 440.260

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
Coordination of Medicaid with Medicare and Other Insurance						
063	Medicare Premium Payments	Provisions related to payment of Medicare A, B and C premiums for qualifying Medicaid beneficiaries.	N/A	N/A	N/A	1902(a)(10(E), 1905(p), 1905(s), 1933, 431.625
064	Medicare Coinsurance and Deductibles	Provisions for Medicaid payment of Medicare coinsurance and deductibles for individuals dually eligible for Medicare and Medicaid.	N/A	N/A	N/A	1902(a)(10(E), 1902(n), 1905(p)(3) and (4)
065	Other Medical Insurance Premium Payments	Payment of insurance premiums, if cost-effective, for eligible individuals; payment of COBRA premiums; and requirement of enrollment in an employer-sponsored insurance with payment of premiums, if cost-effective.	N/A	N/A	N/A	1906, 1906A, 1902(a)(10)(F), 1902(u)(1)
Special Benefit Programs						
066	Programs for Distribution of Pediatric Vaccines	The establishment of a pediatric vaccine distribution program, which provides eligible children with qualified pediatric vaccines.	Mandatory	N/A	N/A	1928
Home and Community-Based Services						
067	Laboratory and x-ray services					
068	Home Health Services - Home health aide services provided by a home health agency	N/A	N/A	N/A	N/A	N/A

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
069	Private duty nursing services	N/A	N/A	N/A	N/A	N/A
070	Physical Therapy and Related Services - Audiology services	N/A	N/A	N/A	N/A	N/A
071	Extended services for pregnant women - Additional Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.	N/A	N/A	N/A	N/A	N/A
072	Home and Community Care for Functionally Disabled Elderly individuals as defined and described in the State Plan	N/A	N/A	N/A	N/A	N/A
073	Emergency services for certain legalized aliens and undocumented aliens	An emergency medical condition is a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to	N/A	N/A	N/A	N/A

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
		bodily functions, or serious dysfunction of any bodily organ or part.				
074	Licensed or Otherwise State-Approved Free-Standing Birthing Center and other ambulatory services that are offered by a freestanding birth center	N/A	N/A	N/A	N/A	N/A
075	Homemaker	N/A	N/A	N/A	N/A	N/A
076	Home Health Aide	N/A	N/A	N/A	N/A	N/A
077	Adult Day Health services	N/A	N/A	N/A	N/A	N/A
078	Habilitation	N/A	N/A	N/A	N/A	N/A
079	Habilitation: Residential Habilitation	N/A	N/A	N/A	N/A	N/A
080	Habilitation: Supported Employment	N/A	N/A	N/A	N/A	N/A
081	Habilitation: Education (non IDEA available)	N/A	N/A	N/A	N/A	N/A
082	Habilitation: Day Habilitation	N/A	N/A	N/A	N/A	N/A
083	Habilitation: Pre-Vocational	N/A	N/A	N/A	N/A	N/A
084	Habilitation: Other Habilitative Services	N/A	N/A	N/A	N/A	N/A
085	Respite	N/A	N/A	N/A	N/A	N/A
086	Day Treatment (mental health service)	N/A	N/A	N/A	N/A	N/A
087	Psychosocial rehabilitation	N/A	N/A	N/A	N/A	N/A
088	Environmental Modifications (Home Accessibility Adaptations)	N/A	N/A	N/A	N/A	N/A
089	Vehicle Modifications	N/A	N/A	N/A	N/A	N/A

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
090	Non-Medical Transportation	N/A	N/A	N/A	N/A	N/A
091	Special Medical Equipment (minor assistive Devices)	N/A	N/A	N/A	N/A	N/A
092	Home Delivered meals	N/A	N/A	N/A	N/A	N/A
093	Assistive Technology (i.e., communication devices)	N/A	N/A	N/A	N/A	N/A
094	Personal Emergency Response (PERS)	N/A	N/A	N/A	N/A	N/A
095	Nursing Services	N/A	N/A	N/A	N/A	N/A
096	Community Transition Services	N/A	N/A	N/A	N/A	N/A
097	Adult Foster Care	N/A	N/A	N/A	N/A	N/A
098	Day Supports (non-habilitative)	N/A	N/A	N/A	N/A	N/A
099	Supported Employment	N/A	N/A	N/A	N/A	N/A
100	Supported Living Arrangements	N/A	N/A	N/A	N/A	N/A
101	Supports for Consumer Direction (Supports Facilitation)	N/A	N/A	N/A	N/A	N/A
102	Participant Directed Goods and Services	N/A	N/A	N/A	N/A	N/A
103	Senior Companion (Adult Companion Services)	N/A	N/A	N/A	N/A	N/A
104	Assisted Living	N/A	N/A	N/A	N/A	N/A
Other						
105	Program for All-inclusive Care for the Elderly (PACE) Services	N/A	N/A	N/A	N/A	N/A

Code Value	Benefit	Short Description	Category	Type of Care	Long Term Care*	Citations (Act and 42 CFR)
106	Self-directed Personal Assistance Services under 1915(j)	N/A	N/A	N/A	N/A	N/A

Appendix I: MBES CBES Category of Service Line Definitions for the 64.9 Base Form

Line	Line - Form Display	Line - Definition
1A	Inpatient Hospital - Reg. Payments	1A. - Inpatient Hospital Services.-- Regular Payments.--Other than services in an institution for mental health conditions. (See 42 CFR 440.10). These are services that: - Are ordinarily furnished in a hospital for the care and treatment of inpatients; - Are furnished under the direction of a physician or dentist (except in the case of nurse-midwife services under 42 CFR 440.165); and - Are furnished in an institution that: - Is maintained primarily for the care and treatment of patients with disorders other than mental health conditions; - Is licensed and 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 under 42 CFR 440.165); and, - Has, in effect, a utilization review plan (that meets the requirements under 42 CFR 482.30 applicable to all Medicaid patients, unless a waiver has been granted by DHHS. NOTE: Inpatient hospital services do not include NF 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.
1B	Inpatient Hospital - DSH	1.B. Inpatient Hospital Services -- DSH Adjustment Payment. - Other than services in an institution for mental health conditions. DSH payments are for the express purpose of assisting hospitals that serve a disproportionate share of low-income patients with special needs and are made in accordance with section 1923 of the Act. Report the total payments that were determined to be disproportionate share payments to the hospital by entering the amounts on the pop-up feeder form which in turn will pre-fill the Form CMS-64.9D as well as the appropriate lines on the Forms CMS-64.9, CMS-64.9P, CMS-64.21, CMS-64.21P, CMS-6421U or CMS-64.21UPs.

Line	Line - Form Display	Line - Definition
1C	Inpatient Hospital - Sup. Payments	1C. - Inpatient Hospital Services.- Supplemental Payments.--Other than services in an institution for mental health conditions. (Refer to the definition on Line 1A above). These are payments made in addition to the standard fee schedule or other standard payment for those services. These payments are separate and apart from regular payments and are based on their own payment methodology. Payments may be made to all providers or targeted to specific groups or classes of providers. Groups may be defined by ownership type (state, county or private) and/or by the other characteristics, e.g., caseload, services or costs. The combined standard payment and supplemental payment cannot exceed the upper payment limit described in 42 CFR 447.272. Address supplemental payments for inpatient hospitals associated with (1) state government operated facilities, (2) non-state government operated facilities, and (3) privately operated facilities by entering payments on the pop-up feeder form.
1D	Inpatient Hospital - GME Payments	1D. - Inpatient Hospital Services.—Graduate Medical Education (GME) Payments.-- GME payments include supplemental payments for direct medical education (DME) (i.e. costs of training physicians such as resident and teaching physician salaries/benefits, overhead and other costs directly related to the program) and indirect medical education (IME) costs hospitals incur for operating teaching programs. Report all supplemental payments for DME and IME that are provided for in the State plan.
2A	Mental Health Facility Services - Reg. Payments	2.A. Mental Health Facility Services - Report Institution for Mental Disease (IMD) (or mental health conditions) services for individuals age 65 or older and/or under age 21 (See 42 CFR 440.140 and 440.160.). Report Other Mental Services which are not provided in an inpatient setting in the Other Appropriate Service categories, e.g., Physician Services, Clinic Services. 1. Mental Health Hospital Services for the Aged.--Refers to those inpatient hospital services provided under the direction of a physician for the care and treatment of recipients in an institution for mental health conditions that meets the Conditions of Participation under 42 CFR Part 482. Institution for mental health conditions means an institution that is primarily engaged in providing diagnosis, treatment, or care of individuals with mental health conditions, including medical care, nursing care, and related services. (See 42 CFR 440.140(a)(2).) 2. NF Services for the Aged.--Means those NF services (as defined at 42 CFR 440.40) and those ICF services (as defined at 42 CFR 483, Subpart B) provided in an institution for mental health conditions to recipients determined to be in need of such services. (See 42 CFR 440.140.) 3. Inpatient Psychiatric Facility Services for Individuals Age 21 and Under. (See 42 CFR 441.151) --Means those services that: • Are provided under the direction of a physician; • Are provided in a facility or program accredited by the Joint Commission on the Accreditation of Health Care Organizations; and • Meet the requirements set forth at Subpart D of Part 441 (Inpatient Psychiatric Services for Individuals Age 21 and under in Psychiatric Facilities or Programs).

Line	Line - Form Display	Line - Definition
2B	Mental Health Facility - DSH	2.B. Mental Health Facility Services -- DSH Adjustment Payments.- (See 42 CFR 440.140 and 440.160). DSH payments are for the express purpose of assisting hospitals that serve a disproportionate share of low-income patients with special needs and are made in accordance with section 1923 of the Act. Report the total payments that were determined to be disproportionate share payments to the hospital by entering the amounts on the pop-up feeder form which in turn will pre-fill the Form CMS-64.9D as well as the appropriate lines on the Forms CMS-64.9, CMS-64.9P, CMS-64.21, CMS-64.21P, CMS-6421U or CMS-64.21UPs.
3A	Nursing Facility Services - Reg. Payments	3A. - Nursing Facility Services.--Regular Payments.-- (Other than services in an institution for mental health conditions). (See 42 CFR 483.5 and 440.155). These are services provided by an institution (or a distinct part of an institution) which: • 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 health conditions; 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 Residences Rights, and, • Requirements relating to Administration and Other Matters.
3B	Nursing Facility Services - Sup. Payments	3B. - Nursing Facility Services - Supplemental Payments.-- (Other than services in an institution for mental health conditions). (Refer to the definition on Line 3A above). These are payments made in addition to the standard fee schedule or other standard payment for those services. These payments are separate and apart from regular payments and are based on their own payment methodology. Payments may be made to all providers or targeted to specific groups or classes of providers. Groups may be defined by ownership type (state, county or private) and/or by the other characteristics, e.g., caseload, services or costs. The combined standard payment and supplemental payment cannot exceed the upper payment limit described in 42 CFR 447.272. Address supplemental payments for nursing facility services associated with (1) state government operated facilities, (2) non-state government operated facilities, and (3) privately operated facilities by entering payments on the pop-up feeder form.

Line	Line - Form Display	Line - Definition
4A	Intermediate Care Facility Services – Individuals with Intellectual Disabilities: Public Providers	4A Intermediate Care Facility Services - Public Providers – Individuals with Intellectual Disabilities (ICF/IID) (See 42 CFR 440.150). These include services provided in an institution for individuals with intellectual disabilities or persons with related conditions if: • The primary purpose of the institution is to provide health or rehabilitative services to such individuals; • The institution meets the standards in 42 CFR 442, Subpart C (Intermediate Care Facility Requirements; All Facilities); and, • Individuals with intellectual disabilities recipient for whom payment is requested is receiving active treatment as defined in 42 CFR 435.1009. NOTE: Line 4 is divided into sections for public providers (Line 4.A.) and private providers (Line 4.B.). Public providers are owned or operated by a State, county, city or other local governmental agency or instrumentality. Increasing adjustments related to private providers are considered current expenditures for the quarter in which the expenditure was made and are matched at the FMAP rate for that quarter. Increasing adjustments related to public providers are considered adjustments to prior period claims and are matched using the FMAP rate in effect at the earlier of the time the expenditure was paid or recorded by any State agency. (See 45 CFR Part 95 and §2560.)
4B	Intermediate Care Facility Services - Individuals with Intellectual Disabilities: Private Providers	4B --Intermediate Care Facility Services - Private Providers - Individuals with Intellectual Disabilities (ICF/IID). (See 42 CFR 440.150). These include services provided in an institution for individuals with intellectual disabilities or persons with related conditions if: • The primary purpose of the institution is to provide health or rehabilitative services to such individuals; • The institution meets the standards in 42 CFR 442, Subpart C (Intermediate Care Facility Requirements; All Facilities); and • Individuals with intellectual disabilities recipient for whom payment is requested is receiving active treatment as defined in 42 CFR 435.1009. • NOTE: Line 4 is divided into sections for public providers (Line 4.A.) and private providers (Line 4.B.). Public providers are owned or operated by a State, county, city or other local governmental agency or instrumentality. Increasing adjustments related to private providers are considered current expenditures for the quarter in which the expenditure was made and are matched at the FMAP rate for that quarter. Increasing adjustments related to public providers are considered adjustments to prior period claims and are matched using the FMAP rate in effect at the earlier of the time the expenditure was paid or recorded by any State agency. (See 45 CFR Part 95 and §2560.)

Line	Line - Form Display	Line - Definition
4C	Intermediate Care Facility Services – Individuals with Intellectual Disabilities: Supplemental Payments	Line 4C. Intermediate Care Facility Services (ICF/IID) - Supplemental Payments (Refer to the definition on Line 4A above). These are payments made in addition to the standard fee schedule or other standard payment for those services. These payments are separate and apart from regular payments and are based on their own payment methodology. Payments may be made to all providers or targeted to specific groups or classes of providers. Groups may be defined by ownership type (state, county or private) and/or by the other characteristics, e.g., caseload, services or costs. The combined standard payment and supplemental payment cannot exceed the upper payment limit described in 42 CFR 447.272. Address supplemental payments for ICF/IID services associated with (1) state government operated facilities, (2) non-state government operated facilities, and (3) privately operated facilities by entering payments on the pop-up feeder form.
5A	Physician & Surgical Services - Reg. Payments	5A. - Physician and Surgical Services.--Regular Payments.-- (See 42 CFR 440.50.).--Whether furnished in the office, the recipient's home, a hospital, a NF, or elsewhere, physicians' services are 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. • NOTE: Exclude all services provided and billed for by a hospital, clinic, or laboratory. Include any services provided and billed by a physician under physician services with the exception of lab and X-ray services. Include such services provided and billed for by a physician under the lab and X-ray services category. In a primary care case management system under a Freedom of Choice waiver, you sometimes use a physician as the case manager. In these situations, the physician is allowed to charge a flat fee for each person. Although this fee is not truly a physician service, report the expenditures for the fee on this line.
5B	Physician & Surgical Services - Sup. Payments	5B. - Physician and Surgical Services.--Supplemental Payments.-- (refer to definition for Line 5A above) Payments for physician and other practitioner services as defined in Line 5A that are made in addition to the standard fee schedule payment for those services. When combined with regular payments, these supplemental payments are equal to or less than the Federal upper payment limit. Address supplemental payments for physicians and practitioners associated with (1) governmental hospitals or university teaching hospitals, (2) private hospitals, and (3) other supplemental payments by entering payment information on the pop-up feeder sheet.
5C	Physician & Surgical Services - Evaluation and Management	5C. Physician & Surgical Services - Evaluation and Management -- ACA Section 1202 - Services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System. 100% Federal Share Matching.

Line	Line - Form Display	Line - Definition
5D	Physician & Surgical Services - Vaccine codes	5D. Physician & Surgical Services - Vaccine codes -- ACA Section 1202 - Services related to immunization administration for vaccines and toxoids for which CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 (as subsequently modified) apply under such system. 100% Federal Share Matching Rate
6A	Outpatient Hospital Services - Reg. Payments	6A. - Outpatient Hospital Services.--Regular Payments.-- (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), are furnished by, or under the direction of, a physician or dentist; and • Are furnished 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, meets the requirements for participation in Medicare. (See 42 CFR 440.165.)
6B	Outpatient Hospital Services - Sup. Payments	6B. - Outpatient Hospital Services.--Supplemental Payments.-- (refer to definition for Line 6A above) Payments for outpatient hospital services as defined in line 6A that are made in addition to the base fee schedule or other standard payment for those services. These payments are separate and apart from regular payments and are based on their own payment methodology. The combined standard payment and supplemental payment cannot exceed the Federal upper payment limit. Address outpatient hospital services supplemental payments associated with (1) state owned or operated hospitals, (2) non state government owned or operated hospitals and (3) private hospitals by entering payment information on the pop-up feeder sheet.
7	Prescribed Drugs	7 - Prescribed Drugs. (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 of the healing arts within the scope of a 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 record.

Line	Line - Form Display	Line - Definition
7A1	Drug Rebate Offset - National	7.A.1. Drug Rebate Offset.--This is a refund from the manufacturer to the State Medical Assistance plan for single source drugs, innovator multiple source drugs, and non-innovator multiple source drugs that are dispensed to Medicaid recipients. Rebates are to take place quarterly. Report these offsets as (1) National Agreement or (2) State Sidebar Agreement. National Agreement refers to rebates manufacturers pay your State pursuant to the manufacturers' agreements with CMS under OBRA 1990 provisions. State Sidebar Agreements refer to rebates manufacturers pay under an agreement directly with your State. These may have been entered into before January 1, 1991, the effective date of the OBRA rebate program. Or they may represent agreements your State entered into with a given manufacturer on or after January 1, 1991, under which the manufacturer pays at least as great a rebate as it would under the National Agreement. All States receive rebates under the National Agreements. A few States receive most of their rebates under the National Agreement, but some States receive other rebates under their State Sidebar Agreement with specific manufacturers. All manufacturer rebates received under CMS's National Agreement are reported on Line 7.A.1, National Agreement. All rebates received under State Sidebar Agreements are reported on Line 7.A.2, State Sidebar Agreement. NOTE: Vaccines are not subject to the rebate agreements.
7A2	Drug Rebate Offset - State Sidebar Agreement	7A2. Drug Rebate Offset.--This is the rebate collected under a separate State agreement Sidebar Agreement. These are rebates received that do not fall under 7A1 (National Drug Rebate).
7A3	MCO - National Agreement	7.A.3. National Agreement 7A3. Managed Care Organizations (MCO) – National Agreement: The Affordable Care Act requires manufacturers that participate in the Medicaid Drug Rebate Program to pay rebates for drugs dispensed to individuals enrolled with a Medicaid MCO if the MCO is responsible for coverage of such drugs, effective March 23, 2010. This is a refund from the manufacturer to the State Medical Assistance plan for single source drugs, innovator multiple source drugs, and non-innovator multiple source drugs that are dispensed to Medicaid recipients who are enrolled in a Medicaid MCO. Rebates are to take place quarterly. Report these offsets as MCO National Agreement. National Agreement refers to rebates manufacturers pay your State pursuant to the manufacturers agreements with CMS under OBRA 1990 provisions. All States receive rebates under the National Agreement. For rebates for Medicaid MCO drugs, there will be no rebates under their State Sidebar Agreement with specific manufacturers. All MCO manufacturer rebates received under CMS National Agreement are reported on Line 7.A.3, National Agreement NOTE: Vaccines are not subject to the National agreement.
7A4	MCO - State Sidebar Agreement	7.A.4. MCO State Sidebar Agreement. This is the rebate collected under a separate State agreement Sidebar Agreement. These are rebates received that do not fall under 7A3 (National Drug Rebate).

Line	Line - Form Display	Line - Definition
7A5	Increased ACA OFFSET - Fee for Service - 100%	Brand name drugs that are blood clotting factors and drugs approved by the FDA exclusively for pediatric indications are subject to a minimum rebate percentage of 17.1 percent of AMP: • If the difference between AMP and BP is less than or equal to 15.1 percent of AMP, then we plan to offset the full 2 percent of AMP (the difference between 17.1 percent of AMP and 15.1 percent of AMP). • If the difference between AMP and BP is greater than 15.1 percent of AMP, but less than 17.1 percent of AMP, then we plan to offset the difference between 17.1 percent of AMP and AMP minus BP. • If the difference between AMP and BP is greater than or equal to 17.1 percent of AMP, then we do not plan to take any offset amount. For a drug that is a line extension of a brand name drug that is an oral solid dosage form, we plan to apply the same offset calculation as described above to the basic rebate. Further, we plan to offset only the difference in the additional rebate of the reformulated drug based on the calculation methodology of the additional rebate for the drug preceding the requirements of the Affordable Care Act and the calculation of the additional rebate for the reformulated drug, if greater, in accordance with the Affordable Care Act. If there is no difference in the additional rebate amount in accordance with the Affordable Care Act, then we do not plan to take any offset amount. For a noninnovator multiple source drug, we plan to offset an amount equal to two percent of the AMP (the difference between 13 percent of AMP and 11 percent of AMP).

Line	Line - Form Display	Line - Definition
7A6	Increased ACA OFFSET - MCO - 100%	7.A.6. Increased ACA OFFSET - MCO - 100% 7A6. Increased ACA OFFSET – MCO: Similar to the increased ACA offset for fee-for-service, for covered outpatient drugs that are dispensed to Medicaid MCO enrollees, the Affordable Care Act also required that amounts “attributable” to the increased rebates be remitted to the Federal Government. Below is a description of how the offset is calculated: Brand name drugs other than blood clotting factors and drugs approved by the Food and Drug Administration (FDA) exclusively for pediatric indications are subject to a minimum rebate percentage of 23.1 percent of AMP: • If the difference between AMP and BP is less than or equal to 15.1 percent of AMP, then we plan to offset the full 8 percent of AMP (the difference between 23.1 percent of AMP and 15.1 percent of AMP). • If the difference between AMP and BP is greater than 15.1 percent of AMP, but less than 23.1 percent of AMP, then we plan to offset the difference between 23.1 percent of AMP and AMP minus BP. • If the difference between AMP and BP is greater than or equal to 23.1 percent of AMP, then we do not plan to take any offset amount. Brand name drugs that are blood clotting factors and drugs approved by the FDA exclusively for pediatric indications are subject to a minimum rebate percentage of 17.1 percent of AMP: • If the difference between AMP and BP is less than or equal to 15.1 percent of AMP, then we plan to offset the full 2 percent of AMP (the difference between 17.1 percent of AMP and 15.1 percent of AMP). • If the difference between AMP and BP is greater than 15.1 percent of AMP, but less than 17.1 percent of AMP, then we plan to offset the difference between 17.1 percent of AMP and AMP minus BP. • If the difference between AMP and BP is greater than or equal to 17.1 percent of AMP, then we do not plan to take any offset amount. For a drug that is a line extension of a brand name drug that is an oral solid dosage form, we plan to apply the same offset calculation as described above to the basic rebate. Further, we plan to offset only the difference in the additional rebate of the reformulated drug based on the calculation methodology of the additional rebate for the drug preceding the requirements of the Affordable Care Act and the calculation of the additional rebate for the reformulated drug, if greater, in accordance with the Affordable Care Act. If there is no difference in the additional rebate amount in accordance with the Affordable Care Act, then we do not plan to take any offset amount. For a noninnovator multiple source drug, we plan to offset an amount equal to two percent of the AMP (the difference between 13 percent of AMP and 11 percent of AMP).

Line	Line - Form Display	Line - Definition
8	Dental Services	8. Dental Services (See 42 CFR 440.100.).--These are services that are diagnostic, preventive, or corrective procedures provided by, or under the supervision of, a dentist in the practice of his/her profession including treatment of: • The teeth and associated structures of the oral cavity; and, • Disease, injury, or impairment that may affect the oral or general health of the recipient. Report all EPSDT dental services on this line. Dentist means an individual licensed to practice dentistry or dental surgery. NOTE: Exclude all such services provided as part of inpatient hospital, outpatient hospital, nondental, clinic or laboratory services and billed for by the hospital, nondental clinic, or laboratory.
9A	Other Practitioners Services - Reg. Payments	9A. - Other Practitioners Services - Regular Payments (see CFR 440.60). Any medical or remedial care or services, other than physicians' services, provided by licensed practitioners with the scope of practice defined under State law. Chiropractors' services may be included here as long as the services that (1) are provided by a chiropractor who is licensed by the State and meets standards issued by the Secretary under section 405.232(b), and (2) consists of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by the State to perform.
9B	Other Practitioners Services - Sup. Payments	9B. - Other Practitioners Services - Supplemental Payments. Payments for other practitioner services as defined in Line 9A that are made in addition to the standard fee schedule payment for those services. When combined with regular payments, these supplemental payments are equal to or less than the Federal upper payment limit. Address supplemental payments for other practitioners associated with (1) governmental hospitals or university medical schools, and (2) private hospitals or university medical schools, and (3) other supplemental payments by entering payment information on the pop-up feeder sheet.
10	Clinic Services	10. Clinic Services (See 42 CFR 440.90.).--These are preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that: Are provided to outpatients; • Are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. For reporting purposes, consider a group of physicians who share, only for mutual convenience, space, services of supporting staff, etc., as physicians, rather than a clinic, even though they practice under the name of a clinic; and • 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 clinics under Dental Services. Report any services not included above under Other Care Services. A clinic staff may include practitioners with different specialties.

Line	Line - Form Display	Line - Definition
11	Laboratory/Radiological	11. Laboratory And Radiological Services (See 42 CFR 440.30.).--These are professional, technical laboratory and radiological services: • Ordered and provided by, or under, the direction of a physician or other licensed practitioner of the healing arts within the scope of a practice as defined by State law or ordered and billed by a physician but provided by an independent laboratory; • Provided in an office or similar facility other than a hospital inpatient or outpatient department or clinic; and • Provided by a laboratory that meets the requirements for participation in Medicare. • NOTE: Report X-rays by dentists under Dental Services, Line 8.
12	Home Health Services	12, Home Health Services (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 is renewed every 60 days and includes the following items and services: • Nursing service as defined in the State Nurse Practice Act, that is provided on a part-time or intermittent basis by a home health agency (HHA) (a public or private agency or organization, or part of an 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 case and services provided; and • Has had orientation to acceptable clinical and administrative record keeping from a health department nurse. Home health aide services provided by an HHA; • Medical supplies, equipment, and appliances suitable for use in the home; and • Physical therapy, occupational therapy, or speech pathology and audiology services provided by an HHA or by a facility licensed by the State to provide medical rehabilitation services. (See 42 CFR 441.15 - Home Health Services.) Place of residence is normally interpreted to mean the patient's home, and does not apply to hospitals or NFs. Services received in a NF that are different from those normally provided as part of the institution's care may qualify as Home Health Services. 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.
13	Sterilizations	13. Sterilizations (See 42 CFR 441, Subpart F.).--These are medical procedures, treatments, or operations for the primary purpose of rendering an individual permanently incapable of reproducing.

Line	Line - Form Display	Line - Definition
14	Other Pregnancy-related Procedures	14. Other Pregnancy-related Procedures (See 42 CFR 441, Subpart E.).--FFP is available when a physician has certified, in writing, to the Medicaid agency, that on the basis of professional judgment the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless a termination is performed. The certification must contain the name and address of the patient. The revision to the Hyde Amendment, P.L. 103-112, Health and Human Services Appropriations Bill, made FFP available for expenditures for other pregnancy-related procedures when the pregnancy is a result of an act of rape or incest. This reimbursement is effective for dates of service October 1, 1993 and thereafter. Provide a breakout of the number of other pregnancy-related procedures and associated expenditures in the following cases: • Procedures performed to save the life of the mother, • Procedures performed in the case of pregnancies resulting from incest, and • Procedures performed in the case of pregnancies resulting from rape. NOTE 1: Report all other pregnancy-related procedures on this line regardless of the type of provider. For prior period adjustments, only include any entry in number of procedures if, for increasing claims, it is a new pregnancy-related procedure that has not been previously reported, or, for decreasing claims, you want to remove a procedure previously claimed. Make no entry in number of procedures if all you are changing is the dollar amount claimed. NOTE 2: The "morning after pill" (ECP) is not considered a termination as it is a contraceptive to prevent pregnancy. However, the drug Mifepristone (RU486) should be counted as another pregnancy-related procedure as long as all Hyde amendment and other federal requirements are met.

Line	Line - Form Display	Line - Definition
15	EPSDT Screening	15. EPSDT Screening Services - Physical and mental assessment given to Medicaid eligibles under age 21 to carry out the screening provisions of the EPSDT program. However, the agency must provide at least the following services through consultation with health experts, determine the specific health evaluation procedures to be used, and the mechanisms needed to carry out the screening program. • A comprehensive health and developmental history (including assessment of both physical and mental health development); • A comprehensive unclothed physical exam; • Appropriate immunizations according to the Advisory Committee on Immunization Practices • Laboratory tests (including blood lead level assessment according to age/risk factors); • Health education (including anticipatory guidance); and • Dental Services - Referral to a dentist in accordance with the States' periodicity schedule. • Vision Services The above services may be provided by any qualified Medicaid provider. NOTE: Do not include data for dental, hearing, or vision services here. Report dental examinations and preventative dental services on Line 8, Dental Services. Report hearing services, including hearing aids, on Line 32, Services for Speech, Hearing and Language. Report vision services rendered by professionals (e.g. – examinations, etc.) on Line 9, Other Practitioners' Services. Note that the cost of eyeglasses and other aids to vision is to be reported on Line 33, Prosthetic Devices, Dentures, and Eyeglasses. Report other necessary health care according to the appropriate category.

Line	Line - Form Display	Line - Definition
16	Rural Health	16. Rural Health Clinic (RHC) Services (See 42 CFR 440.20(b).).--If a State permits the delivery of primary care by a nurse practitioner (NP) or physician's assistant (PA), rural health clinic (RHC) means the following services furnished by a RHC that has been certified in accordance with the conditions of 42 CFR Part 491 (Certification of Certain Health Facilities): • Services furnished by a physician within a professional scope under State law, whether the physician performs these services in or away from the clinic and the physician has an agreement with the clinic to be paid by it for such services. • Services furnished by a PA, NP, nurse midwife or other specialized NP (as defined in 42 CFR 405.2401 and 491.2) if they are furnished in accordance with the requirements specified in 42 CFR 405.2414(a). • Services and supplies that are furnished as incident to professional services furnished by a physician, PA, NP, nurse midwife, or specialized NP. (See 42 CFR 405.2413 and 405.2415 for the criteria determining whether services and supplies are included.) • Part-time or intermittent visiting nurse care and related medical supplies (other than drugs and biological) if: • The clinic is located in an area in which the Secretary has determined that there is a shortage of HHAs (see 42 CFR 405.2417); • The services are furnished by an RN or licensed PN or a licensed vocational nurse employed by, or otherwise compensated for the services by, the clinic; • The services are furnished under a written plan of treatment that is established and reviewed at least every 60 days by a supervising physician of the clinic or that is established by a physician, PA, NP, nurse midwife, or specialized NP and reviewed and approved at least every 60 days by a supervising physician of the clinic; and • The services are furnished to a homebound recipient. 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, place of residence does not include a hospital or an NF.Rural Health Clinic (RHC) Services (See 42 CFR 440.20(b).).--If a State permits the delivery of primary care by a nurse practitioner (NP) or physician's assistant (PA), rural health clinic (RHC) means the following services furnished by a RHC that has been certified in accordance with the conditions of 42 CFR Part 491 (Certification of Certain Health Facilities):

Line	Line - Form Display	Line - Definition
16	Rural Health	• Services furnished by a physician within a professional scope under State law, whether the physician performs these services in or away from the clinic and the physician has an agreement with the clinic to be paid by it for such services. • Services furnished by a PA, NP, nurse midwife or other specialized NP (as defined in 42 CFR 405.2401 and 491.2) if they are furnished in accordance with the requirements specified in 42 CFR 405.2414(a). • Services and supplies that are furnished as incident to professional services furnished by a physician, PA, NP, nurse midwife, or specialized NP. (See 42 CFR 405.2413 and 405.2415 for the criteria determining whether services and supplies are included.) • Part-time or intermittent visiting nurse care and related medical supplies (other than drugs and biological) if: • The clinic is located in an area in which the Secretary has determined that there is a shortage of HHAs (see 42 CFR 405.2417); • The services are furnished by an RN or licensed PN or a licensed vocational nurse employed by, or otherwise compensated for the services by, the clinic; • The services are furnished under a written plan of treatment that is established and reviewed at least every 60 days by a supervising physician of the clinic or that is established by a physician, PA, NP, nurse midwife, or specialized NP and reviewed and approved at least every 60 days by a supervising physician of the clinic; and • The services are furnished to a homebound recipient. 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, place of residence does not include a hospital or an NF.
17A	Medicare - Part A	17A. Part A Premiums--(See §301 P.L. 100-360 and §1902 (a)(10) (E)(ii) of the Act)-- Include Part A premiums paid for Qualified Disabled and Working Individuals (QWDIs) under §1902(a)(10)(E)(ii) of the Act.
17B	Medicare - Part B	17B. Part B Premiums--(See §1902(a). Part B Premiums - Include premiums paid through Medicare buy-in under 1843 for Qualified Medicare Beneficiaries (QMBs) under 1902(a)(10)(E)(i),Specified Low-Income Medicare Beneficiaries (SLMBs) under 1902(a)(10)(E)(iii),and other Medicare/Medicaid dual eligibles covered in 1902(a)(10) of the Act. Do not include part B premiums for line 17C (Qualifying Individuals). This amount is shown on the bottom of each monthly bill sent to you on the summary accounting statement Form CMS-1604.
17C1	120% - 134% Of Poverty	Line 17C.1. - 120% - 134% of Poverty - Include premiums paid for Medicare Part B under §1902(a)(10)(E)(iv)(I).

Line	Line - Form Display	Line - Definition
17D	Coinsurance	17D. Coinsurance and Deductibles-- Include Medicare deductibles and coinsurance required to be paid for QMBs under §1905 (p)(3). (Do not include any Medicare deductibles and coinsurance for other Medicare/Medicaid dual eligibles. Report expenditures for Medicaid services also covered by Medicare under the appropriate Medicaid service category.) Coinsurance is a joint assumption of risk by the insured and the insurer, whereby each shares on a specific basis, the applicable medical expenses of the insured. The insured's share of coinsurance may be paid on his/her behalf. For example, under part B of Medicare, the beneficiary's coinsurance responsibility is a percent of reasonable and customary expenses greater than the stipulated deductible. A deductible is that portion of applicable medical expenses which must be borne by the insured (or be paid on his/her behalf) before insurance benefits for the calendar year begin. EXCEPTION: REPORT ALL OTHER PREGNANCY-RELATED PROCEDURES ON LINE 14.
18A	Medicaid - MCO	18A. Managed Care Organizations (MCOs)-- (See §1903(m)(1)(A) of the Act revised by BBA §4701(b)). - Include capitated payments made to a Medicaid Managed Care Organization which is defined as follows: A Medicaid Managed Care Organization (MCO) means a health maintenance organization, an eligible organization with a contract under §1876 or a Medicare+ Choice organization with a contract under part C of title XVIII, a provider sponsored organization, which meets the requirements of §1902(w)and - (i) makes services it provides to individuals eligible for benefits under this title accessible to such individuals, within the area served by the organization, to the same extent as such services are made accessible to individuals (eligible for Medical Assistance under the State plan) not enrolled with the organization, and (ii) has made adequate provision against the risk of insolvency, which provision is satisfactory to the State and which assures that individuals eligible for benefits under this title are in no case held liable for debts of the organization in case of the organization's insolvency. An organization that is a qualified health maintenance organization (as defined in §1310(d) of the Public Health Service Act) is deemed to meet the requirements of clauses (i) and (ii).
18A1	Medicaid MCO - Evaluation and Management	18A1. Medicaid MCO - Evaluation and Management -- ACA Section 1202 - Services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System. 100% Federal Share Matching.
18A2	Medicaid MCO - Vaccine codes	18A2. Medicaid MCO - Vaccine codes -- ACA Section 1202 - Services related to immunization administration for vaccines and toxoids for which CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 (as subsequently modified) apply under such system. 100% Federal Share matching rate

Line	Line - Form Display	Line - Definition
18A3	Medicaid MCO - Community First Choice	18A3. Medicaid MCO - Community First Choice -- 6% FMAP rate for Total Computable entered at the FMAP Federal Share rate. ACA Section 2401 - The provision established a new Medicaid State Plan option effective October 1, 2011 to allow States to cover HCBS and supports for individuals with incomes not exceeding 150 percent of the FPL, or, if greater, who have been determined to require an institutional level of care. States are provided an additional 6% increase in the FMAP matching funds for services and supports provided to such individuals.
18A4	Medicaid MCO - Preventive Services Grade A OR B, ACIP Vaccines and their Admin	18A4. Medicaid MCO - Preventive Services Grade A or B, ACIP Vaccines and their Admin -- 1% FMAP rate for Total Computable entered at the FMAP Federal Share rate. As a result of ACA 4106 Any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force. States get the 1% additional FMAP upon an approved SPA. Effective January 1, 2013
18B1	Prepaid Ambulatory Health Plan	A Prepaid Ambulatory Health Plan (PAHP) means an entity that provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates. A PAHP does not provide or arrange for the provision of any inpatient hospital or institutional services for its enrollees, and does not have a comprehensive risk contract. NOTE: Include dental, mental health, transportation and other plans covering limited services (without inpatient hospital or institutional services) under PAHP.
18B1a	MCO PAHP - Evaluation and Management	18B1a. MCO PAHP - Evaluation and Management -- ACA Section 1202 - Services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System. 100% Federal Share Matching.
18B1b	MCO PAHP - Vaccine codes	18B1b. MCO PAHP - Vaccine codes -- ACA Section 1202 - Services related to immunization administration for vaccines and toxoids for which CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 (as subsequently modified) apply under such system. 100% Federal Share matching rate
18B1c	MCO PAHP - Community First Choice	18B1c. MCO PAHP - Community First Choice -- 6% FMAP rate for Total Computable entered at the FMAP Federal Share rate. ACA Section 2401 - The provision established a new Medicaid State Plan option effective October 1, 2011 to allow States to cover HCBS and supports for individuals with incomes not exceeding 150 percent of the FPL, or, if greater, who have been determined to require an institutional level of care. States are provided an additional 6% increase in the FMAP matching funds for services and supports provided to such individuals.
18B1d	MCO PAHP - Preventive Services Grade A OR B, ACIP Vaccines and their Admin	18B1d. MCO PAHP. Preventive Services Grade A OR B, ACIP Vaccines and their Admin -- 1% FMAP rate for Total Computable entered at the FMAP Federal Share rate. As a result of ACA 4106 Any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force. States get the 1% additional FMAP upon an approved SPA. Effective January 1,

Line	Line - Form Display	Line - Definition
18B2	Prepaid Inpatient Health Plan	A Prepaid Inpatient Health Plan (PIHP) means an entity that provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates. A PIHP provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees. A PIHP does not have a comprehensive risk contract. NOTE: Include dental, mental health, transportation and other plans covering limited services (with inpatient hospital or institutional services) under PIHP.
18B2a	MCO PIHP - Evaluation and Management	18B2a. MCO PIHP - Evaluation and Management -- ACA Section 1202 - Services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System. 100% Federal Share Matching.
18B2b	MCO PIHP - Vaccine codes	18B2b. MCO PIHP - Vaccine codes -- ACA Section 1202 - Services related to immunization administration for vaccines and toxoids for which CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 (as subsequently modified) apply under such system. 100% Federal Share matching rate
18B2c	MCO PIHP - Community First Choice	18B2c. MCO PIHP - Community First Choice -- 6% FMAP rate for Total Computable entered at the FMAP Federal Share rate. ACA Section 2401 - The provision establishes a new Medicaid State Plan option effective October 1, 2011 to allow States to cover HCBS and supports for individuals with incomes not exceeding 150 percent of the FPL, or, if greater, who have been determined to require an institutional level of care. States are provided an additional 6% increase in the FMAP matching funds for services and supports provided to such individuals.
18B2d	MCO PIHP - Preventive Services Grade A OR B, ACIP Vaccines and their Admin	18B2d. MCO PIHP. Preventive Services Grade A OR B, ACIP Vaccines and their Admin -- 1% FMAP rate for Total Computable entered at the FMAP Federal Share rate. As a result of ACA 4106 Any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force. States get the 1% additional FMAP upon an approved SPA. Effective January 1,
18C	Medicaid - Group Health	18C. Group Health Plan Payments-- Include payments for premiums for cost effective employer group health insurance under §1906 of the Act.
18D	Medicaid - Coinsurance	18D. Coinsurance and Deductibles-- Include payments for coinsurance and deductibles for cost employer group health insurance under §1906 of the Act.
18E	Medicaid - Other	18E. Other--Include premiums paid for other insurance for medical or any other type of remedial care in order to maintain a third party resource under §1905(a). (Report expenditures here only if you have elected to pay these premiums in item 3.2(a)(2) on page 29b of your State Plan Preprint.) EXCEPTION: REPORT ALL OTHER PREGNANCY-RELATED PROCEDURES ON LINE 14.
19A	Home & Community-Based Services - Reg. Pay. (Waiv)	19A. Home and Community-Based Services (See 42 CFR 440.180.(a).).--These are services furnished under a 1915(c) waiver approved under the provisions in 42 CFR 441, Subpart G (Home and Community-Based Services; Waiver Requirements). NOTE: Report only approved waiver services as designated in the State's approved waiver applications which are provided to eligible waiver recipients.

Line	Line - Form Display	Line - Definition
19B	Home & Community-Based Services - St. Plan 1915(i) Only Pay.	19B. - Other Practitioners Services - State Plan 1915(i) Only Payment. Only the home and community based services elected and defined in the approved State plan may be claimed on this line and form. Enter cost data on the lines in the pop-up feeder sheet that match the services approved in the State plan.
19C	Home & Community-Based Services - St. Plan 1915(j) Only Pay.	19C Home and Community Based Services – State Plan 1915(j) Only Payment – 42 CFR Part 441 – Self-Directed Personal Assistance Services Program State Plan Option. These are PAS services provided under the self-directed service delivery model authorized by 1915(j) including any approved home and community-based services otherwise available under a 1915(c) waiver. The MBES will automatically enter in row 19C the totals from the pop-up 1915(j) Self-Directed Personal Assistance Services Feeder Form. Expenditures for 1915(c) waiver like services provided under 1915(j) Self Direction are entered on the line 19C Feeder Form rather than on the Line 19A Waiver Form which is reserved for approved waiver expenditures. NOTE: 1915(j) services that are using the self-directed service delivery model for State Plan Personal Care and related services should be claimed separately on Line 23B.
19D	Home & Community Based Services State Plan 1915(k) Community First Choice	19D Home and Community Based Services State Plan 1915(k) Community First Choice ACA Section 2401 - The provision established a new Medicaid State Plan option effective October 1, 2011 to allow States to cover HCBS and supports for individuals with incomes not exceeding 150 percent of the FPL, or, if greater, who have been determined to require an institutional level of care. States are provided an additional 6% increase in the FMAP matching funds for services and supports provided to such individuals.
22	All-Inclusive Care Elderly	22. Programs of All-Inclusive Care for the Elderly (PACE)(See 42 CFR Part 460).--PACE provides pre-paid, capitated, comprehensive health care services designed to enhance the quality of life and autonomy for frail, older adults. Required services (See 42 CFR 460.92) The PACE benefit package for all participants, must include: (a) All Medicaid-covered services, as specified in the State's approved Medicaid plan. NOTE: This is an option within the Medicaid Program to establish Programs of All-Inclusive Care for the Elderly beginning August 5, 1998. (See §1905(a)(26) and §1934 of the Act.) Do not report payments for PACE programs which continue to operate under §1115 authority on this line. Report payments for PACE programs continuing to operate under §1115 waiver authority on the appropriate waiver forms under the appropriate categories of services.

Line	Line - Form Display	Line - Definition
23A	Personal Care Services - Reg. Payments	23A. - Personal Care Services.--Regular Payment.-- (See 42 CFR 440.167).--Unless defined differently by a State agency for purposes of a waiver granted under Part 441, subpart G of this chapter Personal care services means services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or institution for mental health conditions that are-- (1) 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; (2) Provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and (3) Furnished in a home, and at the State's option in another location.
23B	Personal Care Services - SDS 1915(j)	23B. - Personal Care Services.--SDS 1915(j).-- (See 42 CFR Part 441).-- Self-Directed Personal Assistance Services (PAS) State Plan Option. These are PAS provided under the self-directed service delivery model authorized by 1915(j) for State plan personal care and related services. NOTE: 1915(j) PAS that are using the self-directed service delivery model for section 1915(c) home and community-based services should be claimed separately on line 19C.
24A	Targeted Case Management Services - Com. Case-Man.	24A. - Targeted Case Management Services (see section 1915(g)(1) of the Social Security Act) are case management services that are furnished without regard to the requirements of section 1902(a)(1) and section 1902(a)(10)(B) to specific classes of individuals or to individuals who reside in specified areas. Case management services means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services (See section 1915(g)(2) of the Act).
24B	Case Management - State Wide	24B. - Case Management.--State Wide.-- (See §1915(g)(2) of the Act.).--These are services that assist individuals eligible under the State plan in gaining access to needed medical, social, educational and other services. The agency must permit individuals to freely choose any qualified Medicaid provider when obtaining case management services in accordance with 42 CFR 431.51.
25	Primary Care Case Management	25. Primary Care Case Management Services (PCCM) (See §1905(a)(25) and §1905 (t)--These are case-management related services (including locating, coordinating, and monitoring of health care services) provided by a primary care case manager under a primary care case management contract. Currently most PCCM programs pay the primary care case manager a monthly case management fee. Report service costs and/or related fees on this line. Report other service costs and/or related fees on the appropriate type of service line. NOTE: Where the fee includes services beyond case management, report the fees under line 18B.

Line	Line - Form Display	Line - Definition
26	Hospice Benefits	26 - Hospice Benefits (See Section 1905(o)(1)(A) of the Act.).--The care described in section 1861(dd)(1) furnished by a hospice program (as defined in section 1861(dd)(2)) to a terminally ill individual who has voluntarily elected to have payment made for hospice care instead of having payment made for certain benefits described under 1812(d)(2)(A) and for which payment may otherwise be made under Title XVIII and intermediate care facility services under the plan. Hospice care may be provided to an individual while such individual is a resident of a skilled nursing facility or intermediate care facility, but the only payment made under the State plan shall be for the hospice care. NOTE: These are services that are: • Covered in 42 CFR 418.202; • 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; • Furnished under a written plan that is established and periodically reviewed by: • The attending physician; • The medical director of the program, as described in 42 CFR 418.54; or • The interdisciplinary group described in 42 CFR 418.68.
27	Emergency Services for Undocumented Aliens	27. Emergency Services Undocumented Aliens Pursuant to the Act The Medicaid program pays for emergency medical services provided to certain aliens. Section §1903(v) of the Act sates that "…no payment may be made to a State under this section for medical assistance furnished to an alien who is not lawfully admitted… "The only exception is if such care and services are for 1) an emergency medical condition, 2) if such alien otherwise meets the eligibility requirements for medical assistance under the State Plan, and 3) such care and services are not related to an organ transplant procedure.
28	Federally-Qualified Health Center	28. Federally-Qualified Health Center (FQHC) (See §1905(a)(2) of the Act.) -- These are services performed by facilities or programs more commonly known as Community Health Centers, Migrant Health Centers, and Health Care for the Homeless Programs. FQHCs qualify to provide covered services under Medicaid if: • They receive grants under §§329, 330, or 340 of the Public Health Service (PHS) Act; • 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.

Line	Line - Form Display	Line - Definition
29	Non-Emergency Medical Transportation	29. - Non-Emergency Medical Transportation (see 42CFR431.53; 440.170; 440.170(a); 440.170(a)(4))--A ride, or reimbursement for a ride, provided so that a Medicaid beneficiary with no other transportation resources can receive services from a medical provider. (NEMT does not include transportation provided on an emergency basis, such as trips to the emergency room for life-threatening situations. NOTE: Transportation provided via the State is consider an administrative cost and should be reported on the form CMS-64.10.
30	Physical Therapy	30. - Physical Therapy (See 42CFR440.110(a)(1)).--Services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified physical therapist. It includes any necessary supplies and equipment. NOTE: Do not include any costs for physical therapy services provided under the school based environment. Those costs should be reported on the pop-up feeder form for Line 39 below. NOTE: Do not include any costs for physical therapy services provided under the rehabilitative services option. Those costs should be reported on the pop-up feeder form for Line 40 below.
31	Occupational Therapy	31. - Occupational Therapy (see 42CFR440.110(b))--Occupational therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified occupational therapist. It includes any necessary supplies and equipment. NOTE: Do not include any costs for occupational therapy services provided under the school based environment. Those costs should be reported on the pop-up feeder form for Line 39 below. NOTE: Do not include any costs for occupational therapy services provided under the rehabilitative services option. Those costs should be reported on the pop-up feeder form for Line 40 below.
32	Services for Speech, Hearing & Language	32. - Services for Speech, Hearing and Language--Services for individuals with speech, hearing, and language disorders (See 42CFR440.110(c)). Services for individuals with speech, hearing, and language disorders means diagnostic, screening, preventive, or correction services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. It includes any necessary supplies and equipment, including hearing aids. NOTE: Do not include any costs for speech and language services provided under the school based environment. Those costs should be reported on the pop-up feeder form for Line 39 below. NOTE: Do not include any costs for speech / language therapy services provided under the rehabilitative services option. Those costs should be reported on the pop-up feeder form for Line 40 below. . It includes any necessary supplies and equipment.

Line	Line - Form Display	Line - Definition
33	Prosthetic Devices, Dentures, Eyeglasses	Line 33 - Prosthetic Devices, Dentures, Eyeglasses (See 42 CFR 440.120) Prosthetic devises means replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner to: 1. Artificially replace a missing portion of the body; 2. Prevent or correct physical deformity or malfunction; 3. Support a weak or deformed portion of the body. Dentures are artificial structures made by or under the direction of a dentist to replace a full or partial set of teeth. Eyeglasses means lenses, including frames, and other aids to vision prescribed by a physician skilled in diseases of the eye or an optometrist.
34	Diagnostic Screening & Preventive Services	34. - Diagnostic Screening & Preventive Services (see 42CFR440.130) (a) "Diagnostic services", except as otherwise provided under this subpart, includes any medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law, to enable him to identify the existence, nature, or extent of illness, injury, or other health deviation in a recipient. (b) "Screening services" means the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases. (c) "Preventive services" means services provided by a physician or other licensed practitioner of the healing arts within the scope of his practice under State law to: (1) Prevent disease, disability, and other health conditions or their progression; (2) Prolong life; and (3) Promote physical and mental health and efficiency. NOTE: This does not include Rehabilitative services - those services are reported on the pop-up feeder sheet for line 40 below.
34A	Preventive Services Grade A OR B, ACIP Vaccines and their Admin	34A. Preventive Services Grade A OR B, ACIP Vaccines and their Admin -- 1% FMAP rate for Total Computable entered at the FMAP Federal Share rate. As a result of ACA 4106- Any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force. States get the 1% additional FMAP upon an approved SPA. Effective January 1, 2013
35	Nurse Mid-Wife	Line 35 - Nurse Mid-Wife (See 42 CFR 440.165) "Nurse-midwife services" means services that are furnished within the scope or practice authorized by State law or regulation and, in the case of inpatient or outpatient hospital services or clinic services, are furnished by or under the direction of a nurse mid-wife to the extent permitted by the facility. Unless required by required by State law or regulations or a facility, are reimbursed without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider. See 42 CFR 441.21 for provisions on independent provider agreements for nurse-midwives.

Line	Line - Form Display	Line - Definition
36	Emergency Hospital Services	36. - Emergency Hospital Services (See 42 CFR 440.170) Emergency hospital services means services that: 1. Are necessary to prevent the death or serious impairment of the health of the recipient; and 2. Because of the threat to the life or health of the recipient necessitate the use of the most accessible hospital available that is equipped to furnish the services, even if the hospital does not currently meet- (i) The conditions for participation under Medicare; or (ii) The definitions of inpatient or outpatient hospital services under 42 CFR 440.10 and 440.20. NOTE: Emergency health services provided to undocumented aliens and funded under an allotment established under §4723 of the Balanced Budget Act of 1997 P.L. 105-33 should be reported on Line 27.
37	Critical Access Hospitals	Line 37 - Critical Access Hospitals (See 42 CFR 440.170) -- Critical access hospital services that are furnished by a provider that meet the requirements for participation in Medicare as a CAH (see subpart F of 42 CFR part 485), and (ii) are of a type that would be paid for by Medicare when furnished to a Medicare beneficiary. Inpatient CAH services do not include nursing facility services furnished by a CAH with a swing-bed approval.
38	Nurse Practitioner Services	Line 38 - Nurse Practitioner Services (See 42 CFR 440.166) Nurse practitioner services means services that are furnished by a registered professional nurse who meets a 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. See 42 CFR 440.166 for requirements related to certified pediatric nurse practitioner and certified family nurse practitioner.
39	School Based Services	39. - School Based Services (See section 1903(c) of the Act)--These services include medical assistance for covered services (see section 1905(a)) furnished to a child with a disability because such services are included in the child's individualized educational program established pursuant to Part B of the Individuals with Disabilities Education Act or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan.
40	Rehabilitative Services (non-school-based)	40. - Rehabilitative Services (non-school-based) (see 42CFR440.130(d))--Except as otherwise provided under this subpart, rehabilitative services includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, with the scope of his practice under State law, for maximum reduction of physical or mental health condition and restoration of a recipient to his best possible functional level. NOTE: Do not include any costs for rehabilitative services provided under the school based environment which should be reported on Line 39.

Line	Line - Form Display	Line - Definition
41	Private Duty Nursing	41. - Private Duty Nursing (see 42CFR440.80)--Nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility. These services are provided: (a) by a registered nurse or a licensed practical nurse; (b) under the direction of the recipient's physician ; and (c) to a recipient in one or more of the following locations at the option of the State: (1) his or her own home; (2) a hospital; or (3) a skilled nursing facility.
42	Freestanding Birth Center	Line 42 - Freestanding Birth Center --COVERAGE FOR FREESTANDING BIRTH CENTER SERVICES Section 2301 of the Affordable Care Act amended section 1905(a) of the Social Security Act (the Act) to provide coverage for freestanding birth center services, as defined in section 1905(l)(3)(A) of the Act. In that provision, the benefit is defined as services furnished at a freestanding birth center, which is defined in new subparagraph 1905(l)(3)(B) as a health facility: • that is not a hospital; • where childbirth is planned to occur away from the pregnant woman's residence; • that is licensed or otherwise approved by the State to provide prenatal, labor and delivery, or postpartum care and other ambulatory services included in the State plan; and • that must comply with a State's requirements relating to the health and safety of individuals receiving services delivered by the facility. In addition to payment for freestanding birth center facilities, section 1905(l)(3)(C) of the Act requires separate payment for the services furnished by practitioners providing prenatal, labor and delivery, or postpartum care in a freestanding birth center facility, such as nurse midwives and birth attendants. Payment must be made to these practitioners directly, regardless of whether the individual is under the supervision of, or associated with, a physician or other health care provider. It is important to note that section 2301 of the Affordable Care Act does not require States to license or otherwise recognize freestanding birth centers or practitioners who provide services in these facilities if they do not already do so. Coverage and payment are limited to only those facilities and practitioners licensed or otherwise recognized under State law.

Line	Line - Form Display	Line - Definition
42	Freestanding Birth Center	Prior to passage of the Affordable Care Act, only nurse midwife services were mandatory services under section 1905(a)(17) of the Act and implementing regulations at 42 CFR 440.165. In addition, States had the option to cover the services of other practitioners who are licensed by the State to provide midwifery services such as Certified Professional Midwives (CPM) under section 1905(a)(6) of the Act and implementing regulations at 42 CFR 440.60. These practitioner services are now mandatory when provided in a freestanding birth center as defined above. Further, other practitioner services, such as those furnished by so-called direct entry or lay midwives or birth attendants, who are not licensed but are recognized under State law to provide these services, are now required to be covered when provided in the freestanding birth center. Submission of State Plan Amendments These provisions became effective with the enactment of the Affordable Care Act, beginning March 23, 2010. To implement these provisions, States will need to submit amendments to their State plans that specify coverage and separate reimbursement of freestanding birth center facility services and professional services. Unless the compliance exception discussed below applies, or the State does not license or otherwise recognize freestanding birth centers or practitioners who provide services in these facilities, States must submit a State plan amendment (SPA) not later than the end of the next calendar quarter that follows the date of this guidance. In accordance with section 2301(c) of the Affordable Care Act, States that require State legislation (other than appropriation legislation) to meet the new requirements related to their Medicaid coverage of freestanding birth center services will not be regarded as out of compliance with the standards governing this coverage option as long as they come into compliance not later than the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of the Affordable Care Act. For example, if the next regular legislative session beginning after March 23, 2010, is from January 1 through April 30, 2011, then the State would have until September 30, 2011, to submit the required SPA with an effective date of July 1, 2011. In the case of the State that has a 2-year legislative session, each year is treated as a separate regular session of the State legislature. For example, if a legislature is in session from January 1, 2010, through December 31, 2012, then the State would have until March 31, 2011, to submit a SPA with an effective date that is no later than January 1, 2011. A State should promptly notify its CMS regional office if this compliance exception is applicable.
43	Health Home for Enrollees w Chronic Conditions	43. Health Home for Enrollees w Chronic Conditions - Health Home services which includes - Comprehensive care Management - Care Coordination - Health promotion - Comprehensive transitional care (Planning and coordination) - Individual and Family Support - Referral to community/social supports - Use of Health Information Technology to link services as feasible and appropriate
44	Tobacco Cessation for Pregnant Women	44. Tobacco Cessation for Preg Women - ACA Section 4107 Payments for tobacco cessation counseling services for pregnant women and smoking/tobacco cessation outpatient drugs for pregnant women.

Line	Line - Form Display	Line - Definition
49	Other Care Services	49 -- Other Care Services --These are any medical or remedial care services recognized under State law and authorized by the approved Medicaid State Plan. Such services do not meet the definition of, and are not classified under, any category of service included on Lines 1 through 41.

Appendix J: MBES CBES Category of Service Line Definitions for the 21 Form

Line	Line - Form Display	Line - Definition
1A	Premiums - Up To 150%: Gross Premiums Paid	Line 1.A. Gross Premiums Paid.--Report on line 1.A. the amount of expenditures related to premiums paid for children whose family income is up to 150 percent of the Federal poverty level. Use the definition as contained in Part 2 Section 2500.2.E., lines 18.A. -18.E. (Medicaid Health Insurance Payments-Health Maintenance Organizations (HMO), Health Insuring Organization (HIO), Prepaid Health Plans (PHP), Group Health Plan Payments, and Other, respectively) of the State Medicaid Manual. Remember to report the total amount of the premiums. DO NOT NET THE OFFSETS WITH THE PREMIUMS. For example, it costs the State 500 per month per person and there are 100 people under this plan. Assume that the state receives $20 from one of the individuals covered for his share of the cost. Report $50,000 (500 x 100) on Line 1.A. and $20 on Line 1.B.
1B	Premiums - Up To 150%: Cost Sharing Offset	Line 1.B. Cost Sharing Offsets.--Report any cost sharing offset amounts received with respect to the amounts reported on Line 1.A. for children whose family income is up to 150 percent of the Federal poverty level. As indicated above, for line 1.A, the cost sharing offset amounts relate to the expenditures reported on line 1.A. should be reported separately on line 1.B.
1C	I Premiums - Over 150%: Gross Premiums Paid	Line 1.C. Gross Premiums Paid.--For children above 150% of poverty, premiums may be imposed on a sliding scale related to family income. Use the definition as contained in Part 2 Section 2500.2.E., lines 18.A. -.18.E (Medicaid Health Insurance Payments-Health Maintenance Organizations (HMO), Health Insuring Organization (HIO), Prepaid Health Plans (PHP), Group Health Plan Payments, and Other, respectively) of the State Medicaid Manual. DO NOT NET THE OFFSETS WITH THE PREMIUMS For an example see item 1.A.

Line	Line - Form Display	Line - Definition
1D	Premiums - Over 150%: Cost Sharing Offset	Line 1.D. Cost Sharing Offsets.--Report any cost sharing offset amounts received with respect to the amounts reported on line 1.C. for children whose family income is above 150 percent of the Federal poverty level. As indicated above for line 1.A, the cost sharing offset amounts related to the expenditures reported on line 1.A. should be reported separately on line 1.B. NOTE: Line items 1.A. - D. above relate to capitated payments on behalf of CHIP recipients in Managed Care Arrangements. Do not breakout out the amounts reported on lines 1.A.- 1.D. in lines 2 - 26 below, as they relate to expenditures for CHIP recipients in Fee-For-Service Plans.
2	Inpatient Hospital	Line 2. Inpatient Hospital Services - Regular Payments.--Use the definition as contained in Part 2 Section 2500.2.E., line 1.A. (Inpatient Hospital Services - Regular Payments) of the State Medicaid Manual.
3	Inpatient Mental Health	Line 3. Inpatient Mental Health Facility Services - Regular Payments.---Use the definition as contained in Part 2 Section 2500.2.E., line 2.A. (Mental Health Facility Services-Regular Payments) of the State Medicaid Manual.
4	Nursing Care Services	Line 4. Nursing Care Services. - (Other than services in an institution for mental health conditions).---Use the definition as contained in Part 2 Section 2500.2.E., line 29 paragraph g., (Other Care Services- nurse midwife services), of the State Medicaid Manual.
5	Physician/Surgical	Line 5. Physician and Surgical Services.--Use the definition as contained in Part 2 Section 2500.2.E., line 5. (Physicians' Services) of the State Medicaid Manual.
6	Outpatient Hospital	Line 6. Outpatient Hospital Services. .-:-Use the definition as contained in Part 2 Section 2500.2.E., line 6. (Outpatient Hospital Services) of the State Medicaid Manual for services related to non-mental health facilities which are reported on line 7 below.
7	Outpatient Mental Health	Line 7. Outpatient Mental Health Facility Services.---Use the definition as contained in Part 2 Section 2500.2.E., line 6 (Outpatient Hospital Services) of the State Medicaid Manual for services related to mental health facilities only.
8	Prescribed Drugs	Line 8. Prescribed Drugs.--Use the definition as contained in Part 2 Section 2500.2.E., line 7. (Prescribed Drugs) of the State Medicaid Manual.
8A	Drug Rebate	8.A.1. Drug Rebate Offset.--This is a refund from the manufacturer for single source drugs, innovator multiple source drugs, and non-innovator multiple source drugs.

Line	Line - Form Display	Line - Definition
9	Dental Services	Line 9. Dental Services..--Use the definition as contained in Part 2 Section 2500.2.E., lines 8 (Dental Services) and 29 paragraph e. (Other Care Services-Dentures) of the State Medicaid Manual
10	Vision Services	Line 10. Vision Services...--Use the definition as contained in Part 2 Section 2500.2.E., line 29 paragraph e., (Other Care Services-eyeglasses) of the State Medicaid Manual.
11	Other Practitioners	Line 11. Other Practitioners' Services.---Use the definition as contained in Part 2 Section 2500.2.E., lines 9. (Other Practitioners' Services) and 29 paragraph f. (Other Care Services--diagnostic, screening, rehabilitative, and preventive services) of the State Medicaid Manual.
12	Clinic Services	Line 12. Clinic Services..--Use the definition as contained in Part 2 Section 2500.2.E., lines 10.(Clinic Services) and 16. (Rural Health Clinic Services) of the State Medicaid Manual.
13	Therapy Services	Line 13. Therapy Services..---Use the definition as contained in Part 2 Section 2500.2.E., line 29 (Other Care Services) paragraphs b. (Physical Therapy), c. (Occupational Therapy), and d. (Services for individuals with speech, hearing, and language disorders) of the State Medicaid Manual.
14	Laboratory/Radiological	Line 14. Laboratory And Radiological Services..--Use the definition as contained in Part 2 Section 2500.2.E., line 11. (Laboratory and Radiological Services of the State Medicaid Manual.
15	Medical Equipment	Line 15. Durable and Disposable Medical Equipment.-Use the definition as contained in Part 2 Section 2500.2.E., line 29. paragraph e. (Other Care Services-prosthetic devices) of the State Medicaid Manual
16	Family Planning	Line 16.Family Planning..--On the Form HCFA-64.21 series, the reporting on the family planning line 16 is blocked. This is because of the way family planning services are treated with respect to the available FMAP rate and the application of payments against the States' FY CHIP allotments (refer to SMM §2500.9.I.1. and .2).
17	Other Pregnancy-related Procedures	Line 17. Other Pregnancy-related Procedures .--Use the definition as contained in Part 2 Section 2500.2.E., line 14 of the State Medicaid Manual.
18	Screening Services	Line 18. Screening Services.--Use the definition as contained in Part 2 Section 2500.2.E., line 15. (EPSDT Screening Services) of the State Medicaid Manual.
19	Home Health	Line 19. Home Health Services. ---Use the definition as contained in Part 2 Section 2500.2.E., line 12. (Home Health Services) of the State Medicaid Manual.

Line	Line - Form Display	Line - Definition
20	Health Services Initiatives	Line 20. Health Services Initiatives States may use funds available under their 10 percent administrative cap to fund Health Service Initiatives (HSIs). An HSI is an activity that protects public health, protects the health of individuals, improves or promotes a state's capacity to deliver public health services, or strengthens the human and material resources necessary to accomplish public health goals relating to improving the health of children, including targeted low-income children and other low-income children. States are not limited in the number of different HSIs they may fund, as long as the state ensures that title XXI funding, within the state's 10 percent limit, is sufficient to continue the proper administration of the CHIP program. If such funds become less than sufficient, the state agrees to redirect title XXI funds from the support of HSIs to the administration of the CHIP program.
21	Home and Community	Line 21. Home and Community-Based Services. ---Use the definition as contained in Part 2 Section 2500.2.E., lines 19. (Home and Community-Based Services) and 23. (Personal Care Services) of the State Medicaid Manual.
22	Hospice	Line 22. Hospice Care Services.--Use the definition as contained in Part 2 Section 2500.2.E., line 26. (Hospice Benefits) of the State Medicaid Manual.
23	Medical Transportation	Line 23. Medical Transportation Services.--Use the definition as contained in Part 2 Section 2500.2.E., line 29 paragraph a. (Other Care Services-Transportation) of the State Medicaid Manual.
24	Case Management	Line 24. Case Management Services.--Use the definition as contained in Part 2 Section 2500.2.E., lines 24. (Targeted Case Management Services) and 25 (Primary Care Case Management Services) of the State Medicaid Manual.
25	Translation and Interpretation	Line 25. Translation and Interpretation (Section 201 CHIPRA) Translation may be allowable as an administrative activity if it is not included and paid for as part of a direct medical service and if it is necessary for the proper and efficient administration of the State plan. However, in order for translation to be claimable as administration, it must be provided either by separate units or separate employees performing solely translation activities and it must facilitate access
31	Other Services	Line 31. Other Services
32	Outreach	Outreach Amounts reported on this line should NOT include any amounts reported on Lines 32A or 32B

Line	Line - Form Display	Line - Definition
32A	Increased Outreach and Enrollment of Indians	Line 32.A - Increased Outreach and Enrollment of Indians (Section 202 CHIPRA))--Enter in Column (a) the total computable amount of expenditures for the Increased Outreach and Enrollment of Indians The MBES will automatically calculate the Federal Share in Columns (b) and (e) at the CHIP rate. These expenditures are NOT applicable to the 10% limit on Outreach and Certain other expenditures. Amounts reported on this line should NOT include any amounts reported on Lines 32 or 32B
32B	Increase outreach and enrollment of children through premium subsidies	Line 32.B - Increase Outreach and Enrollment of children through premium subsidies Amounts reported on this line should NOT include any amounts reported on Lines 32 or 32A
33	Administration	Line 33. Administration. (section 2105(a)(2)(D) of the Act).--Enter the amount of other reasonable costs incurred by the State to administer the plan. NOTE: All of these administrative activities are subject to the 10 percent limit and must be entered in Column(c). See Section 2115 K above for a discussion of administrative costs and Section 2115 J above for a discussion of the 10 percent limit.
34	PERM Administration	Line 34 - PERM Administration - (Section 601 CHIPRA)--Enter in Column (a) the total computable amount of expenditures for the administration of PERM. The MBES will automatically enter in Columns (b) and (e) 90 percent of the amount reported in Column (a).
35	Citizenship Verification Technology CHIPRA	Line 35. Citizenship Verification Technology- (Section 211 CHIPRA)
35A	CVT Development	Line 35A. CVT Development: (Section 211 CHIPRA)--Enter in Column (a) the total computable amount of expenditures for the design, development, or installation of Citizenship Verification technology. The MBES will automatically enter in Columns (b) and (e) 90 percent of the amount reported in Column (a).
35B	CVT Operation	Line 35B. CVT Operation (Section 211 CHIPRA)--Enter in Column (a) the total computable amount of expenditures for the operation of Citizenship Verification technology. The MBES will automatically enter in Columns (b) and (e) 75 percent of the amount reported in Column (a).

Appendix K: Crosswalk of T-MSIS to MSIS Type of Service Values

MSIS Code Definitions	MSIS Valid Values	T-MSIS 2.1 Valid Values	T-MSIS v2.1 Code Definitions
Inpatient Hospital	01	001	Inpatient hospital services, other than services in an institution for mental diseases
Inpatient Hospital	01	090	Critical access hospital services – IP
Inpatient Hospital	01	091	Skilled care – hospital residing
Inpatient Hospital	01	092	Exceptional care – hospital residing
Inpatient Hospital	01	093	Non-acute care – hospital residing
Mental Health Hospital Services for the Aged	02	044	Inpatient hospital services for individuals age 65 or older in institutions for mental diseases
Mental Health Hospital Services for the Aged	02	045	Nursing facility services for individuals age 65 or older in institutions for mental diseases
Disproportionate Share Hospital (DSH)	03	123	Disproportionate share hospital (DSH) payments
Inpatient Psychiatric Facility Services for Individuals Age 21 Years and Under	04	048	Inpatient psychiatric services for individuals under age 21
ICF Services for Individuals with Mental Health Condition	05	046	Intermediate care facility (ICF/IIDICF/IID) services
NF'S - All Other	07	009	Nursing facility services for individuals age 21 or older (other than services in an institution for mental disease)
NF'S - All Other	07	047	Nursing facility services, other than in institutions for mental diseases
NF'S - All Other	07	059	Skilled nursing facility services for individuals under age 21
Physicians	08	012	Physicians' services
Physicians	08	042	Well-baby and well-child care services as defined by the State.
Dental	09	029	Dental Services
Dental	09	013	Medical and surgical services of a dentist
Other Practitioners	10	015	Medical or other remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under State law
Other Practitioners	10	010	Early and periodic screening and diagnosis and treatment (EPSDT) services
Outpatient Hospital	11	002	Outpatient hospital services
Outpatient Hospital	11	061	Critical access hospital services – OT
Clinic	12	028	Clinic services
Clinic	12	041	Preventive Services

MSIS Code Definitions	MSIS Valid Values	T-MSIS 2.1 Valid Values	T-MSIS v2.1 Code Definitions
Clinic	12	014	Outpatient substance abuse treatment services.
Clinic	12	003	Rural health clinic services
Home Health	13	016	Home health services - Nursing services
Home Health	13	017	Home health services - Home health aide services
Home Health	13	018	Home health services - Medical supplies, equipment, and appliances suitable for use in the home
Home Health	13	019	Home health services - Physical therapy provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services
Home Health	13	020	Home health services - Occupational therapy provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services
Home Health	13	021	Home health services - Speech pathology and audiology services provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services
Lab and X-Ray	15	005	Professional laboratory services, Technical laboratory services
Lab and X-Ray	15	006	Technical laboratory services
Lab and X-Ray	15	007	Professional radiological services
Lab and X-Ray	15	008	Technical radiological services
Prescribed Drugs	16	033	Prescribed drugs
Prescribed Drugs	16	033	Over-the-counter medications.
Prescribed Drugs	16	036	Medical Equipment/Prosthetic devices
Prescribed Drugs	16	131	Drug Rebates
Other Services	19	064	HCBS - Home health aide services
Other Services	19	035	Dentures
Other Services	19	037	Eyeglasses
Other Services	19	062	HCBS - Case management services
Other Services	19	063	HCBS - Homemaker services
Other Services	19	065	HCBS - Personal care services
Other Services	19	066	HCBS - Adult day health services
Other Services	19	067	HCBS - Habilitation services
Other Services	19	068	HCBS - Respite care services
Other Services	19	069	HCBS - Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness
Other Services	19	073	HCBS - Other services requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization
Other Services	19	074	HCBS - Expanded habilitation services - Prevocational services

MSIS Code Definitions	MSIS Valid Values	T-MSIS 2.1 Valid Values	T-MSIS v2.1 Code Definitions
Other Services	19	075	HCBS - Expanded habilitation services - Educational services
Other Services	19	076	HCBS - Expanded habilitation services - Supported employment services, which facilitate paid employment
Other Services	19	077	HCBS-65-plus - Case management services
Other Services	19	078	HCBS-65-plus - Homemaker services
Other Services	19	079	HCBS-65-plus - Home health aide services
Other Services	19	080	HCBS-65-plus - Personal care services
Other Services	19	081	HCBS-65-plus - Adult day health services
Other Services	19	082	HCBS-65-plus - Respite care services
Other Services	19	083	HCBS-65-plus - Other medical and social services
Other Services	19	034	Over-the-counter medications.
Other Services	19	039	Diagnostic services
Other Services	19	040	Screening services
Other Services	19	050	Inpatient substance abuse treatment services and residential substance abuse treatment services.
Other Services	19	057	Enabling services
Other Services	19	060	Emergency hospital services
Other Services	19	071	HCBS - Training for family members
Other Services	19	072	HCBS - Minor modification to the home
Other Services	19	085	Prenatal care and pre-pregnancy family planning services and supplies.
Other Services	19	088	Any other health care services or items specified by the Secretary and not excluded under regulations.
Other Services	19	089	Disposable medical supplies.
Other Services	19	135	EHR payments to provider
Capitated Payment s to HMO, HIO or PACE Plan	20	119	Capitated payments to HMOs, HIOs, or PACE plans
Capitated Payments to Prepaid Health Plans (PHPs)	21	122	Capitated payments to prepaid health plans (PHPs)
Capitated Payments for Primary Care Case Management (PCCM)	22	120	Capitated payments for primary care case management (PCCM)
Capitated Payments for Private Health Insurance	23	121	Premium payments for private health insurance
Sterilizations	24	084	Sterilizations
Other Pregnancy-related Procedures	25	086	Other Pregnancy-related Procedures
Transportation Services	26	056	Transportation services
Personal Care Services	30	051	Personal care services
Targeted Case Management	31	053	Targeted case management services
Targeted Case Management	31	052	Primary care case management services
Targeted Case Management	31	054	Case Management services other than those that meet the definition of primary care case management services or targeted case management services
Targeted Case Management	31	055	Care coordination services
Rehabilitation Services	33	043	Rehabilitative services
PT, OT, Speech, Hearing Language	34	030	Physical therapy services (when not provided under home health services)

MSIS Code Definitions	MSIS Valid Values	T-MSIS 2.1 Valid Values	T-MSIS v2.1 Code Definitions
PT, OT, Speech, Hearing Language	34	031	Occupational therapy services (when not provided under home health services)
PT, OT, Speech, Hearing Language	34	032	Speech, hearing, and language disorders services (when not provided under home health services)
PT, OT, Speech, Hearing Language	34	038	Hearing Aids
Hospice Benefits	35	087	Hospice Benefits
Nurse Midwife Services	36	025	Nurse-midwife service
Nurse Practitioner Services	37	026	Nurse practitioner services
Nurse Practitioner Services	37	023	Advanced practice nurse services
Private Duty Nursing	38	022	Private duty nursing services
Private Duty Nursing	38	024	Pediatric nurse
Religious Non-Medical Health Care Institutions	39	058	Services furnished in a religious nonmedical health care institution
Supplemental Payment - Inpatient	40	132	Supplemental payment – inpatient
Supplemental Payment - Nursing	41	133	Supplemental payment – nursing
Supplemental Payment - Outpatient	42	134	Supplemental payment – outpatient
Durable Medical Equipment and Supplies (including emergency response systems and home modifications)	51	018	Home health services - Medical supplies, equipment, and appliances suitable for use in the home
Durable Medical Equipment and Supplies (including emergency response systems and home modifications)	51	027	Respiratory care for ventilator-dependent individuals
Residential Care	52	115	Residential Care
Psychiatric services (excluding adult day care)	53	048	Inpatient psychiatric services for individuals under age 21
Psychiatric services (excluding adult day care)	53	049	Outpatient mental health services, other than Outpatient substance abuse treatment services. This TOS includes services furnished in a State-operated mental hospital and including community-based services.
Adult Day Care	54	066	HCBS - Adult day health services
Adult Day Care	54	069	HCBS - Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness
Adult Day Care	54	070	HCBS - Day Care
Indian Health Service (IHS) - Family Plan	60	011	Family planning services and supplies for individuals of child-bearing age
Indian Health Service (IHS) - Family Plan	60	127	Indian Health Service (IHS) - Family Plan
Indian Health Service (IHS) - BCC	61	004	Other ambulatory services furnished by a rural health clinic
Indian Health Service (IHS) - BIP	62	004	Other ambulatory services furnished by a rural health clinic

Appendix L: Crosswalk of WPC Provider Taxonomy Codes to Provider Facility Type Categories

Source: http://www.wpc-edi.com/reference/

Table Pages 1 – 20

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
193200000X	Unspecified Multi-Specialty Group	100000000	Individuals or Groups (of Individuals)
193400000X	Unspecified Single Specialty Group	100000000	Individuals or Groups (of Individuals)
207K00000X	Allergy & Immunology	100000000	Individuals or Groups (of Individuals)
207KA0200X	Allergy	100000000	Individuals or Groups (of Individuals)
207KI0005X	Clinical & Laboratory Immunology	100000000	Individuals or Groups (of Individuals)
207L00000X	Anesthesiology	100000000	Individuals or Groups (of Individuals)
207LA0401X	Addiction Medicine	100000000	Individuals or Groups (of Individuals)
207LC0200X	Critical Care Medicine	100000000	Individuals or Groups (of Individuals)
207LH0002X	Hospice and Palliative Medicine	100000000	Individuals or Groups (of Individuals)
207LP2900X	Pain Medicine	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
207LP3000X	Pediatric Anesthesiology	100000000	Individuals or Groups (of Individuals)
208U00000X	Clinical Pharmacology	100000000	Individuals or Groups (of Individuals)
208C00000X	Colon & Rectal Surgery	100000000	Individuals or Groups (of Individuals)
207N00000X	Dermatology	100000000	Individuals or Groups (of Individuals)
207NI0002X	Clinical & Laboratory Dermatological Immunology	100000000	Individuals or Groups (of Individuals)
207ND0900X	Dermatopathology	100000000	Individuals or Groups (of Individuals)
207ND0101X	MOHS-Micrographic Surgery	100000000	Individuals or Groups (of Individuals)
207NP0225X	Pediatric Dermatology	100000000	Individuals or Groups (of Individuals)
207NS0135X	Procedural Dermatology	100000000	Individuals or Groups (of Individuals)
204R00000X	Electrodiagnostic Medicine	100000000	Individuals or Groups (of Individuals)
207P00000X	Emergency Medicine	100000000	Individuals or Groups (of Individuals)
207PE0004X	Emergency Medical Services	100000000	Individuals or Groups (of Individuals)
207PH0002X	Hospice and Palliative Medicine	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
207PT0002X	Medical Toxicology	100000000	Individuals or Groups (of Individuals)
207PP0204X	Pediatric Emergency Medicine	100000000	Individuals or Groups (of Individuals)
207PS0010X	Sports Medicine	100000000	Individuals or Groups (of Individuals)
207PE0005X	Undersea and Hyperbaric Medicine	100000000	Individuals or Groups (of Individuals)
207Q00000X	Family Medicine	100000000	Individuals or Groups (of Individuals)
207QA0401X	Addiction Medicine	100000000	Individuals or Groups (of Individuals)
207QA0000X	Adolescent Medicine	100000000	Individuals or Groups (of Individuals)
207QA0505X	Adult Medicine	100000000	Individuals or Groups (of Individuals)
207QB0002X	Bariatric Medicine	100000000	Individuals or Groups (of Individuals)
207QG0300X	Geriatric Medicine	100000000	Individuals or Groups (of Individuals)
207QH0002X	Hospice and Palliative Medicine	100000000	Individuals or Groups (of Individuals)
207QS1201X	Sleep Medicine	100000000	Individuals or Groups (of Individuals)
207QS0010X	Sports Medicine	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
208D00000X	General Practice	100000000	Individuals or Groups (of Individuals)
208M00000X	Hospitalist	100000000	Individuals or Groups (of Individuals)
202C00000X	Independent Medical Examiner	100000000	Individuals or Groups (of Individuals)
207R00000X	Internal Medicine	100000000	Individuals or Groups (of Individuals)
207RA0401X	Addiction Medicine	100000000	Individuals or Groups (of Individuals)
207RA0000X	Adolescent Medicine	100000000	Individuals or Groups (of Individuals)
207RA0201X	Allergy & Immunology	100000000	Individuals or Groups (of Individuals)
207RB0002X	Bariatric Medicine	100000000	Individuals or Groups (of Individuals)
207RC0000X	Cardiovascular Disease	100000000	Individuals or Groups (of Individuals)
207RI0001X	Clinical & Laboratory Immunology	100000000	Individuals or Groups (of Individuals)
207RC0001X	Clinical Cardiac Electrophysiology	100000000	Individuals or Groups (of Individuals)
207RC0200X	Critical Care Medicine	100000000	Individuals or Groups (of Individuals)
207RE0101X	Endocrinology, Diabetes & Metabolism	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
207RG0100X	Gastroenterology	100000000	Individuals or Groups (of Individuals)
207RG0300X	Geriatric Medicine	100000000	Individuals or Groups (of Individuals)
207RH0000X	Hematology	100000000	Individuals or Groups (of Individuals)
207RH0003X	Hematology & Oncology	100000000	Individuals or Groups (of Individuals)
207RI0008X	Hepatology	100000000	Individuals or Groups (of Individuals)
207RH0002X	Hospice and Palliative Medicine	100000000	Individuals or Groups (of Individuals)
207RH0005X	Hypertension Specialist	100000000	Individuals or Groups (of Individuals)
207RI0200X	Infectious Disease	100000000	Individuals or Groups (of Individuals)
207RI0011X	Interventional Cardiology	100000000	Individuals or Groups (of Individuals)
207RM1200X	Magnetic Resonance Imaging (MRI)	100000000	Individuals or Groups (of Individuals)
207RX0202X	Medical Oncology	100000000	Individuals or Groups (of Individuals)
207RN0300X	Nephrology	100000000	Individuals or Groups (of Individuals)
207RP1001X	Pulmonary Disease	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
207RR0500X	Rheumatology	100000000	Individuals or Groups (of Individuals)
207RS0012X	Sleep Medicine	100000000	Individuals or Groups (of Individuals)
207RS0010X	Sports Medicine	100000000	Individuals or Groups (of Individuals)
207RT0003X	Transplant Hepatology	100000000	Individuals or Groups (of Individuals)
209800000X	Legal Medicine	100000000	Individuals or Groups (of Individuals)
207SG0202X	Clinical Biochemical Genetics	100000000	Individuals or Groups (of Individuals)
207SC0300X	Clinical Cytogenetic	100000000	Individuals or Groups (of Individuals)
207SG0201X	Clinical Genetics (M.D.)	100000000	Individuals or Groups (of Individuals)
207SG0203X	Clinical Molecular Genetics	100000000	Individuals or Groups (of Individuals)
207SM0001X	Molecular Genetic Pathology	100000000	Individuals or Groups (of Individuals)
207SG0205X	Ph.D. Medical Genetics	100000000	Individuals or Groups (of Individuals)
207T00000X	Neurological Surgery	100000000	Individuals or Groups (of Individuals)
207U00000X	Nuclear Medicine	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
207UN0903X	In Vivo & In Vitro Nuclear Medicine	100000000	Individuals or Groups (of Individuals)
207UN0901X	Nuclear Cardiology	100000000	Individuals or Groups (of Individuals)
207UN0902X	Nuclear Imaging & Therapy	100000000	Individuals or Groups (of Individuals)
204D00000X	Neuromusculoskeletal Medicine & OMM	100000000	Individuals or Groups (of Individuals)
204C00000X	Neuromusculoskeletal Medicine, Sports Medicine	100000000	Individuals or Groups (of Individuals)
207V00000X	Obstetrics & Gynecology	100000000	Individuals or Groups (of Individuals)
207VB0002X	Bariatric Medicine	100000000	Individuals or Groups (of Individuals)
207VC0200X	Critical Care Medicine	100000000	Individuals or Groups (of Individuals)
207VF0040X	Female Pelvic Medicine and Reconstructive Surgery	100000000	Individuals or Groups (of Individuals)
207VX0201X	Gynecologic Oncology	100000000	Individuals or Groups (of Individuals)
207VG0400X	Gynecology	100000000	Individuals or Groups (of Individuals)
207VH0002X	Hospice and Palliative Medicine	100000000	Individuals or Groups (of Individuals)
207VM0101X	Maternal & Fetal Medicine	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
207VX0000X	Obstetrics	100000000	Individuals or Groups (of Individuals)
207VE0102X	Reproductive Endocrinology	100000000	Individuals or Groups (of Individuals)
207W00000X	Ophthalmology	100000000	Individuals or Groups (of Individuals)
204E00000X	Oral & Maxillofacial Surgery	100000000	Individuals or Groups (of Individuals)
207X00000X	Orthopaedic Surgery	100000000	Individuals or Groups (of Individuals)
207XS0114X	Adult Reconstructive Orthopaedic Surgery	100000000	Individuals or Groups (of Individuals)
207XX0004X	Foot and Ankle Surgery	100000000	Individuals or Groups (of Individuals)
207XS0106X	Hand Surgery	100000000	Individuals or Groups (of Individuals)
207XS0117X	Orthopaedic Surgery of the Spine	100000000	Individuals or Groups (of Individuals)
207XX0801X	Orthopaedic Trauma	100000000	Individuals or Groups (of Individuals)
207XP3100X	Pediatric Orthopaedic Surgery	100000000	Individuals or Groups (of Individuals)
207XX0005X	Sports Medicine	100000000	Individuals or Groups (of Individuals)
207Y00000X	Otolaryngology	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
207YS0123X	Facial Plastic Surgery	100000000	Individuals or Groups (of Individuals)
207YX0602X	Otolaryngic Allergy	100000000	Individuals or Groups (of Individuals)
207YX0905X	Otolaryngology/Facial Plastic Surgery	100000000	Individuals or Groups (of Individuals)
207YX0901X	Otology & Neurotology	100000000	Individuals or Groups (of Individuals)
207YP0228X	Pediatric Otolaryngology	100000000	Individuals or Groups (of Individuals)
207YX0007X	Plastic Surgery within the Head & Neck	100000000	Individuals or Groups (of Individuals)
207YS0012X	Sleep Medicine	100000000	Individuals or Groups (of Individuals)
207ZP0101X	Anatomic Pathology	100000000	Individuals or Groups (of Individuals)
207ZP0102X	Anatomic Pathology & Clinical Pathology	100000000	Individuals or Groups (of Individuals)
207ZB0001X	Blood Banking & Transfusion Medicine	100000000	Individuals or Groups (of Individuals)
207ZP0104X	Chemical Pathology	100000000	Individuals or Groups (of Individuals)
207ZC0006X	Clinical Pathology	100000000	Individuals or Groups (of Individuals)
207ZP0105X	Clinical Pathology/Laboratory Medicine	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
207ZC0500X	Cytopathology	100000000	Individuals or Groups (of Individuals)
207ZD0900X	Dermatopathology	100000000	Individuals or Groups (of Individuals)
207ZF0201X	Forensic Pathology	100000000	Individuals or Groups (of Individuals)
207ZH0000X	Hematology	100000000	Individuals or Groups (of Individuals)
207ZI0100X	Immunopathology	100000000	Individuals or Groups (of Individuals)
207ZM0300X	Medical Microbiology	100000000	Individuals or Groups (of Individuals)
207ZP0007X	Molecular Genetic Pathology	100000000	Individuals or Groups (of Individuals)
207ZN0500X	Neuropathology	100000000	Individuals or Groups (of Individuals)
207ZP0213X	Pediatric Pathology	100000000	Individuals or Groups (of Individuals)
208000000X	Pediatrics	100000000	Individuals or Groups (of Individuals)
2080A0000X	Adolescent Medicine	100000000	Individuals or Groups (of Individuals)
2080C0008X	Child Abuse Pediatrics	100000000	Individuals or Groups (of Individuals)
2080I0007X	Clinical & Laboratory Immunology	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
2080P0006X	Developmental – Behavioral Pediatrics	100000000	Individuals or Groups (of Individuals)
2080H0002X	Hospice and Palliative Medicine	100000000	Individuals or Groups (of Individuals)
2080T0002X	Medical Toxicology	100000000	Individuals or Groups (of Individuals)
2080N0001X	Neonatal-Perinatal Medicine	100000000	Individuals or Groups (of Individuals)
2080P0008X	Neurodevelopmental Disabilities	100000000	Individuals or Groups (of Individuals)
2080P0201X	Pediatric Allergy/Immunology	100000000	Individuals or Groups (of Individuals)
2080P0202X	Pediatric Cardiology	100000000	Individuals or Groups (of Individuals)
2080P0203X	Pediatric Critical Care Medicine	100000000	Individuals or Groups (of Individuals)
2080P0204X	Pediatric Emergency Medicine	100000000	Individuals or Groups (of Individuals)
2080P0205X	Pediatric Endocrinology	100000000	Individuals or Groups (of Individuals)
2080P0206X	Pediatric Gastroenterology	100000000	Individuals or Groups (of Individuals)
2080P0207X	Pediatric Hematology-Oncology	100000000	Individuals or Groups (of Individuals)
2080P0208X	Pediatric Infectious Diseases	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
2080P0210X	Pediatric Nephrology	100000000	Individuals or Groups (of Individuals)
2080P0214X	Pediatric Pulmonology	100000000	Individuals or Groups (of Individuals)
2080P0216X	Pediatric Rheumatology	100000000	Individuals or Groups (of Individuals)
2080T0004X	Pediatric Transplant Hepatology	100000000	Individuals or Groups (of Individuals)
2080S0012X	Sleep Medicine	100000000	Individuals or Groups (of Individuals)
2080S0010X	Sports Medicine	100000000	Individuals or Groups (of Individuals)
202K00000X	Phlebology	100000000	Individuals or Groups (of Individuals)
208100000X	Physical Medicine & Rehabilitation	100000000	Individuals or Groups (of Individuals)
2081H0002X	Hospice and Palliative Medicine	100000000	Individuals or Groups (of Individuals)
2081N0008X	Neuromuscular Medicine	100000000	Individuals or Groups (of Individuals)
2081P2900X	Pain Medicine	100000000	Individuals or Groups (of Individuals)
2081P0010X	Pediatric Rehabilitation Medicine	100000000	Individuals or Groups (of Individuals)
2081P0004X	Spinal Cord Injury Medicine	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
2081S0010X	Sports Medicine	100000000	Individuals or Groups (of Individuals)
208200000X	Plastic Surgery	100000000	Individuals or Groups (of Individuals)
2082S0099X	Plastic Surgery Within the Head and Neck	100000000	Individuals or Groups (of Individuals)
2082S0105X	Surgery of the Hand	100000000	Individuals or Groups (of Individuals)
2083A0100X	Aerospace Medicine	100000000	Individuals or Groups (of Individuals)
2083T0002X	Medical Toxicology	100000000	Individuals or Groups (of Individuals)
2083X0100X	Occupational Medicine	100000000	Individuals or Groups (of Individuals)
2083P0500X	Preventive Medicine/Occupational Environmental Medicine	100000000	Individuals or Groups (of Individuals)
2083P0901X	Public Health & General Preventive Medicine	100000000	Individuals or Groups (of Individuals)
2083S0010X	Sports Medicine	100000000	Individuals or Groups (of Individuals)
2083P0011X	Undersea and Hyperbaric Medicine	100000000	Individuals or Groups (of Individuals)
2084A0401X	Addiction Medicine	100000000	Individuals or Groups (of Individuals)
2084P0802X	Addiction Psychiatry	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
2084B0002X	Bariatric Medicine	100000000	Individuals or Groups (of Individuals)
2084B0040X	Behavioral Neurology & Neuropsychiatry	100000000	Individuals or Groups (of Individuals)
2084P0804X	Child & Adolescent Psychiatry	100000000	Individuals or Groups (of Individuals)
2084N0600X	Clinical Neurophysiology	100000000	Individuals or Groups (of Individuals)
2084D0003X	Diagnostic Neuroimaging	100000000	Individuals or Groups (of Individuals)
2084F0202X	Forensic Psychiatry	100000000	Individuals or Groups (of Individuals)
2084P0805X	Geriatric Psychiatry	100000000	Individuals or Groups (of Individuals)
2084H0002X	Hospice and Palliative Medicine	100000000	Individuals or Groups (of Individuals)
2084P0005X	Neurodevelopmental Disabilities	100000000	Individuals or Groups (of Individuals)
2084N0400X	Neurology	100000000	Individuals or Groups (of Individuals)
2084N0402X	Neurology with Special Qualifications in Child Neurology	100000000	Individuals or Groups (of Individuals)
2084N0008X	Neuromuscular Medicine	100000000	Individuals or Groups (of Individuals)
2084P2900X	Pain Medicine	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
2084P0800X	Psychiatry	100000000	Individuals or Groups (of Individuals)
2084P0015X	Psychosomatic Medicine	100000000	Individuals or Groups (of Individuals)
2084S0012X	Sleep Medicine	100000000	Individuals or Groups (of Individuals)
2084S0010X	Sports Medicine	100000000	Individuals or Groups (of Individuals)
2084V0102X	Vascular Neurology	100000000	Individuals or Groups (of Individuals)
208VP0014X	Interventional Pain Medicine	100000000	Individuals or Groups (of Individuals)
208VP0000X	Pain Medicine	100000000	Individuals or Groups (of Individuals)
2085B0100X	Body Imaging	100000000	Individuals or Groups (of Individuals)
2085D0003X	Diagnostic Neuroimaging	100000000	Individuals or Groups (of Individuals)
2085R0202X	Diagnostic Radiology	100000000	Individuals or Groups (of Individuals)
2085U0001X	Diagnostic Ultrasound	100000000	Individuals or Groups (of Individuals)
2085H0002X	Hospice and Palliative Medicine	100000000	Individuals or Groups (of Individuals)
2085N0700X	Neuroradiology	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
2085N0904X	Nuclear Radiology	100000000	Individuals or Groups (of Individuals)
2085P0229X	Pediatric Radiology	100000000	Individuals or Groups (of Individuals)
2085R0001X	Radiation Oncology	100000000	Individuals or Groups (of Individuals)
2085R0205X	Radiological Physics	100000000	Individuals or Groups (of Individuals)
2085R0203X	Therapeutic Radiology	100000000	Individuals or Groups (of Individuals)
2085R0204X	Vascular & Interventional Radiology	100000000	Individuals or Groups (of Individuals)
208600000X	Surgery	100000000	Individuals or Groups (of Individuals)
2086H0002X	Hospice and Palliative Medicine	100000000	Individuals or Groups (of Individuals)
2086S0120X	Pediatric Surgery	100000000	Individuals or Groups (of Individuals)
2086S0122X	Plastic and Reconstructive Surgery	100000000	Individuals or Groups (of Individuals)
2086S0105X	Surgery of the Hand	100000000	Individuals or Groups (of Individuals)
2086S0102X	Surgical Critical Care	100000000	Individuals or Groups (of Individuals)
2086X0206X	Surgical Oncology	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
2086S0127X	Trauma Surgery	100000000	Individuals or Groups (of Individuals)
2086S0129X	Vascular Surgery	100000000	Individuals or Groups (of Individuals)
208G00000X	Thoracic Surgery (Cardiothoracic Vascular Surgery)	100000000	Individuals or Groups (of Individuals)
204F00000X	Transplant Surgery	100000000	Individuals or Groups (of Individuals)
208800000X	Urology	100000000	Individuals or Groups (of Individuals)
2088F0040X	Female Pelvic Medicine and Reconstructive Surgery	100000000	Individuals or Groups (of Individuals)
2088P0231X	Pediatric Urology	100000000	Individuals or Groups (of Individuals)
103K00000X	Behavioral Analyst	100000000	Individuals or Groups (of Individuals)
103G00000X	Clinical Neuropsychologist	100000000	Individuals or Groups (of Individuals)
103GC0700X	Clinical	100000000	Individuals or Groups (of Individuals)
101Y00000X	Counselor	100000000	Individuals or Groups (of Individuals)
101YA0400X	Addiction (Substance Use Disorder)	100000000	Individuals or Groups (of Individuals)
101YM0800X	Mental Health	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
101YP1600X	Pastoral	100000000	Individuals or Groups (of Individuals)
101YP2500X	Professional	100000000	Individuals or Groups (of Individuals)
101YS0200X	School	100000000	Individuals or Groups (of Individuals)
106H00000X	Marriage & Family Therapist	100000000	Individuals or Groups (of Individuals)
102X00000X	Poetry Therapist	100000000	Individuals or Groups (of Individuals)
102L00000X	Psychoanalyst	100000000	Individuals or Groups (of Individuals)
103T00000X	Psychologist	100000000	Individuals or Groups (of Individuals)
103TA0400X	Addiction (Substance Use Disorder)	100000000	Individuals or Groups (of Individuals)
103TA0700X	Adult Development & Aging	100000000	Individuals or Groups (of Individuals)
103TC0700X	Clinical	100000000	Individuals or Groups (of Individuals)
103TC2200X	Clinical Child & Adolescent	100000000	Individuals or Groups (of Individuals)
103TB0200X	Cognitive & Behavioral	100000000	Individuals or Groups (of Individuals)
103TC1900X	Counseling	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
103TE1000X	Educational	100000000	Individuals or Groups (of Individuals)
103TE1100X	Exercise & Sports	100000000	Individuals or Groups (of Individuals)
103TF0000X	Family	100000000	Individuals or Groups (of Individuals)
103TF0200X	Forensic	100000000	Individuals or Groups (of Individuals)
103TP2701X	Group Psychotherapy	100000000	Individuals or Groups (of Individuals)
103TH0004X	Health	100000000	Individuals or Groups (of Individuals)
103TH0100X	Health Service	100000000	Individuals or Groups (of Individuals)
103TM1700X	Men & Masculinity	100000000	Individuals or Groups (of Individuals)
103TM1800X	Mental Retardation & Developmental Disabilities	100000000	Individuals or Groups (of Individuals)
103TP0016X	Prescribing (Medical)	100000000	Individuals or Groups (of Individuals)
103TP0814X	Psychoanalysis	100000000	Individuals or Groups (of Individuals)
103TP2700X	Psychotherapy	100000000	Individuals or Groups (of Individuals)
103TR0400X	Rehabilitation	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
103TS0200X	School	100000000	Individuals or Groups (of Individuals)
103TW0100X	Women	100000000	Individuals or Groups (of Individuals)
104100000X	Social Worker	100000000	Individuals or Groups (of Individuals)
1041C0700X	Clinical	100000000	Individuals or Groups (of Individuals)
1041S0200X	School	100000000	Individuals or Groups (of Individuals)
111N00000X	Chiropractor	100000000	Individuals or Groups (of Individuals)
111NI0013X	Independent Medical Examiner	100000000	Individuals or Groups (of Individuals)
111NI0900X	Internist	100000000	Individuals or Groups (of Individuals)
111NN0400X	Neurology	100000000	Individuals or Groups (of Individuals)
111NN1001X	Nutrition	100000000	Individuals or Groups (of Individuals)
111NX0100X	Occupational Health	100000000	Individuals or Groups (of Individuals)
111NX0800X	Orthopedic	100000000	Individuals or Groups (of Individuals)
111NP0017X	Pediatric Chiropractor	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
111NR0200X	Radiology	100000000	Individuals or Groups (of Individuals)
111NR0400X	Rehabilitation	100000000	Individuals or Groups (of Individuals)
111NS0005X	Sports Physician	100000000	Individuals or Groups (of Individuals)
111NT0100X	Thermography	100000000	Individuals or Groups (of Individuals)
125K00000X	Advanced Practice Dental Therapist	100000000	Individuals or Groups (of Individuals)
126800000X	Dental Assistant	100000000	Individuals or Groups (of Individuals)
124Q00000X	Dental Hygienist	100000000	Individuals or Groups (of Individuals)
126900000X	Dental Laboratory Technician	100000000	Individuals or Groups (of Individuals)
125J00000X	Dental Therapist	100000000	Individuals or Groups (of Individuals)
122300000X	Dentist	100000000	Individuals or Groups (of Individuals)
1223D0001X	Dental Public Health	100000000	Individuals or Groups (of Individuals)
1223D0004X	Dentist Anesthesiologist	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
1223E0200X	Endodontics	100000000	Individuals or Groups (of Individuals)
1223G0001X	General Practice	100000000	Individuals or Groups (of Individuals)
1223P0106X	Oral and Maxillofacial Pathology	100000000	Individuals or Groups (of Individuals)
1223X0008X	Oral and Maxillofacial Radiology	100000000	Individuals or Groups (of Individuals)
1223S0112X	Oral and Maxillofacial Surgery	100000000	Individuals or Groups (of Individuals)
1223X0400X	Orthodontics and Dentofacial Orthopedics	100000000	Individuals or Groups (of Individuals)
1223P0221X	Pediatric Dentistry	100000000	Individuals or Groups (of Individuals)
1223P0300X	Periodontics	100000000	Individuals or Groups (of Individuals)
1223P0700X	Prosthodontics	100000000	Individuals or Groups (of Individuals)
122400000X	Denturist	100000000	Individuals or Groups (of Individuals)
132700000X	Dietary Manager	100000000	Individuals or Groups (of Individuals)
136A00000X	Dietetic Technician, Registered	100000000	Individuals or Groups (of Individuals)
133V00000X	Dietitian, Registered	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
133VN1006X	Nutrition, Metabolic	100000000	Individuals or Groups (of Individuals)
133VN1004X	Nutrition, Pediatric	100000000	Individuals or Groups (of Individuals)
133VN1005X	Nutrition, Renal	100000000	Individuals or Groups (of Individuals)
133N00000X	Nutritionist	100000000	Individuals or Groups (of Individuals)
133NN1002X	Nutrition, Education	100000000	Individuals or Groups (of Individuals)
146N00000X	Emergency Medical Technician, Basic	100000000	Individuals or Groups (of Individuals)
146M00000X	Emergency Medical Technician, Intermediate	100000000	Individuals or Groups (of Individuals)
146L00000X	Emergency Medical Technician, Paramedic	100000000	Individuals or Groups (of Individuals)
146D00000X	Personal Emergency Response Attendant	100000000	Individuals or Groups (of Individuals)
152W00000X	Optometrist	100000000	Individuals or Groups (of Individuals)
152WC0802X	Corneal and Contact Management	100000000	Individuals or Groups (of Individuals)
152WL0500X	Low Vision Rehabilitation	100000000	Individuals or Groups (of Individuals)
152WX0102X	Occupational Vision	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
152WP0200X	Pediatrics	100000000	Individuals or Groups (of Individuals)
152WS0006X	Sports Vision	100000000	Individuals or Groups (of Individuals)
152WV0400X	Vision Therapy	100000000	Individuals or Groups (of Individuals)
156F00000X	Technician/Technologist	100000000	Individuals or Groups (of Individuals)
156FC0800X	Contact Lens	100000000	Individuals or Groups (of Individuals)
156FC0801X	Contact Lens Fitter	100000000	Individuals or Groups (of Individuals)
156FX1700X	Ocularist	100000000	Individuals or Groups (of Individuals)
156FX1100X	Ophthalmic	100000000	Individuals or Groups (of Individuals)
156FX1101X	Ophthalmic Assistant	100000000	Individuals or Groups (of Individuals)
156FX1800X	Optician	100000000	Individuals or Groups (of Individuals)
156FX1201X	Optometric Assistant	100000000	Individuals or Groups (of Individuals)
156FX1202X	Optometric Technician	100000000	Individuals or Groups (of Individuals)
156FX1900X	Orthoptist	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
164W00000X	Licensed Practical Nurse	100000000	Individuals or Groups (of Individuals)
167G00000X	Licensed Psychiatric Technician	100000000	Individuals or Groups (of Individuals)
164X00000X	Licensed Vocational Nurse	100000000	Individuals or Groups (of Individuals)
163W00000X	Registered Nurse	100000000	Individuals or Groups (of Individuals)
163WA0400X	Addiction (Substance Use Disorder)	100000000	Individuals or Groups (of Individuals)
163WA2000X	Administrator	100000000	Individuals or Groups (of Individuals)
163WP2201X	Ambulatory Care	100000000	Individuals or Groups (of Individuals)
163WC3500X	Cardiac Rehabilitation	100000000	Individuals or Groups (of Individuals)
163WC0400X	Case Management	100000000	Individuals or Groups (of Individuals)
163WC1400X	College Health	100000000	Individuals or Groups (of Individuals)
163WC1500X	Community Health	100000000	Individuals or Groups (of Individuals)
163WC2100X	Continence Care	100000000	Individuals or Groups (of Individuals)
163WC1600X	Continuing Education/Staff Development	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
163WC0200X	Critical Care Medicine	100000000	Individuals or Groups (of Individuals)
163WD0400X	Diabetes Educator	100000000	Individuals or Groups (of Individuals)
163WD1100X	Dialysis, Peritoneal	100000000	Individuals or Groups (of Individuals)
163WE0003X	Emergency	100000000	Individuals or Groups (of Individuals)
163WE0900X	Enterostomal Therapy	100000000	Individuals or Groups (of Individuals)
163WF0300X	Flight	100000000	Individuals or Groups (of Individuals)
163WG0100X	Gastroenterology	100000000	Individuals or Groups (of Individuals)
163WG0000X	General Practice	100000000	Individuals or Groups (of Individuals)
163WG0600X	Gerontology	100000000	Individuals or Groups (of Individuals)
163WH0500X	Hemodialysis	100000000	Individuals or Groups (of Individuals)
163WH0200X	Home Health	100000000	Individuals or Groups (of Individuals)
163WH1000X	Hospice	100000000	Individuals or Groups (of Individuals)
163WI0600X	Infection Control	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
163WI0500X	Infusion Therapy	100000000	Individuals or Groups (of Individuals)
163WL0100X	Lactation Consultant	100000000	Individuals or Groups (of Individuals)
163WM0102X	Maternal Newborn	100000000	Individuals or Groups (of Individuals)
163WM0705X	Medical-Surgical	100000000	Individuals or Groups (of Individuals)
163WN0002X	Neonatal Intensive Care	100000000	Individuals or Groups (of Individuals)
163WN0003X	Neonatal, Low-Risk	100000000	Individuals or Groups (of Individuals)
163WN0300X	Nephrology	100000000	Individuals or Groups (of Individuals)
163WN0800X	Neuroscience	100000000	Individuals or Groups (of Individuals)
163WM1400X	Nurse Massage Therapist (NMT)	100000000	Individuals or Groups (of Individuals)
163WN1003X	Nutrition Support	100000000	Individuals or Groups (of Individuals)
163WX0002X	Obstetric, High-Risk	100000000	Individuals or Groups (of Individuals)
163WX0003X	Obstetric, Inpatient	100000000	Individuals or Groups (of Individuals)
163WX0106X	Occupational Health	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
163WX0200X	Oncology	100000000	Individuals or Groups (of Individuals)
163WX1100X	Ophthalmic	100000000	Individuals or Groups (of Individuals)
163WX0800X	Orthopedic	100000000	Individuals or Groups (of Individuals)
163WX1500X	Ostomy Care	100000000	Individuals or Groups (of Individuals)
163WX0601X	Otorhinolaryngology & Head-Neck	100000000	Individuals or Groups (of Individuals)
163WP0000X	Pain Management	100000000	Individuals or Groups (of Individuals)
163WP0218X	Pediatric Oncology	100000000	Individuals or Groups (of Individuals)
163WP0200X	Pediatrics	100000000	Individuals or Groups (of Individuals)
163WP1700X	Perinatal	100000000	Individuals or Groups (of Individuals)
163WS0121X	Plastic Surgery	100000000	Individuals or Groups (of Individuals)
163WP0808X	Psychiatric/Mental Health	100000000	Individuals or Groups (of Individuals)
163WP0809X	Psychiatric/Mental Health, Adult	100000000	Individuals or Groups (of Individuals)
163WP0807X	Psychiatric/Mental Health, Child & Adolescent	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
163WR0006X	Registered Nurse First Assistant	100000000	Individuals or Groups (of Individuals)
163WR0400X	Rehabilitation	100000000	Individuals or Groups (of Individuals)
163WR1000X	Reproductive Endocrinology/Infertility	100000000	Individuals or Groups (of Individuals)
163WS0200X	School	100000000	Individuals or Groups (of Individuals)
163WU0100X	Urology	100000000	Individuals or Groups (of Individuals)
163WW0101X	Women's Health Care, Ambulatory	100000000	Individuals or Groups (of Individuals)
163WW0000X	Wound Care	100000000	Individuals or Groups (of Individuals)
372600000X	Adult Companion	100000000	Individuals or Groups (of Individuals)
372500000X	Chore Provider	100000000	Individuals or Groups (of Individuals)
373H00000X	Day Training/Habilitation Specialist	100000000	Individuals or Groups (of Individuals)
374J00000X	Doula	100000000	Individuals or Groups (of Individuals)
374U00000X	Home Health Aide	100000000	Individuals or Groups (of Individuals)
376J00000X	Homemaker	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
376K00000X	Nurse's Aide	100000000	Individuals or Groups (of Individuals)
376G00000X	Nursing Home Administrator	100000000	Individuals or Groups (of Individuals)
374T00000X	Religious Nonmedical Nursing Personnel	100000000	Individuals or Groups (of Individuals)
374K00000X	Religious Nonmedical Practitioner	100000000	Individuals or Groups (of Individuals)
374700000X	Technician	100000000	Individuals or Groups (of Individuals)
3747A0650X	Attendant Care Provider	100000000	Individuals or Groups (of Individuals)
3747P1801X	Personal Care Attendant	100000000	Individuals or Groups (of Individuals)
171100000X	Acupuncturist	100000000	Individuals or Groups (of Individuals)
171M00000X	Case Manager/Care Coordinator	100000000	Individuals or Groups (of Individuals)
174V00000X	Clinical Ethicist	100000000	Individuals or Groups (of Individuals)
172V00000X	Community Health Worker	100000000	Individuals or Groups (of Individuals)
171W00000X	Contractor	100000000	Individuals or Groups (of Individuals)
171WH0202X	Home Modifications	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
171WV0202X	Vehicle Modifications	100000000	Individuals or Groups (of Individuals)
172A00000X	Driver	100000000	Individuals or Groups (of Individuals)
176P00000X	Funeral Director	100000000	Individuals or Groups (of Individuals)
170300000X	Genetic Counselor, MS	100000000	Individuals or Groups (of Individuals)
174H00000X	Health Educator	100000000	Individuals or Groups (of Individuals)
175L00000X	Homeopath	100000000	Individuals or Groups (of Individuals)
171R00000X	Interpreter	100000000	Individuals or Groups (of Individuals)
174N00000X	Lactation Consultant, Non-RN	100000000	Individuals or Groups (of Individuals)
173000000X	Legal Medicine	100000000	Individuals or Groups (of Individuals)
172M00000X	Mechanotherapist	100000000	Individuals or Groups (of Individuals)
170100000X	Medical Genetics, Ph.D. Medical Genetics	100000000	Individuals or Groups (of Individuals)
176B00000X	Midwife	100000000	Individuals or Groups (of Individuals)
175M00000X	Midwife, Lay	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
171000000X	Military Health Care Provider	100000000	Individuals or Groups (of Individuals)
1710I1002X	Independent Duty Corpsman	100000000	Individuals or Groups (of Individuals)
1710I1003X	Independent Duty Medical Technicians	100000000	Individuals or Groups (of Individuals)
172P00000X	Naprapath	100000000	Individuals or Groups (of Individuals)
175F00000X	Naturopath	100000000	Individuals or Groups (of Individuals)
173C00000X	Reflexologist	100000000	Individuals or Groups (of Individuals)
173F00000X	Sleep Specialist, PhD	100000000	Individuals or Groups (of Individuals)
174400000X	Specialist	100000000	Individuals or Groups (of Individuals)
1744G0900X	Graphics Designer	100000000	Individuals or Groups (of Individuals)
1744P3200X	Prosthetics Case Management	100000000	Individuals or Groups (of Individuals)
1744R1103X	Research Data Abstracter/Coder	100000000	Individuals or Groups (of Individuals)
1744R1102X	Research Study	100000000	Individuals or Groups (of Individuals)
174M00000X	Veterinarian	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
174MM1900X	Medical Research	100000000	Individuals or Groups (of Individuals)
183500000X	Pharmacist	100000000	Individuals or Groups (of Individuals)
1835G0000X	General Practice	100000000	Individuals or Groups (of Individuals)
1835G0303X	Geriatric	100000000	Individuals or Groups (of Individuals)
1835N0905X	Nuclear	100000000	Individuals or Groups (of Individuals)
1835N1003X	Nutrition Support	100000000	Individuals or Groups (of Individuals)
1835X0200X	Oncology	100000000	Individuals or Groups (of Individuals)
1835P0018X	Pharmacist Clinician (PhC)/ Clinical Pharmacy Specialist	100000000	Individuals or Groups (of Individuals)
1835P1200X	Pharmacotherapy	100000000	Individuals or Groups (of Individuals)
1835P1300X	Psychiatric	100000000	Individuals or Groups (of Individuals)
183700000X	Pharmacy Technician	100000000	Individuals or Groups (of Individuals)
367A00000X	Advanced Practice Midwife	100000000	Individuals or Groups (of Individuals)
367H00000X	Anesthesiologist Assistant	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
364S00000X	Clinical Nurse Specialist	100000000	Individuals or Groups (of Individuals)
364SA2100X	Acute Care	100000000	Individuals or Groups (of Individuals)
364SA2200X	Adult Health	100000000	Individuals or Groups (of Individuals)
364SC2300X	Chronic Care	100000000	Individuals or Groups (of Individuals)
364SC1501X	Community Health/Public Health	100000000	Individuals or Groups (of Individuals)
364SC0200X	Critical Care Medicine	100000000	Individuals or Groups (of Individuals)
364SE0003X	Emergency	100000000	Individuals or Groups (of Individuals)
364SE1400X	Ethics	100000000	Individuals or Groups (of Individuals)
364SF0001X	Family Health	100000000	Individuals or Groups (of Individuals)
364SG0600X	Gerontology	100000000	Individuals or Groups (of Individuals)
364SH1100X	Holistic	100000000	Individuals or Groups (of Individuals)
364SH0200X	Home Health	100000000	Individuals or Groups (of Individuals)
364SI0800X	Informatics	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
364SL0600X	Long-Term Care	100000000	Individuals or Groups (of Individuals)
364SM0705X	Medical-Surgical	100000000	Individuals or Groups (of Individuals)
364SN0000X	Neonatal	100000000	Individuals or Groups (of Individuals)
364SN0800X	Neuroscience	100000000	Individuals or Groups (of Individuals)
364SX0106X	Occupational Health	100000000	Individuals or Groups (of Individuals)
364SX0200X	Oncology	100000000	Individuals or Groups (of Individuals)
364SX0204X	Oncology, Pediatrics	100000000	Individuals or Groups (of Individuals)
364SP0200X	Pediatrics	100000000	Individuals or Groups (of Individuals)
364SP1700X	Perinatal	100000000	Individuals or Groups (of Individuals)
364SP2800X	Perioperative	100000000	Individuals or Groups (of Individuals)
364SP0808X	Psychiatric/Mental Health	100000000	Individuals or Groups (of Individuals)
364SP0809X	Psychiatric/Mental Health, Adult	100000000	Individuals or Groups (of Individuals)
364SP0807X	Psychiatric/Mental Health, Child & Adolescent	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
364SP0810X	Psychiatric/Mental Health, Child & Family	100000000	Individuals or Groups (of Individuals)
364SP0811X	Psychiatric/Mental Health, Chronically Ill	100000000	Individuals or Groups (of Individuals)
364SP0812X	Psychiatric/Mental Health, Community	100000000	Individuals or Groups (of Individuals)
364SP0813X	Psychiatric/Mental Health, Geropsychiatric	100000000	Individuals or Groups (of Individuals)
364SR0400X	Rehabilitation	100000000	Individuals or Groups (of Individuals)
364SS0200X	School	100000000	Individuals or Groups (of Individuals)
364ST0500X	Transplantation	100000000	Individuals or Groups (of Individuals)
364SW0102X	Women's Health	100000000	Individuals or Groups (of Individuals)
367500000X	Nurse Anesthetist, Certified Registered	100000000	Individuals or Groups (of Individuals)
363L00000X	Nurse Practitioner	100000000	Individuals or Groups (of Individuals)
363LA2100X	Acute Care	100000000	Individuals or Groups (of Individuals)
363LA2200X	Adult Health	100000000	Individuals or Groups (of Individuals)
363LC1500X	Community Health	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
363LC0200X	Critical Care Medicine	100000000	Individuals or Groups (of Individuals)
363LF0000X	Family	100000000	Individuals or Groups (of Individuals)
363LG0600X	Gerontology	100000000	Individuals or Groups (of Individuals)
363LN0000X	Neonatal	100000000	Individuals or Groups (of Individuals)
363LN0005X	Neonatal, Critical Care	100000000	Individuals or Groups (of Individuals)
363LX0001X	Obstetrics & Gynecology	100000000	Individuals or Groups (of Individuals)
363LX0106X	Occupational Health	100000000	Individuals or Groups (of Individuals)
363LP0200X	Pediatrics	100000000	Individuals or Groups (of Individuals)
363LP0222X	Pediatrics, Critical Care	100000000	Individuals or Groups (of Individuals)
363LP1700X	Perinatal	100000000	Individuals or Groups (of Individuals)
363LP2300X	Primary Care	100000000	Individuals or Groups (of Individuals)
363LP0808X	Psychiatric/Mental Health	100000000	Individuals or Groups (of Individuals)
363LS0200X	School	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
363LW0102X	Women's Health	100000000	Individuals or Groups (of Individuals)
363A00000X	Physician Assistant	100000000	Individuals or Groups (of Individuals)
363AM0700X	Medical	100000000	Individuals or Groups (of Individuals)
363AS0400X	Surgical	100000000	Individuals or Groups (of Individuals)
211D00000X	Assistant, Podiatric	100000000	Individuals or Groups (of Individuals)
213E00000X	Podiatrist	100000000	Individuals or Groups (of Individuals)
213ES0103X	Foot & Ankle Surgery	100000000	Individuals or Groups (of Individuals)
213ES0131X	Foot Surgery	100000000	Individuals or Groups (of Individuals)
213EG0000X	General Practice	100000000	Individuals or Groups (of Individuals)
213EP1101X	Primary Podiatric Medicine	100000000	Individuals or Groups (of Individuals)
213EP0504X	Public Medicine	100000000	Individuals or Groups (of Individuals)
213ER0200X	Radiology	100000000	Individuals or Groups (of Individuals)
213ES0000X	Sports Medicine	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
229N00000X	Anaplastologist	100000000	Individuals or Groups (of Individuals)
221700000X	Art Therapist	100000000	Individuals or Groups (of Individuals)
224Y00000X	Clinical Exercise Physiologist	100000000	Individuals or Groups (of Individuals)
225600000X	Dance Therapist	100000000	Individuals or Groups (of Individuals)
222Q00000X	Developmental Therapist	100000000	Individuals or Groups (of Individuals)
226300000X	Kinesiotherapist	100000000	Individuals or Groups (of Individuals)
225700000X	Massage Therapist	100000000	Individuals or Groups (of Individuals)
224900000X	Mastectomy Fitter	100000000	Individuals or Groups (of Individuals)
225A00000X	Music Therapist	100000000	Individuals or Groups (of Individuals)
225X00000X	Occupational Therapist	100000000	Individuals or Groups (of Individuals)
225XR0403X	Driving and Community Mobility	100000000	Individuals or Groups (of Individuals)
225XE0001X	Environmental Modification	100000000	Individuals or Groups (of Individuals)
225XE1200X	Ergonomics	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
225XF0002X	Feeding, Eating & Swallowing	100000000	Individuals or Groups (of Individuals)
225XG0600X	Gerontology	100000000	Individuals or Groups (of Individuals)
225XH1200X	Hand	100000000	Individuals or Groups (of Individuals)
225XH1300X	Human Factors	100000000	Individuals or Groups (of Individuals)
225XL0004X	Low Vision	100000000	Individuals or Groups (of Individuals)
225XM0800X	Mental Health	100000000	Individuals or Groups (of Individuals)
225XN1300X	Neurorehabilitation	100000000	Individuals or Groups (of Individuals)
225XP0200X	Pediatrics	100000000	Individuals or Groups (of Individuals)
225XP0019X	Physical Rehabilitation	100000000	Individuals or Groups (of Individuals)
224Z00000X	Occupational Therapy Assistant	100000000	Individuals or Groups (of Individuals)
224ZR0403X	Driving and Community Mobility	100000000	Individuals or Groups (of Individuals)
224ZE0001X	Environmental Modification	100000000	Individuals or Groups (of Individuals)
224ZF0002X	Feeding, Eating & Swallowing	100000000	Individuals or Groups (of Individuals)

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Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
224ZL0004X	Low Vision	100000000	Individuals or Groups (of Individuals)
225000000X	Orthotic Fitter	100000000	Individuals or Groups (of Individuals)
222Z00000X	Orthotist	100000000	Individuals or Groups (of Individuals)
224L00000X	Pedorthist	100000000	Individuals or Groups (of Individuals)
225100000X	Physical Therapist	100000000	Individuals or Groups (of Individuals)
2251C2600X	Cardiopulmonary	100000000	Individuals or Groups (of Individuals)
2251E1300X	Electrophysiology, Clinical	100000000	Individuals or Groups (of Individuals)
2251E1200X	Ergonomics	100000000	Individuals or Groups (of Individuals)
2251G0304X	Geriatrics	100000000	Individuals or Groups (of Individuals)
2251H1200X	Hand	100000000	Individuals or Groups (of Individuals)
2251H1300X	Human Factors	100000000	Individuals or Groups (of Individuals)
2251N0400X	Neurology	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
2251X0800X	Orthopedic	100000000	Individuals or Groups (of Individuals)
2251P0200X	Pediatrics	100000000	Individuals or Groups (of Individuals)
2251S0007X	Sports	100000000	Individuals or Groups (of Individuals)
225200000X	Physical Therapy Assistant	100000000	Individuals or Groups (of Individuals)
224P00000X	Prosthetist	100000000	Individuals or Groups (of Individuals)
225B00000X	Pulmonary Function Technologist	100000000	Individuals or Groups (of Individuals)
225800000X	Recreation Therapist	100000000	Individuals or Groups (of Individuals)
225C00000X	Rehabilitation Counselor	100000000	Individuals or Groups (of Individuals)
225CA2400X	Assistive Technology Practitioner	100000000	Individuals or Groups (of Individuals)
225CA2500X	Assistive Technology Supplier	100000000	Individuals or Groups (of Individuals)
225CX0006X	Orientation and Mobility Training Provider	100000000	Individuals or Groups (of Individuals)
225400000X	Rehabilitation Practitioner	100000000	Individuals or Groups (of Individuals)
227800000X	Respiratory Therapist, Certified	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
2278C0205X	Critical Care	100000000	Individuals or Groups (of Individuals)
2278E1000X	Educational	100000000	Individuals or Groups (of Individuals)
2278E0002X	Emergency Care	100000000	Individuals or Groups (of Individuals)
2278G1100X	General Care	100000000	Individuals or Groups (of Individuals)
2278G0305X	Geriatric Care	100000000	Individuals or Groups (of Individuals)
2278H0200X	Home Health	100000000	Individuals or Groups (of Individuals)
2278P3900X	Neonatal/Pediatrics	100000000	Individuals or Groups (of Individuals)
2278P3800X	Palliative/Hospice	100000000	Individuals or Groups (of Individuals)
2278P4000X	Patient Transport	100000000	Individuals or Groups (of Individuals)
2278P1004X	Pulmonary Diagnostics	100000000	Individuals or Groups (of Individuals)
2278P1006X	Pulmonary Function Technologist	100000000	Individuals or Groups (of Individuals)
2278P1005X	Pulmonary Rehabilitation	100000000	Individuals or Groups (of Individuals)
2278S1500X	SNF/Subacute Care	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
227900000X	Respiratory Therapist, Registered	100000000	Individuals or Groups (of Individuals)
2279C0205X	Critical Care	100000000	Individuals or Groups (of Individuals)
2279E1000X	Educational	100000000	Individuals or Groups (of Individuals)
2279E0002X	Emergency Care	100000000	Individuals or Groups (of Individuals)
2279G1100X	General Care	100000000	Individuals or Groups (of Individuals)
2279G0305X	Geriatric Care	100000000	Individuals or Groups (of Individuals)
2279H0200X	Home Health	100000000	Individuals or Groups (of Individuals)
2279P3900X	Neonatal/Pediatrics	100000000	Individuals or Groups (of Individuals)
2279P3800X	Palliative/Hospice	100000000	Individuals or Groups (of Individuals)
2279P4000X	Patient Transport	100000000	Individuals or Groups (of Individuals)
2279P1004X	Pulmonary Diagnostics	100000000	Individuals or Groups (of Individuals)
2279P1006X	Pulmonary Function Technologist	100000000	Individuals or Groups (of Individuals)
2279P1005X	Pulmonary Rehabilitation	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
2279S1500X	SNF/Subacute Care	100000000	Individuals or Groups (of Individuals)
225500000X	Specialist/Technologist	100000000	Individuals or Groups (of Individuals)
2255A2300X	Athletic Trainer	100000000	Individuals or Groups (of Individuals)
2255R0406X	Rehabilitation, Blind	100000000	Individuals or Groups (of Individuals)
231H00000X	Audiologist	100000000	Individuals or Groups (of Individuals)
231HA2400X	Assistive Technology Practitioner	100000000	Individuals or Groups (of Individuals)
231HA2500X	Assistive Technology Supplier	100000000	Individuals or Groups (of Individuals)
237600000X	Audiologist-Hearing Aid Fitter	100000000	Individuals or Groups (of Individuals)
237700000X	Hearing Instrument Specialist	100000000	Individuals or Groups (of Individuals)
235500000X	Specialist/Technologist	100000000	Individuals or Groups (of Individuals)
2355A2700X	Audiology Assistant	100000000	Individuals or Groups (of Individuals)
2355S0801X	Speech-Language Assistant	100000000	Individuals or Groups (of Individuals)
235Z00000X	Speech-Language Pathologist	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
390200000X	Student in an Organized Health Care Education/Training Program	100000000	Individuals or Groups (of Individuals)
242T00000X	Perfusionist	100000000	Individuals or Groups (of Individuals)
247100000X	Radiologic Technologist	100000000	Individuals or Groups (of Individuals)
2471B0102X	Bone Densitometry	100000000	Individuals or Groups (of Individuals)
2471C1106X	Cardiac-Interventional Technology	100000000	Individuals or Groups (of Individuals)
2471C1101X	Cardiovascular-Interventional Technology	100000000	Individuals or Groups (of Individuals)
2471C3401X	Computed Tomography	100000000	Individuals or Groups (of Individuals)
2471M1202X	Magnetic Resonance Imaging	100000000	Individuals or Groups (of Individuals)
2471M2300X	Mammography	100000000	Individuals or Groups (of Individuals)
2471N0900X	Nuclear Medicine Technology	100000000	Individuals or Groups (of Individuals)
2471Q0001X	Quality Management	100000000	Individuals or Groups (of Individuals)
2471R0002X	Radiation Therapy	100000000	Individuals or Groups (of Individuals)
2471C3402X	Radiography	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
2471S1302X	Sonography	100000000	Individuals or Groups (of Individuals)
2471V0105X	Vascular Sonography	100000000	Individuals or Groups (of Individuals)
2471V0106X	Vascular-Interventional Technology	100000000	Individuals or Groups (of Individuals)
243U00000X	Radiology Practitioner Assistant	100000000	Individuals or Groups (of Individuals)
246X00000X	Specialist/Technologist Cardiovascular	100000000	Individuals or Groups (of Individuals)
246XC2901X	Cardiovascular Invasive Specialist	100000000	Individuals or Groups (of Individuals)
246XS1301X	Sonography	100000000	Individuals or Groups (of Individuals)
246XC2903X	Vascular Specialist	100000000	Individuals or Groups (of Individuals)
246Y00000X	Specialist/Technologist, Health Information	100000000	Individuals or Groups (of Individuals)
246YC3301X	Coding Specialist, Hospital Based	100000000	Individuals or Groups (of Individuals)
246YC3302X	Coding Specialist, Physician Office Based	100000000	Individuals or Groups (of Individuals)
246YR1600X	Registered Record Administrator	100000000	Individuals or Groups (of Individuals)
246Z00000X	Specialist/Technologist, Other	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
246ZA2600X	Art, Medical	100000000	Individuals or Groups (of Individuals)
246ZB0500X	Biochemist	100000000	Individuals or Groups (of Individuals)
246ZB0301X	Biomedical Engineering	100000000	Individuals or Groups (of Individuals)
246ZB0302X	Biomedical Photographer	100000000	Individuals or Groups (of Individuals)
246ZB0600X	Biostatistician	100000000	Individuals or Groups (of Individuals)
246ZC0007X	Certified First Assistant	100000000	Individuals or Groups (of Individuals)
246ZE0500X	EEG	100000000	Individuals or Groups (of Individuals)
246ZE0600X	Electroneurodiagnostic	100000000	Individuals or Groups (of Individuals)
246ZG1000X	Geneticist, Medical (PhD)	100000000	Individuals or Groups (of Individuals)
246ZG0701X	Graphics Methods	100000000	Individuals or Groups (of Individuals)
246ZI1000X	Illustration, Medical	100000000	Individuals or Groups (of Individuals)
246ZN0300X	Nephrology	100000000	Individuals or Groups (of Individuals)
246ZS0400X	Surgical	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
246Q00000X	Specialist/Technologist, Pathology	100000000	Individuals or Groups (of Individuals)
246QB0000X	Blood Banking	100000000	Individuals or Groups (of Individuals)
246QC1000X	Chemistry	100000000	Individuals or Groups (of Individuals)
246QC2700X	Cytotechnology	100000000	Individuals or Groups (of Individuals)
246QH0401X	Hemapheresis Practitioner	100000000	Individuals or Groups (of Individuals)
246QH0000X	Hematology	100000000	Individuals or Groups (of Individuals)
246QH0600X	Histology	100000000	Individuals or Groups (of Individuals)
246QI0000X	Immunology	100000000	Individuals or Groups (of Individuals)
246QL0900X	Laboratory Management	100000000	Individuals or Groups (of Individuals)
246QL0901X	Laboratory Management, Diplomate	100000000	Individuals or Groups (of Individuals)
246QM0706X	Medical Technologist	100000000	Individuals or Groups (of Individuals)
246QM0900X	Microbiology	100000000	Individuals or Groups (of Individuals)
246W00000X	Technician, Cardiology	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
247000000X	Technician, Health Information	100000000	Individuals or Groups (of Individuals)
2470A2800X	Assistant Record Technician	100000000	Individuals or Groups (of Individuals)
247200000X	Technician, Other	100000000	Individuals or Groups (of Individuals)
2472B0301X	Biomedical Engineering	100000000	Individuals or Groups (of Individuals)
2472D0500X	Darkroom	100000000	Individuals or Groups (of Individuals)
2472E0500X	EEG	100000000	Individuals or Groups (of Individuals)
2472R0900X	Renal Dialysis	100000000	Individuals or Groups (of Individuals)
2472V0600X	Veterinary	100000000	Individuals or Groups (of Individuals)
246R00000X	Technician, Pathology	100000000	Individuals or Groups (of Individuals)
247ZC0005X	Clinical Laboratory Director, Non-physician	100000000	Individuals or Groups (of Individuals)
246RH0600X	Histology	100000000	Individuals or Groups (of Individuals)
246RM2200X	Medical Laboratory	100000000	Individuals or Groups (of Individuals)
246RP1900X	Phlebotomy	100000000	Individuals or Groups (of Individuals)

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
251300000X	Local Education Agency (LEA)	250000000	Non-Individual - Agencies
251B00000X	Case Management	250000000	Non-Individual - Agencies
251S00000X	Community/Behavioral Health	250000000	Non-Individual - Agencies
251C00000X	Day Training, Developmentally Disabled Services	250000000	Non-Individual - Agencies
252Y00000X	Early Intervention Provider Agency	250000000	Non-Individual - Agencies
253J00000X	Foster Care Agency	250000000	Non-Individual - Agencies
251E00000X	Home Health	250000000	Non-Individual - Agencies
251F00000X	Home Infusion	250000000	Non-Individual - Agencies
251G00000X	Hospice Care, Community Based	250000000	Non-Individual - Agencies
253Z00000X	In Home Supportive Care	250000000	Non-Individual - Agencies
251J00000X	Nursing Care	250000000	Non-Individual - Agencies
251T00000X	Program of All-Inclusive Care for the Elderly (PACE) Provider Organization	250000000	Non-Individual - Agencies
251K00000X	Public Health or Welfare	250000000	Non-Individual - Agencies
251X00000X	Supports Brokerage	250000000	Non-Individual - Agencies
251V00000X	Voluntary or Charitable	250000000	Non-Individual - Agencies
261Q00000X	Clinic/Center	260000000	Non-Individual - Ambulatory Health Care Facilities
261QM0855X	Adolescent and Children Mental Health	260000000	Non-Individual - Ambulatory Health Care Facilities
261QA0600X	Adult Day Care	260000000	Non-Individual - Ambulatory Health Care Facilities

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
261QM0850X	Adult Mental Health	260000000	Non-Individual - Ambulatory Health Care Facilities
261QA0005X	Ambulatory Family Planning Facility	260000000	Non-Individual - Ambulatory Health Care Facilities
261QA0006X	Ambulatory Fertility Facility	260000000	Non-Individual - Ambulatory Health Care Facilities
261QA1903X	Ambulatory Surgical	260000000	Non-Individual - Ambulatory Health Care Facilities
261QA0900X	Amputee	260000000	Non-Individual - Ambulatory Health Care Facilities
261QA3000X	Augmentative Communication	260000000	Non-Individual - Ambulatory Health Care Facilities
261QB0400X	Birthing	260000000	Non-Individual - Ambulatory Health Care Facilities
261QC1500X	Community Health	260000000	Non-Individual - Ambulatory Health Care Facilities
261QC1800X	Corporate Health	260000000	Non-Individual - Ambulatory Health Care Facilities
261QC0050X	Critical Access Hospital	260000000	Non-Individual - Ambulatory Health Care Facilities
261QD0000X	Dental	260000000	Non-Individual - Ambulatory Health Care Facilities
261QD1600X	Developmental Disabilities	260000000	Non-Individual - Ambulatory Health Care Facilities
261QE0002X	Emergency Care	260000000	Non-Individual - Ambulatory Health Care Facilities

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
261QE0800X	Endoscopy	260000000	Non-Individual - Ambulatory Health Care Facilities
261QE0700X	End-Stage Renal Disease (ESRD) Treatment	260000000	Non-Individual - Ambulatory Health Care Facilities
261QF0050X	Family Planning, Non-Surgical	260000000	Non-Individual - Ambulatory Health Care Facilities
261QF0400X	Federally Qualified Health Center (FQHC)	260000000	Non-Individual - Ambulatory Health Care Facilities
261QG0250X	Genetics	260000000	Non-Individual - Ambulatory Health Care Facilities
261QH0100X	Health Service	260000000	Non-Individual - Ambulatory Health Care Facilities
261QH0700X	Hearing and Speech	260000000	Non-Individual - Ambulatory Health Care Facilities
261QI0500X	Infusion Therapy	260000000	Non-Individual - Ambulatory Health Care Facilities
261QL0400X	Lithotripsy	260000000	Non-Individual - Ambulatory Health Care Facilities
261QM1200X	Magnetic Resonance Imaging (MRI)	260000000	Non-Individual - Ambulatory Health Care Facilities
261QM2500X	Medical Specialty	260000000	Non-Individual - Ambulatory Health Care Facilities
261QM3000X	Medically Fragile Infants and Children Day Care	260000000	Non-Individual - Ambulatory Health Care Facilities
261QM0801X	Mental Health (Including Community Mental Health Center)	260000000	Non-Individual - Ambulatory Health Care Facilities

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
261QM2800X	Methadone	260000000	Non-Individual - Ambulatory Health Care Facilities
261QM1000X	Migrant Health	260000000	Non-Individual - Ambulatory Health Care Facilities
261QM1103X	Military Ambulatory Procedure Visits Operational (Transportable)	260000000	Non-Individual - Ambulatory Health Care Facilities
261QM1101X	Military and U.S. Coast Guard Ambulatory Procedure	260000000	Non-Individual - Ambulatory Health Care Facilities
261QM1102X	Military Outpatient Operational (Transportable) Component	260000000	Non-Individual - Ambulatory Health Care Facilities
261QM1100X	Military/U.S. Coast Guard Outpatient	260000000	Non-Individual - Ambulatory Health Care Facilities
261QM1300X	Multi-Specialty	260000000	Non-Individual - Ambulatory Health Care Facilities
261QX0100X	Occupational Medicine	260000000	Non-Individual - Ambulatory Health Care Facilities
261QX0200X	Oncology	260000000	Non-Individual - Ambulatory Health Care Facilities
261QX0203X	Oncology, Radiation	260000000	Non-Individual - Ambulatory Health Care Facilities
261QS0132X	Ophthalmologic Surgery	260000000	Non-Individual - Ambulatory Health Care Facilities
261QS0112X	Oral and Maxillofacial Surgery	260000000	Non-Individual - Ambulatory Health Care Facilities
261QP3300X	Pain	260000000	Non-Individual - Ambulatory Health Care Facilities

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
261QP2000X	Physical Therapy	260000000	Non-Individual - Ambulatory Health Care Facilities
261QP1100X	Podiatric	260000000	Non-Individual - Ambulatory Health Care Facilities
261QP2300X	Primary Care	260000000	Non-Individual - Ambulatory Health Care Facilities
261QP2400X	Prison Health	260000000	Non-Individual - Ambulatory Health Care Facilities
261QP0904X	Public Health, Federal	260000000	Non-Individual - Ambulatory Health Care Facilities
261QP0905X	Public Health, State or Local	260000000	Non-Individual - Ambulatory Health Care Facilities
261QR0200X	Radiology	260000000	Non-Individual - Ambulatory Health Care Facilities
261QR0206X	Radiology, Mammography	260000000	Non-Individual - Ambulatory Health Care Facilities
261QR0208X	Radiology, Mobile	260000000	Non-Individual - Ambulatory Health Care Facilities
261QR0207X	Radiology, Mobile Mammography	260000000	Non-Individual - Ambulatory Health Care Facilities
261QR0800X	Recovery Care	260000000	Non-Individual - Ambulatory Health Care Facilities
261QR0400X	Rehabilitation	260000000	Non-Individual - Ambulatory Health Care Facilities
261QR0404X	Rehabilitation, Cardiac Facilities	260000000	Non-Individual - Ambulatory Health Care Facilities

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
261QR0401X	Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF)	260000000	Non-Individual - Ambulatory Health Care Facilities
261QR0405X	Rehabilitation, Substance Use Disorder	260000000	Non-Individual - Ambulatory Health Care Facilities
261QR1100X	Research	260000000	Non-Individual - Ambulatory Health Care Facilities
261QR1300X	Rural Health	260000000	Non-Individual - Ambulatory Health Care Facilities
261QS1200X	Sleep Disorder Diagnostic	260000000	Non-Individual - Ambulatory Health Care Facilities
261QS1000X	Student Health	260000000	Non-Individual - Ambulatory Health Care Facilities
261QU0200X	Urgent Care	260000000	Non-Individual - Ambulatory Health Care Facilities
261QV0200X	VA	260000000	Non-Individual - Ambulatory Health Care Facilities
273100000X	Epilepsy Unit	270000000	Non-Individual - Hospital Units
275N00000X	Medicare Defined Swing Bed Unit	270000000	Non-Individual - Hospital Units
273R00000X	Psychiatric Unit	270000000	Non-Individual - Hospital Units
273Y00000X	Rehabilitation Unit	270000000	Non-Individual - Hospital Units
276400000X	Rehabilitation, Substance Use Disorder Unit	270000000	Non-Individual - Hospital Units
287300000X	Christian Science Sanitorium	280000000	Non-Individual - Hospitals
281P00000X	Chronic Disease Hospital	280000000	Non-Individual - Hospitals
281PC2000X	Children	280000000	Non-Individual - Hospitals

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
282N00000X	General Acute Care Hospital	280000000	Non-Individual - Hospitals
282NC2000X	Children	280000000	Non-Individual - Hospitals
282NC0060X	Critical Access	280000000	Non-Individual - Hospitals
282NR1301X	Rural	280000000	Non-Individual - Hospitals
282NW0100X	Women	280000000	Non-Individual - Hospitals
282E00000X	Long Term Care Hospital	280000000	Non-Individual - Hospitals
286500000X	Military Hospital	280000000	Non-Individual - Hospitals
2865C1500X	Community Health	280000000	Non-Individual - Hospitals
2865M2000X	Military General Acute Care Hospital	280000000	Non-Individual - Hospitals
2865X1600X	Military General Acute Care Hospital. Operational (Transportable)	280000000	Non-Individual - Hospitals
283Q00000X	Psychiatric Hospital	280000000	Non-Individual - Hospitals
283X00000X	Rehabilitation Hospital	280000000	Non-Individual - Hospitals
283XC2000X	Children	280000000	Non-Individual - Hospitals
282J00000X	Religious Nonmedical Health Care Institution	280000000	Non-Individual - Hospitals
284300000X	Special Hospital	280000000	Non-Individual - Hospitals
291U00000X	Clinical Medical Laboratory	290000000	Non-Individual - Laboratories
292200000X	Dental Laboratory	290000000	Non-Individual - Laboratories
291900000X	Military Clinical Medical Laboratory	290000000	Non-Individual - Laboratories
293D00000X	Physiological Laboratory	290000000	Non-Individual - Laboratories

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
302F00000X	Exclusive Provider Organization	300000000	Non-Individual - Managed Care Organizations
302R00000X	Health Maintenance Organization	300000000	Non-Individual - Managed Care Organizations
305S00000X	Point of Service	300000000	Non-Individual - Managed Care Organizations
305R00000X	Preferred Provider Organization	300000000	Non-Individual - Managed Care Organizations
311500000X	Alzheimer Center (Dementia Center)	310000000	Non-Individual - Nursing & Custodial Care Facilities
310400000X	Assisted Living Facility	310000000	Non-Individual - Nursing & Custodial Care Facilities
3104A0630X	Assisted Living, Behavioral Disturbances	310000000	Non-Individual - Nursing & Custodial Care Facilities
3104A0625X	Assisted Living, Mental Illness	310000000	Non-Individual - Nursing & Custodial Care Facilities
317400000X	Christian Science Facility	310000000	Non-Individual - Nursing & Custodial Care Facilities
311Z00000X	Custodial Care Facility	310000000	Non-Individual - Nursing & Custodial Care Facilities
311ZA0620X	Adult Care Home	310000000	Non-Individual - Nursing & Custodial Care Facilities
315D00000X	Hospice, Inpatient	310000000	Non-Individual - Nursing & Custodial Care Facilities
310500000X	Intermediate Care Facility, Mental Illness	310000000	Non-Individual - Nursing & Custodial Care Facilities

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
315P00000X	Intermediate Care Facility, Mentally Retarded	310000000	Non-Individual - Nursing & Custodial Care Facilities
313M00000X	Nursing Facility/Intermediate Care Facility	310000000	Non-Individual - Nursing & Custodial Care Facilities
314000000X	Skilled Nursing Facility	310000000	Non-Individual - Nursing & Custodial Care Facilities
3140N1450X	Nursing Care, Pediatric	310000000	Non-Individual - Nursing & Custodial Care Facilities
177F00000X	Lodging	170000000	Non-Individual - Other Service Providers
174200000X	Meals	170000000	Non-Individual - Other Service Providers
320800000X	Community Based Residential Treatment Facility, Mental Illness	320000000	Non-Individual - Residential Treatment Facilities
320900000X	Community Based Residential Treatment Facility, Mental Retardation and/or Developmental Disabilities	320000000	Non-Individual - Residential Treatment Facilities
323P00000X	Psychiatric Residential Treatment Facility	320000000	Non-Individual - Residential Treatment Facilities
322D00000X	Residential Treatment Facility, Emotionally Disturbed Children	320000000	Non-Individual - Residential Treatment Facilities
320600000X	Residential Treatment Facility, Mental Retardation and/or Developmental Disabilities	320000000	Non-Individual - Residential Treatment Facilities
320700000X	Residential Treatment Facility, Physical Disabilities	320000000	Non-Individual - Residential Treatment Facilities
324500000X	Substance Abuse Rehabilitation Facility	320000000	Non-Individual - Residential Treatment Facilities

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
3245S0500X	Substance Abuse Treatment, Children	320000000	Non-Individual - Residential Treatment Facilities
385H00000X	Respite Care	380000000	Non-Individual - Respite Care Facility
385HR2050X	Respite Care Camp	380000000	Non-Individual - Respite Care Facility
385HR2055X	Respite Care, Mental Illness, Child	380000000	Non-Individual - Respite Care Facility
385HR2060X	Respite Care, Mental Retardation and/or Developmental Disabilities	380000000	Non-Individual - Respite Care Facility
385HR2065X	Respite Care, Physical Disabilities, Child	380000000	Non-Individual - Respite Care Facility
331L00000X	Blood Bank	330000000	Non-Individual - Suppliers
332100000X	Department of Veterans Affairs (VA) Pharmacy	330000000	Non-Individual - Suppliers
332B00000X	Durable Medical Equipment & Medical Supplies	330000000	Non-Individual - Suppliers
332BC3200X	Customized Equipment	330000000	Non-Individual - Suppliers
332BD1200X	Dialysis Equipment & Supplies	330000000	Non-Individual - Suppliers
332BN1400X	Nursing Facility Supplies	330000000	Non-Individual - Suppliers
332BX2000X	Oxygen Equipment & Supplies	330000000	Non-Individual - Suppliers
332BP3500X	Parenteral & Enteral Nutrition	330000000	Non-Individual - Suppliers
333300000X	Emergency Response System Companies	330000000	Non-Individual - Suppliers
332G00000X	Eye Bank	330000000	Non-Individual - Suppliers
332H00000X	Eyewear Supplier (Equipment, not the service)	330000000	Non-Individual - Suppliers
332S00000X	Hearing Aid Equipment	330000000	Non-Individual - Suppliers
332U00000X	Home Delivered Meals	330000000	Non-Individual - Suppliers

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
332800000X	Indian Health Service/Tribal/Urban Indian Health (I/T/U) Pharmacy	330000000	Non-Individual - Suppliers
335G00000X	Medical Foods Supplier	330000000	Non-Individual - Suppliers
332000000X	Military/U.S. Coast Guard Pharmacy	330000000	Non-Individual - Suppliers
332900000X	Non-Pharmacy Dispensing Site	330000000	Non-Individual - Suppliers
335U00000X	Organ Procurement Organization	330000000	Non-Individual - Suppliers
333600000X	Pharmacy	330000000	Non-Individual - Suppliers
3336C0002X	Clinic Pharmacy	330000000	Non-Individual - Suppliers
3336C0003X	Community/Retail Pharmacy	330000000	Non-Individual - Suppliers
3336C0004X	Compounding Pharmacy	330000000	Non-Individual - Suppliers
3336H0001X	Home Infusion Therapy Pharmacy	330000000	Non-Individual - Suppliers
3336I0012X	Institutional Pharmacy	330000000	Non-Individual - Suppliers
3336L0003X	Long Term Care Pharmacy	330000000	Non-Individual - Suppliers
3336M0002X	Mail Order Pharmacy	330000000	Non-Individual - Suppliers
3336M0003X	Managed Care Organization Pharmacy	330000000	Non-Individual - Suppliers
3336N0007X	Nuclear Pharmacy	330000000	Non-Individual - Suppliers
3336S0011X	Specialty Pharmacy	330000000	Non-Individual - Suppliers
335V00000X	Portable X-Ray Supplier	330000000	Non-Individual - Suppliers
335E00000X	Prosthetic/Orthotic Supplier	330000000	Non-Individual - Suppliers
344800000X	Air Carrier	340000000	Non-Individual - Transportation Services

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
341600000X	Ambulance	340000000	Non-Individual - Transportation Services
3416A0800X	Air Transport	340000000	Non-Individual - Transportation Services
3416L0300X	Land Transport	340000000	Non-Individual - Transportation Services
3416S0300X	Water Transport	340000000	Non-Individual - Transportation Services
347B00000X	Bus	340000000	Non-Individual - Transportation Services
341800000X	Military/U.S. Coast Guard Transport	340000000	Non-Individual - Transportation Services
3418M1120X	Military or U.S. Coast Guard Ambulance, Air Transport	340000000	Non-Individual - Transportation Services
3418M1110X	Military or U.S. Coast Guard Ambulance, Ground Transport	340000000	Non-Individual - Transportation Services
3418M1130X	Military or U.S. Coast Guard Ambulance, Water Transport	340000000	Non-Individual - Transportation Services
343900000X	Non-emergency Medical Transport (VAN)	340000000	Non-Individual - Transportation Services
347C00000X	Private Vehicle	340000000	Non-Individual - Transportation Services
343800000X	Secured Medical Transport (VAN)	340000000	Non-Individual - Transportation Services
344600000X	Taxi	340000000	Non-Individual - Transportation Services

Provider Taxonomy Code	Provider Taxonomy Description	Provider Facility Type Code	Provider Facility Type Description
347D00000X	Train	340000000	Non-Individual - Transportation Services
347E00000X	Transportation Broker	340000000	Non-Individual - Transportation Services

Appendix M: Crosswalk of T-MSIS, MSIS and MMA Dual Eligible Code

Coding requirement on the DUAL-ELIGIBLE-CODE data element

When populating the DUAL-ELIGIBLE-CODE data element, States should ignore the coding requirement regarding Medicare Modernization Act. ("This field should be populated from the same data that were used to populate the State's submission of the Medicare Modernization Act ("State MMA File") monthly file to CMS. In other words, the data values from the State MMA File should match this dual eligible data element.")

CMS has already incorporated the MMA valid values into MSIS and carried them forth into T-MSIS, as can be seen in the crosswalk below.

T-MSIS	MSIS	MMA*
00 Eligible is not a Medicare beneficiary	00 Eligible is not a Medicare beneficiary	00 = Not Medicare enrolled for the month
01 Eligible is entitled to Medicare- QMB only	01 Eligible is entitled to Medicare- QMB only	01 = QMB only
02 Eligible is entitled to Medicare- QMB AND Medicaid coverage	02 Eligible is entitled to Medicare- QMB AND Medicaid coverage including RX	02 = QMB and Medicaid coverage including RX
03 Eligible is entitled to Medicare- SLMB only	03 Eligible is entitled to Medicare- SLMB only	3 = SLMB only
04 Eligible is entitled to Medicare- SLMB AND Medicaid coverage	04 Eligible is entitled to Medicare- SLMB AND Medicaid coverage including RX	04 = SLMB and Medicaid coverage including RX
05 Eligible is entitled to Medicare- QDWI	05 Eligible is entitled to Medicare- QDWI	05 = QDWI
06 Eligible is entitled to Medicare- Qualifying individuals	06 Eligible is entitled to Medicare- Qualifying individuals	06 = Qualifying Individuals

T-MSIS	MSIS	MMA*
08 Eligible is entitled to Medicare- Other Dual Eligibles (Non QMB, SLMB, QDWI or QI)	08 Eligible is entitled to Medicare- Other Dual Eligibles (Non QMB, SLMB, QWDI or QI) with Medicaid coverage including RX	08 = Other Dual Eligibles (Non-QMB, SLMB, QWDI, or QI) w/Medicaid coverage including RX
09 Eligible is entitled to Medicare – Other (*This code is to be used only with specific CMS approval.*)	09 Eligible is entitled to Medicare – Other Dual Eligibles	09 = Other Dual Eligibles but without Medicaid coverage
10 Separate CHIP Eligible is entitled to Medicare	10 Separate CHIP Eligible is entitled to Medicare	N/A
99 Eligible's Medicare status is unknown.	99 Eligible's Medicare status is unknown.	99 – Unknown
N/A	N/A	NA = Non-Medicaid

Appendix N: Coding Specific Data Elements for Claim Files

Clarification of the use of the PROCEDURE-CODE, REVENUE-CODE, HCPCS-RATE, BEGINNING-DATE-OF-SERVICE, and ENDING-DATE-OF-SERVICE fields in the CLAIMOT File.

Because the CLAIMOT file is a catch-all file that includes outpatient facility claims, professional claims and financial transactions, states are having confusion over when to populate the PROCEDURE-CODE, REVENUE-CODE, HCPCS-RATE , BEGINNING-DATE-OF-SERVICE, ENDING-DATE-OF-SERVICE, PROCEDURE-CODE-DATE, PROCEDURE-CODE-FLAG, and PROCEDURE-CODE-MOD-1 thru -4 fields. To assist them we have prepared the following guidelines.

For professional claims:

- **REVENUE-CODE** should be 8-filled, left blank or space-filled.
- **HCPCS-RATE** should be 8-filled, left blank or space-filled.
- **PROCEDURE-CODE-FLAG** should be populated with either "01 (CPT-4), "06" (HCPCS), or "10" through "87" (to indicate other coding schemas).
- **PROCEDURE-CODE** should be used to capture the CPT/HCPCS service codes.
- **PROCEDURE-CODE-MOD-1 thru -4** should be populated as needed.
- **BEGINNING-DATE-OF-SERVICE** should show the 1st DOS associated with the service code in the PROCEDURE-CODE field.
- **ENDING-DATE-OF-SERVICE** should show the last DOS associated with the service code in the PROCEDURE-CODE field.
- **PROCEDURE-CODE-DATE** should be 8-filled, left blank or space-filled (This field is superfluous. Beginning-/Ending-Date-of-Service captures the same information and provides more flexibility if the service is provided repeatedly over a period of time.)

*For institutional claims for ambulatory care (**reported on CLAIMOT file**):*

- **REVENUE-CODE** should be used to capture the services provided.
- **HCPCS-RATE** should be used to capture HCPCS details whenever they are needed to support the value in the REVENUE-CODE field. Otherwise, the field should be 8-filled, left blank or space-filled.
- **PROCEDURE-CODE-FLAG** should be 8-filled, left blank or space-filled.
- **PROCEDURE-CODE** field should be 8-filled, left blank or space-filled.
- **PROCEDURE-CODE-MOD-1 thru -4** should be 8-filled, left blank or space-filled.
- **BEGINNING-DATE-OF-SERVICE** should show the 1st DOS associated with the service code in the REVENUE-CODE field.

- **ENDING-DATE-OF-SERVICE** should show the last DOS associated with the service code in the REVENUE-CODE field.
- **PROCEDURE-CODE-DATE** should be 8-filled, left blank or space-filled (This field is superfluous. Beginning-/Ending-Date-of-Service captures the same information and provides more flexibility if the service is provided repeatedly over a period of time.)

For financial transactions[1]*:*

- **REVENUE-CODE** field should be 8-filled, left blank or space-filled.
- **HCPCS-RATE** should be 8-filled, left blank or space-filled.
- **PROCEDURE-CODE-FLAG** should be 8-filled, left blank or space-filled, or populated with "10" through "87" (to indicate other coding schemas if state-specific codes are used).
- **PROCEDURE-CODE** field should be 8-filled, left blank or space-filled unless the State has state-specific codes it uses to provide further detail (e.g., codes to split capitation payments into subcategories).
- **PROCEDURE-CODE-MOD-1 thru -4** should be 8-filled, left blank or space-filled.
- **BEGINNING-DATE-OF-SERVICE** should show the 1st day of the time period covered by this financial transaction.
- **ENDING-DATE-OF-SERVICE** should show the last day of the time period covered by this financial transaction.
- **PROCEDURE-CODE-DATE** should be 8-filled, left blank or space-filled (This field is superfluous. Beginning-/Ending-Date-of-Service captures the same information and provides more flexibility if the service is provided repeatedly over a period of time.)

[1] *CMS Guidance – Reporting Financial Transactions in T-MSIS – 2014-04-23*

Appendix O: TYPE-OF-SERVICE Hierarchy Table

When a claim has multiple claim lines that could be reported in more than one CLAIMS file, <u>in any combination as represented in columns A, B, C, or D</u>, please report all claim lines in the CLAIMS file type represented by the green highlight in the table below, and report the TYPE-OF-SERVICE as follows:

1. ***For claim lines that would have been reported in the MSIS the LT, OT, and RX files,***
   They are now to be reported in
   - ***the T-MSIS CLAIMIP file as a complete claim, and***
   - ***code the TYPE-OF-SERVICE to reflect the type of service that represents the entire facility claim (****TYPE OF SERVICE CODE of 001, 060, 084, 086, 090, 091, 092, 093, 058, 123, 132, or 135, whichever is most appropriate for CLAIMIP record being reported).***

     Example – a multi-line claim that was reported in MSIS by the state as separate IP and OT records for the inpatient care, laboratory services, and emergency room services -is now to be reported in T-MSIS entirely as a single inpatient hospital facility claim *with every line containing a TYPE-OF-SERVICE – 001.*

2. For claim lines that would have been reported in the MSIS OT and RX files,
They are now to be reported in
- ***the T-MSIS CLAIMLT file as a complete claim,***
- ***and code the TYPE-OF-SERVICE to reflect the type of service that represents the entire facility claim (TYPE-OF-SERVICE 009, 044, 045, 046, 047, 048, 050, 059, or 133 whichever is most appropriate for CLAIMLT claim record being reported)***

3. For claim lines that would have been reported the RX and OT files in MSIS,
They are now to be reported in
- ***the T-MSIS CLAIMRX file as a complete claim billed by a pharmacy or pharmacist (through a pharmacy point-of-sale system),and***
- ***code the TYPE-OF-SERVICE to reflect the type of service that was provided***

Hierarchy Table
– to be used when determining which file a claim is to be reported in when the TYPE-OF-SERVICE may be reportable in more than one claims file type.

A	*NA*	*B*	*NA*	*C*	*NA*	*D*	*NA*
IP	*Code TYPE-OF-SERVICE as one of the following for all lines* *001, 060, 084, 086, 090, 091, 092, 093, 058, 123, 132, or 135*	*IP*	*Code TYPE-OF-SERVICE as one of the following for all lines* *001, 058, 123, 132, 135*	*NA*	*NA*	*NA*	*NA*
LT	*NA*		*NA*	*LT*	*Code TYPE-OF-SERVICE as one of the following for all lines* *009, 044, 045, 046, 047, 048, 050, 059,*	*NA*	*NA*

					133		
OT	*NA*	*OT*	*NA*	*OT*	*NA*	*RX*	*Code RX TYPE-OF-SERVICE for the RX line 011, 018, 033, 034, 036, 085, 089, 127, 131*
RX	*NA*	*RX*	*NA*	*RX*	*NA*	*OT*	*Code OT TYPE-OF-SERVICE as the Specific OT TYPE-OF-SERVICE*

Appendix P: CMS Guidance Library

Appendix P.01: Submitting Adjustment Claims to T-MSIS

Brief Issue Description

There are two ways original claims and their subsequent adjustments can be linked into a claim family – either through all adjustments linking back to the original claim or each subsequent adjustment linking back to the prior claim (i.e. "daisy chain"). Identifying the members of a claim family is necessary in order to evaluate the changes to a claim that occur throughout its life.

Background Discussion

Before delving into CMS' guidance on how to populate the ICN-ORIG and ICN-ADJ fields, some background discussion is needed on terminology and concepts.

What claim transactions should be submitted to T-MSIS?

Every "final adjudicated version of the claim/encounter" should be submitted to T-MSIS.

A "final adjudicated version of the claim/encounter" is a claim that has completed the adjudication process and the paid/denied process. The claim and each claim line will have one of the finalized claim status categories listed in Table 1, below. The actual disposition of the claim can be either "paid" or "denied."

Table 1: Finalized Claim Status Categories

Code	Finalized Claim Status Category Description
F0	Finalized-The encounter has completed the adjudication cycle and no more action will be taken. (Used on encounter records)
F1	Finalized/Payment-The claim/line has been paid.
F2	Finalized/Denial-The claim/line has been denied.
F3	Finalized/Revised - Adjudication information has been changed.

Both original claims (or encounters) and adjusted claims (or encounters) can be a "final adjudicated version of the claim/encounter." Whenever a claim/encounter flows through the adjudication and payment processes (if applicable) and falls into one of the claim status categories in Table 1, the state should send the claim/encounter to T-MSIS.

If a claim flows through the adjudication and payment processes and falls into one of the finalized claim status categories multiple times within a single T-MSIS reporting period, CMS expects each of these final adjudicated versions of the claim/encounter to be submitted to T-MSIS, not just the one effective on the last day of the reporting period.

If the claim has not been through the final adjudication process or is "pending" (or in "suspense"), the claim should not be sent to T-MSIS until disposition has been settled to one of the finalized claim status categories. Table 2 provides examples and CMS' expectations.

Table 2: Scenarios for When to Submit Claims

Claim Submission Scenario	CMS' Expectation
Adjudicated and paid in the same reporting month	CMS expects the claim to be sent to T-MSIS in the reporting month.
Adjudicated in one reporting period, but paid in another reporting month	CMS expects the claim to be sent to T-MSIS in the month that the claim was paid.
Adjudicated and paid in one reporting month, and then re-adjudicated and paid in a subsequent month	The claim should be reported in the month it is paid, regardless of whether it is an original claim or an adjustment. Therefore, in this scenario, CMS expects the original to be reported in month one and the adjustment to be reported in the subsequent month.
Adjudicated and paid, and then re-adjudicated and paid in the same reporting month	In this scenario, if a claim flows through the adjudication and payment processes and falls into one of the claim status categories in Table 1 multiple times within a single T-MSIS reporting period, CMS expects each of these final adjudicated versions of the claim/encounter to be submitted to T-MSIS, not just the one effective on the last day of the reporting period.
Re-adjudicated and paid multiple times in the same reporting month	In this scenario, if a claim flows through the adjudication and payment processes and falls into one of the claim status categories in Table 1 multiple times within a single T-MSIS reporting period, CMS expects each of these final adjudicated versions of the claim/encounter to be submitted to T-MSIS, not just the one effective on the last day of the reporting period.

What is a claim family?

A "claim family" (a.k.a. "adjustment set")is defined as a set of post-adjudication claim transactions in paid or denied status that relate to the same provider/enrollee/services/dates of service. This grouping of the original claim and all of its subsequent adjustment and/or void claims shows the progression of changes that have occurred since it was first submitted.

How should ADJUSTMENT-IND codes be used?

The table below lists each of the adjustment indicator codes contained in the T-MSIS Data Dictionary version 1.1 and describes when it should be used.

Table 3: Adjustment Indicator Codes and Their Uses

Code	Description of Use
0	Original Claim/Encounter/Payment – Indicates that this is the first (and, when applicable, only) fully adjudicated transaction in a claim family (one or more claims with the related ICN-ORIG and/or ICN-ADJ and typically the same MSIS ID and provider ID(s) also).

Code	Description of Use
1	Void/Reversal/Cancel of a prior submission – Use this code to convey that the purpose of the transaction is to void/reverse/cancel a previously paid/approved claim/encounter/payment where the claim/encounter/payment is not being replaced by a new paid/approved version of the claim/encounter/payment. Typically this would be the last claim/encounter/payment that would ever be associated with a given claim family. These records must have the same ICN-ORIG or ICN-ADJ as the claim/encounter being voided. CMS expects a void transaction to also have the same MSIS ID and provider ID(s) as the claim/encounter/payment being voided/reversed/canceled.
4	Replacement/Resubmission of a previously paid/approved claim/encounter/payment – Use when the purpose of the transaction is to replace a previously paid/approved claim/encounter/payment with a new paid/approved version of the claim/encounter/payment. These records must have the same ICN-ORIG or ICN-ADJ as the claim/encounter being replaced. CMS expects a replacement transaction to also have the same MSIS ID and provider ID(s) as the claim/encounter/payment being replaced/resubmitted.
5	Credit Gross Adjustment – Use this code to indicate an aggregate provider-level recoupment of payments (e.g., not attributable to a single beneficiary). Amounts on these claims should be expressed as negative numbers. If a credit gross adjustment is reported with an ICN that is related to an ICN(s) of another gross adjustment (credit or debit) then CMS will interpret this to mean that the credit gross adjustment with the more recent adjudication date should completely replace the preceding related gross adjustment. If the ICNs of a credit gross adjustment are not related to any other gross adjustments (credit or debit) then the credit gross adjustment will always be treated as a distinct financial transaction.
6	Debit Gross Adjustment – Use this code to indicate an aggregate provider-level payment to a provider (e.g., not attributable to a single beneficiary). Amounts on these claims should be expressed as positive numbers. If a debit gross adjustment is reported with an ICN that is related to an ICN(s) of another gross adjustment (credit or debit) then CMS will interpret this to mean that the credit gross adjustment with the more recent adjudication date should completely replace the preceding related gross adjustment. If the ICNs of a debit gross adjustment are not related to any other gross adjustments (credit or debit) then the debit gross adjustment will always be treated as a distinct financial transaction.

Are gross adjustments considered claims/encounters?

While the gross adjustment adjudication indicator codes (values “5” and “6” in Table 3) are reported to T-MSIS in the CLAIM-OT file, they are not technically “claims” or “encounters.” Each of these transactions does not relate to a specific service-provider/enrollee episode of care. Instead, these transactions represent payments made by the state for services rendered to multiple enrollees (as in the case of a provider providing screening services for a group of enrollees), DSH payments, or a recoupment of funds previously dispensed in a debit gross adjustment. Therefore, the concept of “claims family” does not apply. Each of these transactions stands on its own, and does not constitute a subsequent transaction being a replacement of the earlier transaction.

What alternatives are there for tying the members of a claim family together?

The Original ICN Approach

Under this approach, the state assigns an ICN to the initial final adjudicated version of the claim/encounter and records this identifier in the ICN-ORIG field. If adjustment claims subsequently are created, the ICN assigned to the initial final adjudicated version of the claim/encounter is carried forward on every subsequent adjustment claim. Table 4 illustrates how the ICN-ORIG and ICN-ADJ values on the members of a claim family are populated when the original ICN approach is used.

Table 4: ICN-ORIG/ICN-ADJ Relationships Under the Original ICN Approach

Event	ADJUDICATION-DATE	ICN-ORIG	ICN-ADJ	ADJUSTMENT-IND
On 5/1/2014, the state completes the adjudication process on the initial version of the claim	5/1/2014	1	-	0
On 7/15/2014, the state completes a claim re-adjudication / adjustment	7/15/2014	1	2	4
On 8/12/2014, the state completes a 2nd claim re-adjudication / adjustment	8/12/2014	1	3	4
On 9/5/2014, the state completes a 3rd claim re-adjudication / adjustment	9/5/2014	1	4	4

The Daisy-Chain ICN Approach

Under this approach, the state records the ICN of the previous final adjudicated version of the claim/encounter in the ICN-ORIG field of the adjustment claim record. If additional adjustment claims are subsequently created, the ICN-ORIG on the new adjustment claim only points back one generation. Table 5 illustrates how the ICN-ORIG and ICN-ADJ values on the members of a claim family are populated when the daisy-chain ICN approach is used.

Table 5: ICN-ORIG/ICN-ADJ Relationships Under the Daisy-Chain ICN Approach

Event	ADJUDICATION-DATE	ICN-ORIG	ICN-ADJ	ADJUSTMENT-IND
On 6/1/2014, the state completes the adjudication process on the initial version of the claim	6/1/2014	11	-	0
On 8/15/2014, the state completes a claim re-adjudication/adjustment	8/15/2014	11	12	4
On 9/12/2014, the state completes a 2nd claim re-adjudication/adjustment	9/12/2014	12	13	4
On 10/5/2014, the state completes a 3rd claim re-adjudication/adjustment	10/5/2014	13	14	4

How are ICN-ORIG and ICN-ADJ fields impacted when voids are submitted?

The primary purpose of void transactions (ADJUSTMENT-IND = 1) is to nullify a claim/encounter from T-MSIS when the state does not wish to replace it with an adjusted claim/encounter record. These records must have the same claim key data element values as the claim/encounter being voided. Dollar and quantity fields should be set to zero. The ADJUDICATION-DATE on these records should be set to the date that the state voided the claim. Table 6 illustrates how the ICN-ORIG and ICN-ADJ values on the members of a claim family are populated when the state wishes to void a claim.

Table 6: ICN-ORIG/ICN-ADJ – Impact of Voids

Event	ADJUDICATION-DATE	ICN-ORIG	ICN-ADJ	ADJUSTMENT-IND	Dollar Fields	Quantity Fields
On 6/1/2014, the state completes the adjudication process on the initial version of the claim	6/1/2014	51	-	0	100.00	5
On 8/15/2014, the state completes a claim re-adjudication/adjustment	8/15/2014	51	52	4	80.00	5
On 8/19/2014, the claim is voided	8/19/2014	51	52	1	0.00	0

If a state uses a process to record adjustments whereby they void the previous version of the claim and then follow-up with the creation of a new original transaction, and the state can identify that the void and the new original claim are from the same adjudication set, the state should link them together into one claims family using the ICN-ORIG. CMS recognizes that some states may not be able to link a resubmitted claim after a void to the original claim. Table 7 illustrates how CMS is expecting the states to populate the ICN-ORIG/ICN-ADJ fields when the state processes a void/new original when adjusting claims.

*Table 7: ICN-ORIG/ICN-ADJ – Keeping the Claim Family Intact When the "*Void/New Original" Scenario Occurs

Event	ADJUDICATION-DATE	ICN-ORIG	ICN-ADJ	ADJUSTMENT-IND	Dollar Fields	Quantity Fields
On 6/1/2014, the state completes the adjudication process on the initial version of the claim	6/1/2014	51	-	0	100.00	5
On 8/15/2014, the state completes the adjudication process of a void and associated new original	8/15/2014	51	-	1	0.00	0
	8/15/2014	51	52	0	80.00	5
On 9/20/2014, the state completes the adjudication process of a void and associated new original	9/20/2014	51	52	1	0.00	0
	9/20/2014	51	53	0	60.00	5

How Adjustment Records will be Applied by CMS

There is an inherent limitation in the way that CMS can interpret what to do with two claim transactions having the same ICN-ORIG and ADJUDICATION-DATE when both transactions are received in a single submission file. The processing rules that T-MSIS will follow are outlined below. It is up to each state to assure that claim transactions are processed in the appropriate sequence. If the rules below do not result in the sequence of transactions that the state desires, it is up to the state to submit transactions in separate files so that the desired sequence is attained.

Rules for inserting claim transactions into the T-MSIS database

When two or more claim transactions with the same ICN-ORIG and ADJUDICATION-DATE are in the same submission file

If two or more transactions in an incoming claim file have the same ICN-ORIG and ADJUDICATION-DATE values, T-MSIS will evaluate the ADJUSTMENT-IND values and insert the transactions into the T-MSIS database as follows:

1. If more than two transactions in the incoming claim file have the same ICN-ORIG and ADJUDICATION-DATE values, then T-MSIS will reject all of the incoming transactions;
2. If the ADJUSTMENT-IND values of both incoming transactions are the same (but not '5' or '6'), then T-MSIS will reject both incoming transactions;
3. If the ADJUSTMENT-IND values of both incoming transactions are some combination of '5' and '6' and if there is no active existing transaction in the T-MSIS DB, then T-MSIS will insert both incoming transactions into the T-MSIS DB (note, since neither transaction supersedes the other, the order in which they are inserted does not matter);
4. If the ADJUSTMENT-IND values of both incoming transactions are some combination of '5' and '6' and if there is an active existing transaction in the T-MSIS DB with an ADJUSTMENT-IND value of '5' or '6', then T-MSIS will insert both incoming transactions into the T-MSIS DB (note, since neither transaction supersedes the other, the order in which they are inserted does not matter);
5. If the ADJUSTMENT-IND values of both incoming transactions is a '5' or '6' and if there is an active existing transaction in the T-MSIS DB with an ADJUSTMENT-IND value of '0', '1', or '4', then T-MSIS will reject both the incoming transactions;
6. If the ADJUSTMENT-IND value of one incoming transaction is a '5' or '6' and the ADJUSTMENT-IND of the other transaction is '0', '1', or '4' and if there is an active existing transaction in the T-MSIS DB with an ADJUSTMENT-IND value of '5' or '6', then T-MSIS will insert the incoming transaction with ADJUDICATION-IND of '5' or '6' and reject the incoming transaction with ADJUSTMENT-IND value '0', '1', or '4';
7. If the ADJUSTMENT-IND value of one incoming transaction is a '5' or '6' and the ADJUSTMENT-IND of the other transaction is '0', '1', or '4' and there is an active existing transaction in the T-MSIS DB with an ADJUSTMENT-IND value of '0', '1', or '4', then T-MSIS will reject the incoming transaction with ADJUSTMENT-IND value '5' or '6' and evaluate the remaining incoming transaction as follows:
    a. ADJUSTMENT-IND of the remaining incoming transaction is '0' and the ADJUSTMENT-IND of the active existing transaction is '0', then T-MSIS will reject the incoming transaction;
    b. ADJUSTMENT-IND of the remaining incoming transaction is '0' and the ADJUSTMENT-IND of the active existing transaction is '1', then T-MSIS will insert the incoming transaction;
    c. ADJUSTMENT-IND of the remaining incoming transaction is '0' and the ADJUSTMENT-IND of the active existing transaction is '4', then T-MSIS will reject the incoming transaction;
    d. ADJUSTMENT-IND of the remaining incoming transaction is '1' and the ADJUSTMENT-IND of the active existing transaction is '0', then T-MSIS will insert the incoming transaction;
    e. ADJUSTMENT-IND of the remaining incoming transaction is '1' and the ADJUSTMENT-IND of the active existing transaction is '1', then T-MSIS will reject the incoming transaction;

f. ADJUSTMENT-IND of the remaining incoming transaction is ‘1’ and the ADJUSTMENT-IND of the active existing transaction is ‘4’, then T-MSIS will insert the incoming transaction;

g. ADJUSTMENT-IND of the remaining incoming transaction is ‘4’ and the ADJUSTMENT-IND of the active existing transaction is ‘0’, then T-MSIS will insert the incoming transaction;

h. ADJUSTMENT-IND of the remaining incoming transaction is ‘4’ and the ADJUSTMENT-IND of the active existing transaction is ‘1’, then T-MSIS will insert the incoming transaction;

i. ADJUSTMENT-IND of the remaining incoming transaction is ‘4’ and the ADJUSTMENT-IND of the active existing transaction is ‘4’, then T-MSIS will insert the incoming transaction;

8. If the ADJUSTMENT-IND value of one incoming transaction is ‘1’ and the ADJUSTMENT-IND of the other transaction is ‘0’ or ‘4’ and the ADJUSTMENT-IND of the active existing transaction in the T-MSIS DB is ‘0’ or ‘4’, then T-MSIS will insert the incoming transaction with ADJUSTMENT-IND = ‘1’ first, and then insert the other transaction;

9. If the ADJUSTMENT-IND value of one incoming transaction is ‘1’ and the ADJUSTMENT-IND of the other transaction is ‘0’ or ‘4’ and the ADJUSTMENT-IND of the active transaction in the T-MSIS DB is ‘1’, then T-MSIS will insert the incoming transaction with ADJUSTMENT-IND value of ‘0’ or ‘4’ first and then insert the incoming transaction with ADJUSTMENT-IND = ‘1’;

10. If the ADJUSTMENT-IND value of one incoming transaction is ‘0’ and the ADJUSTMENT-IND value of the other incoming transaction is ‘4’ and there is no active existing transaction in the T-MSIS DB, then T-MSIS will insert the incoming transaction with ADJUSTMENT-IND value of ‘0’ first and then insert the incoming transaction with ADJUSTMENT-IND = ‘4’;

11. If any other combination of ADJUSTMENT-IND values occurs, then T-MSIS will reject all of the transactions.

CMS Guidance

The state can use either the original ICN approach or the daisy-chain ICN approach to populate the ICN-ORIG field on each member of the claims family. T-MSIS will group claim transactions into claim families as part of the ETL process.

Appendix P.02: Reporting Financial Transactions in T-MSIS

How to populate T-MSIS claim files when reporting non-claim expenditures and recoupments

Brief Issue Description:

The purpose of this guidance document is to clarify the appropriate way to report non-claim expenditure and recoupment transactions, since many of the data elements on the claim records (CLAIMIP, CLAIMLT, CLAIMOT, and CLAIMRX) do not seem appropriate for these types of transactions.

Background Discussion

Definition of a financial transaction:

For purposes of this guidance, CMS defines a financial transaction as an expenditure transaction or a recoupment of a previously made expenditure that does not flow through the usual claim adjudication/adjustment process.

The cause or effect of this may be that these types of transactions do not contain the same level of detail as other types of transactions in the state's system. For example, a state might not assign a service code to a capitation claim. Payments made in lump sums, such as Disproportionate Share Hospital (DSH) payments, because they cannot be attributed to a single beneficiary would not contain a beneficiary identifier.

For some states, examples of financial transactions might include capitation payments made to managed care organizations, supplemental payments (i.e., payments that are above a capitation fee or for a sum above a negotiated rate, such as an FQHC additional reimbursement), drug rebates, DSH payments, cost settlements (e.g., program cost reconciliations and settlements, year-end reconciliation of risk pools), aggregate-level payments to providers (e.g., for a set of enrollees, claims, etc.) rather than payments made on a specific claim.

Financial Transactions may be reported on CLAIMIP, CLAIMLT, CLAIMOT, or CLAIMRX depending on the type and circumstances of the financial transaction. "Table 1 – Financial Transactions and the appropriate T-MSIS file for reporting them" identifies which T-MSIS files are appropriate for the various types of financial transactions.

Table 1 – *Financial transactions and the appropriate T-MSIS file for reporting them*

At Enrollee Level (col. 1-4) **For Multiple Enrollees (i.e., a Service Tracking Claim) (col. 5-10)**

1	2	3	4	5	6	7	8	9	10
Cap Pymt	**Drug Rebate**	**Cost Stlmnt**	**Spplmntl Pymt**	**Cap Pymt**	**Drug Rebate**	**Cost Stlmnt**	**Spplmntl Pymt**	**DSH Pymt**	**Other Pymt**
CLAIMOT	CLAIMOT CLAIMRX	CLAIMIP CLAIMLT CLAIMOT CLAIMRX	CLAIMIP CLAIMLT CLAIMOT CLAIMRX	CLAIMOT	CLAIMOT CLAIMRX	CLAIMIP CLAIMLT CLAIMOT CLAIMRX	CLAIMIP CLAIMLT CLAIMOT CLAIMRX	CLAIMIP CLAIMOT	CLAIMIP CLAIMLT CLAIMOT CLAIMRX

Financial transactions can be contained within the same files as fee-for-service claims and encounter records.

CMS Guidance

When and how to populate data elements for financial transactions:

The data elements listed on the following pages are ones that should be populated on financial transactions. Additional verbiage is provided for those data elements that CMS believes need explicit instructions for building T-MSIS files. States should contact their T-MSIS technical assistant or state liaison if they have questions or concerns. Data elements not specifically listed below can be 8-filled, left blank or space-filled.

CLAIM-HEADER-RECORD data elements

a. RECORD-ID
b. SUBMITTING-STATE
c. RECORD-NUMBER
d. MSIS-IDENTIFICATION-NUM – Populate with beneficiary's MSIS ID for any beneficiary-specific financial transactions. Otherwise first character of MSIS-IDENTIFICATION-NUM must be "&" to indicate that any characters that might follow do not represent an individual beneficiary's identifier.
e. ICN-ORIG – See the document entitled CMS Guidance: T-MSIS Adjustment Claim Records-Populating ICN-ORG and ICN-ADJ Fields posted on 2/18/2014 to the T-MSIS State Support.
f. ICN-ADJ – See the document entitled CMS Guidance: T-MSIS Adjustment Claim Records-Populating ICN-ORG and ICN-ADJ Fields posted on 2/18/2014 to the T-MSIS State Support
g. ADJUDICATION-DATE – Date the transaction's approval and payment processes were completed.
h. CHECK-EFF-DATE – Populate with the date that Medicaid funds were disbursed. (Note: Even though the TOT-MEDICAID-PAID-AMT field may be set to zero in some circumstances, Medicaid funds were disbursed – and are captured in the SERVICE-TRACKING-PAYMENT-AMT data element.)
i. ADMISSION-DATE – Populate with the first day of the time period covered by this financial transaction (CLAIMIP and CLAIMLT).
j. DISCHARGE-DATE – Populate with the last day of the time period covered by this financial transaction (CLAIMIP and CLAIMLT).
k. BEGINNING-DATE-OF-SERVICE – Populate with the first day of the time period covered by this financial transaction (CLAIMOT).
l. ENDING-DATE-OF-SERVICE – Populate with the last day of the time period covered by this financial transaction (CLAIMOT).
m. DATE-PRESCRIBED – Populate with the first day of the time period covered by this financial transaction (CLAIMRX).
n. PRESCRIPTION-FILL-DATE – Populate with the last day of the time period covered by this financial transaction (CLAIMRX).
o. WAIVER-TYPE – Populate if applicable and available
p. WAIVER-ID – Populate if applicable and available
q. PLAN-ID-NUMBER – Populate with the managed care plan ID for capitation payments made to managed care plans. 8-fill, leave blank or space-fill if transaction does not involve a manage care plan.

r. BILLING-PROV-NPI-NUM – Populate with the provider or entity that the financial transaction was addressed to. 8-fill, leave blank or space-fill if transaction involves a manage care plan.
s. TOT-MEDICAID-PAID-AMT – If TYPE-OF-CLAIM is 4, D, or X, then set to zero – service tracking payment amount will be populated instead. Otherwise populate with the amount paid to the provider or health plan.
t. SERVICE-TRACKING-PAYMENT-AMT – If TYPE-OF-CLAIM is 4, D, or X, then populate this with the amount paid, otherwise 0-fill.
u. TYPE-OF-CLAIM – valid values appropriate for each type of financial transaction are shown in Table 2. (The descriptions of the TYPE-OF-CLAIM values are shown in Table 3. The values appropriate for financial transactions are highlighted in yellow.)

Valid Values

Table 2 – *TYPE-OF-CLAIM values for financial transactions*

At Enrollee Level (col. 1-4) **For Multiple Enrollees (i.e., a Service Tracking Claim) (col. 5-10)**

1	2	3	4	5	6	7	8	9	10
Cap Pymt	**Drug Rebate**	**Cost Stlmnt**	**Spplmntl Pymt**	**Cap Pymt**	**Drug Rebate**	**Cost Stlmnt**	**Spplmntl Pymt**	**DSH Pymt**	**Other Pymt**
2, B, V	5, E, Y	5, E, Y	5, E, Y	4, D, X	4, D, X	4, D, X	4, D, X	4, D, X	4, D, X

Table 3 – Descriptions of TYPE-OF-CLAIM values

Claim Type (col. 1-3)

Medicaid or Medicaid Expansion	Separate CHIP (Title XXI)	Other	Description	Purpose
1	A	U	Fee-For-Service Claim	Used to report services billed & payments made for specific services rendered to a specific enrollee by a specific provider during a specific period of time. Payment is made only for services actually rendered.
2	B	V	Capitation Payment	Used to report periodic payments made in return for a contractual commitment by the recipient to provide a specified set of services to a specified set of enrollees for a specified period of time. The volume of services actually provided to any given individual is not a factor in the amount of the capitation payment.
3	C	W	Encounter Record	Used to report services provided under a capitated payment arrangement. This includes billing records submitted by providers to non-state entities (e.g., MCOs, health plans) for which the State has no financial liability, since the risk entity has already received a capitated payment from the State.
4	D	X	Service Tracking Claim	Use to report payments made for services rendered to enrollees when the services are not billed and paid at the single enrollee/provider/visit level of detail.
5	E	Y	Supplemental Payment	Used to identify payments that are above a capitation fee or for a sum above a negotiated rate, such as an FQHC additional reimbursement.

v. SOURCE-LOCATION– valid values appropriate for each type of financial transaction are shown in Table 4.

Table 4 – Descriptions of SOURCE-LOCATION values

Code	Description
01	MMIS
02	Non-MMIS CHIP Payment System
03	Pharmacy Benefits Manager (PBM) Vendor
04	Dental Benefits Manager Vendor
05	Transportation Provider System
06	Mental Health Claims Payment System
07	Financial Transaction/Accounting System
08	Other State Agency Claims Payment System
09	County/Local Government Claims Payment System
10	Other Vendor/Other Claims Payment System
20	Managed Care Organization (MCO)

w. SERVICE-TRACKING-TYPE – The appropriate values for financial transactions are shown in Table 5. (The descriptions of the SERVICE-TRACKING-TYPE values are shown in Table 6.)

Table 5 *– SERVICE-TRACKING-TYPE values for financial transactions*

At Enrollee Level (col. 1-4) **For Multiple Enrollees (i.e., a Service Tracking Claim) (col. 5-10)**

1	2	3	4	5	6	7	8	9	10
Cap Pymt	Drug Rebate	Cost Stlmnt	Spplmntl Pymt	Cap Pymt	Drug Rebate	Cost Stlmnt	Spplmntl Pymt	DSH Pymt	Other Pymt
00	00	00	00	03	01	04	05	02	03, 06

Table 6 – Descriptions of SERVICE-TRACKING-TYPE values

Code	Description
00	Not a Service Tracking Claim – Use this code when codes 01 through 06 do not apply
01	Drug Rebate
02	DSH Payment
03	Lump Sum Payment (The "lump sum payment" code identifies payments made for specific services rendered to individual patients, when the state accepts a lump sum bill from a provider that covered similar services delivered to more than one patient (e.g., a group screening for EPSDT).
04	Cost Settlement
05	Supplemental (The "supplemental payment" code identifies payments that are above a capitation fee or sum above a negotiated rate (e.g., FQHC additional reimbursement).)
06	Other

x. FUNDING-CODE – The appropriate values for financial transactions are shown in Table 7. (The descriptions of the FUNDING-CODE values are shown in Table 8.)

Table 7 *– FUNDING-CODE values for financial transactions*

At Enrollee Level (col. 1-4) **For Multiple Enrollees (i.e., a Service Tracking Claim) (col. 5-10)**

1	2	3	4	5	6	7	8	9	10
Cap Pymt	**Drug Rebate**	**Cost Stlmnt**	**Spplmntl Pymt**	**Cap Pymt**	**Drug Rebate**	**Cost Stlmnt**	**Spplmntl Pymt**	**DSH Pymt**	**Other Pymt**
A or B as appro-priate	A through E	A through I as appro-priate	A through I as appro-priate	A or B as appro-priate	A through E	A through I as appro-priate	A through I as appro-priate	A through I as appro-priate	A through I as appro-priate

Table 8 *– Descriptions of FUNDING-CODE values*

Code	Description
A	Medicaid Agency
B	CHIP Agency
C	Mental Health Service Agency
D	Education Agency
E	Child and Family Services Agency
F	County
G	City
H	Providers
I	Other

CLAIM-LINE-RECORD data elements

a. SUBMITTING-STATE
b. RECORD-NUMBER
c. MSIS-IDENTIFICATION-NUM
d. ICN-ORIG
e. ICN-ADJ
f. LINE-NUM-ORIG
g. LINE-NUM-ADJ
h. ADJUDICATION-DATE – Date the line-level transaction's approval and payment processes were completed
i. REVENUE-CODE – 8-fill, leave blank or space-fill
j. PROCEDURE-CODE – 8-fill, leave blank or space-fill
k. NATIONAL-DRUG-CODE – 8-fill, leave blank or space-fill
l. MEDICAID-PAID-AMT – Because there is no data element on the claim line record segment specifically designated to capture service tracking payment amounts at the claim line level, states should populate MEDICAID-PAID-AMT with the amount of Medicaid funds disbursed. For service tracking claims, the sum of the claim line MEDICAID-PAID-AMT values on a claim's claim line record segments should equal the amount reported in the SERVICE-TRACKING-PAYMENT-AMT data element on the claim's claim header record segment.
m. TYPE-OF-SERVICE – The appropriate values for financial transactions are shown in Table 9.

Table 9 *– TYPE-OF-SERVICE values for financial transactions*

At Enrollee Level (col. 1-4) **For Multiple Enrollees (i.e., a Service Tracking Claim) (col. 5-10)**

1	2	3	4	5	6	7	8	9	10
Cap Pymt	**Drug Rebate**	**Cost Stlmnt**	**Spplmntl Pymt**	**Cap Pymt**	**Drug Rebate**	**Cost Stlmnt**	**Spplmntl Pymt**	**DSH Pymt**	**Other Pymt**
119, 120, 121, 122	131	132, 133, 134, 135	Any TOS except 119, 120, 121, 122, 123, 131, 132, 133, 134, 135	119, 120, 121, 122	131	132, 133, 134, 135	Any TOS except 119, 120, 121, 122, 123, 131, 132, 133, 134, 135	123	Any TOS except 119, 120, 121, 122, 123, 131, 132, 133, 134, 135

n. CMS-64-CATEGORY-FOR-FEDERAL-REIMBURSEMENT – The appropriate values for financial transactions are shown in Table 10.

Table 10 *– CMS-64-CATEGORY-FOR-FEDERAL-REIMBURSEMENT values for financial transactions*

At Enrollee Level (col. 1-4) **For Multiple Enrollees (i.e., a Service Tracking Claim) (col. 5-10)**

1	2	3	4	5	6	7	8	9	10
Cap Pymt	**Drug Rebate**	**Cost Stlmnt**	**Spplmntl Pymt**	**Cap Pymt**	**Drug Rebate**	**Cost Stlmnt**	**Spplmntl Pymt**	**DSH Pymt**	**Other Pymt**
If TYPE-OF-CLAIM = 2, then 01 If TYPE-OF-CLAIM = B then 02 If TYPE-OF-CLAIM = V then 03 or 04 as appro-priate	If TYPE-OF-CLAIM = 5, then 01 If TYPE-OF-CLAIM = E then 02 If TYPE-OF-CLAIM = Y then 03 or 04 as appro-priate	If TYPE-OF-CLAIM = 5, then 01 If TYPE-OF-CLAIM = E then 02 If TYPE-OF-CLAIM = Y then 03 or 04 as appro-priate	If TYPE-OF-CLAIM = 5, then 01 If TYPE-OF-CLAIM = E then 02 If TYPE-OF-CLAIM = Y then 03 or 04 as appropriate	If TYPE-OF-CLAIM = 2, then 01 If TYPE-OF-CLAIM = B then 02 If TYPE-OF-CLAIM = V then 03 or 04 as appro-priate	If TYPE-OF-CLAIM = 4, then 01 If TYPE-OF-CLAIM = D then 02 If TYPE-OF-CLAIM = X then 03 or 04 as appro-priate	If TYPE-OF-CLAIM = 4, then 01 If TYPE-OF-CLAIM = D then 02 If TYPE-OF-CLAIM = X then 03 or 04 as appro-priate	If TYPE-OF-CLAIM = 4, then 01 If TYPE-OF-CLAIM = D then 02 If TYPE-OF-CLAIM = X then 03 or 04 as appropriate	If TYPE-OF-CLAIM = 4, then 01 If TYPE-OF-CLAIM = D then 02 If TYPE-OF-CLAIM = X then 03 or 04 as appro-priate	If TYPE-OF-CLAIM = 4, then 01 If TYPE-OF-CLAIM = D then 02 If TYPE-OF-CLAIM = X then 03 or 04 as appropriate

o. XIX-MBESCBES-CATEGORY-OF-SERVICE – The appropriate values for financial transactions are shown in Table 11.

Table 11 *– XIX-MBESCBES-CATEGORY-OF-SERVICE values for financial transactions*
At Enrollee Level (col. 1-4) **For Multiple Enrollees (i.e., a Service Tracking Claim) (col. 5-10)**

1	2	3	4	5	6	7	8	9	10
Cap Pymt	**Drug Rebate**	**Cost Stlmnt**	**Spplmntl Pymt**	**Cap Pymt**	**Drug Rebate**	**Cost Stlmnt**	**Spplmntl Pymt**	**DSH Pymt**	**Other Pymt**
17A, 17B, 17C1, 18A, 18B1, 18B2, 18C, 18E, 22	7A1, 7A2, 7A3, 7A4, 7A5, 7A6	Any code	1C, 1D, 3B, 4C, 5B, 6B, 9B	17A, 17B, 17C1, 18A, 18B1, 18B2, 18C, 18E, 22	7A1, 7A2, 7A3, 7A4, 7A5, 7A6	Any code	1C, 1D, 3B, 4C, 5B, 6B, 9B	1B, 2B	Any code except 1B, 1C, 1D, 2B, 3B, 4C, 5B, 6B, 9B, 7A1, 7A2, 7A3, 7A4, 7A5, 7A6, 17A, 17B, 17C1, 18A, 18B1, 18B2 18C, 18E, 22

p. XXI-MBESCBES-CATEGORY-OF-SERVICE – The appropriate values for financial transactions are shown in Table 12.

Table 12 *– XXI-MBESCBES-CATEGORY-OF-SERVICE values for financial transactions*
At Enrollee Level (col. 1-4) **For Multiple Enrollees (i.e., a Service Tracking Claim) (col. 5-10)**

1	2	3	4	5	6	7	8	9	10
Cap Pymt	**Drug Rebate**	**Cost Stlmnt**	**Spplmntl Pymt**	**Cap Pymt**	**Drug Rebate**	**Cost Stlmnt**	**Spplmntl Pymt**	**DSH Pymt**	**Other Pymt**
1A, 1B, 1C, 1D, or 32B	8A	Any code	8-fill, leave blank or space-fill	1A, 1B, 1C, 1D, or 32B	8A	Any code	8-fill, leave blank or space-fill	8-fill, leave blank or space-fill	Any code except 1A, 1B, 1C, 1D, 32B, or 8A

CMS Guidance: Revised and Consolidated Guidance for Building Non-Claims T-MSIS Files

Brief Issue Description

CMS has made systems upgrades in T-MSIS data storage and file processing methodologies to reduce the complexity and size of full historical refresh data for months in which no data have changed. Essentially, we have removed the necessity for states to resubmit data month-after-month even though nothing changed. This has several benefits:

- Significant reduction of non-claim file sizes;
- Significant reduction in the logic necessary to compile the data required to populate the non-claim files.

There are now two methods that states can use when building their non-claim files – the "full-file refresh" method and the "changed-segments-only" method (both described below) and states can use either method. States can also change from one method to the other if they determine that it is to their advantage to do so. States that have already constructed their T-MSIS non-claim-file-building processes to generate rolling history records and wish to continue with this approach may do so as long as it is in full conformance with CMS' T-MSIS non-claims files expectations as delineated in this document.

CMS Guidance: Building Non-Claim Records

Methods for Submiting non-claim files to T-MSIS

States can utilize either the "full-file refresh" method or the "changed-segment-only" method for submitting non-claim files to T-MSIS.

Full-File Refresh Method

As the name suggests, "full-file refresh" files contain a complete set of historical segments for each record, regardless of whether the data on a segment has changed since the last submission, or not. The only exception to this is archived records. Archived records are ones the state considers to be permanently static, are no longer actively used in the state's system, and which the state has moved to a separate data storage area for long-term retention. Once the state archives a record, it no longer needs to report the record in the state's T-MSIS files. Even though these records are no longer included in the state's "full-file refresh" submissions, they will be maintained in the underlying T-MSIS repository as active records.

Changed-Segment-Only Method

States that chose to use the "changed-segment-only" method only need to submit a segment when one or more of its data element values changes. Under the "changed-segment-only" method, once submitted, a segment will remain active in the T-MSIS data repository until the state takes some action to inactivate it. Under the "changed-segment-only" method, it is not necessary for a state to include unchanged segments in its T-MSIS submissions month after month.

Important Concepts Governing the Submission of Non-Claim Files – *REGARDLESS OF SUBMISSION METHOD*

Regardless of the chosen approach, all states need to keep five important concepts in mind:

1. T-MSIS makes no changes to segment effective and end dates of its own volition.
2. If the state does not set segment effective- and end-dates appropriately, unintended overlapping segments with ambiguous data will occur.
3. It is the state's responsibility to tell T-MSIS the revised segment end date on existing segments whenever values on the segment change.
4. Every instance of a segment has a primary key that uniquely identifies it. ***To do anything to an existing segment***, the primary key field values (***which includes the segment effective date***) on the incoming segment MUST MATCH the primary key field values of the existing segment in T-MSIS. The primary key of each segment is listed in the "Rec Segment Keys & Constraints" tab of the *T-MSIS Data Dictionary*. (See Appendix A: Examples of Non-Claim File Segment and/or Record Modification Scenarios for more information on using primary keys.)
5. Record segments that are not applicable to a state or to a particular entity (i.e., an eligible person, provider, managed care entity, or TPL instance) do not need to be submitted.

Amount of Historical Data That Must Be Submitted

CMS no longer requires states to submit seven years of rolling history in its non-claim T-MSIS files. *Table A: Minimum Historical Record Expectations for Non-Claim File Submissions* outlines CMS' revised expectations. This is true for submissions under both the "Full-File Refresh" method and "Changed-Segment-Only" method for submitting non-claim files. If a state wishes to submit more historical data than is outlined in Table A, it may do so.

Appendix P.05: Populating Qualifier Fields and Their Associated Value Fields

Brief Issue Description

The purpose of this guidance document is to when record segments need to be created for all valid values in a qualifier field's valid value set and when it is appropriate to create a record segment for only one of the valid values.

Background Discussion

Definitions

Simple Qualifier Field – is a data element that contains a code (a.k.a. "flag") that defines/qualifies the coding schema used when populating a set of corresponding data elements. This is necessary because there are several different schemas that a state could use and it needs to be clear which of the schemas is actually used.
Examples of "simple qualifier fields" are the DIAGNOSIS-CODE-FLAG-1 through -12 on the CLAIM-HEADER-RECORD-IP record segment (CIP00002). The valid value set for these fields is:

1 ICD-9
2 ICD-10
3 Other

The state would indicate which coding schema is being used to populate the corresponding data elements DIAGNOSIS-CODE-1 through -12.

Complex Qualifier Field – is a data element that not only defines/qualifies the contents of its corresponding data elements (similar to a "simple qualifier field"), but also represents a situation where the state needs to create a record segment for each valid value that applies to the record's subject.
An example of a "complex qualifier field is LICENSE-TYPE on the PROV-LICENSING-INFO record segment (PRV00004). The valid value set for this field is:

1. State, county, or municipality professional or business license
2. DEA license
3. Professional society accreditation
4. CLIA accreditation
5. Other

The state would create a PROV-LICENSING-INFO record segment and populate the corresponding data elements for each LICENSE-TYPE valid value that applies to the provider.

Corresponding Data Elements – Are data elements that contain values as defined by the qualifier field.

Fully Populated Record Segment – Means that all data elements in the record segment will be populated, not just the qualifier field and its corresponding data elements. These additional data elements are necessary to enable CMS to tie the record segment to its parent segment. These data elements comprise the segment's natural key. Generally these data elements are the ones bulleted below, but there could potentially be additional ones, depending on the record segment. See the "Record Keys & Constraints" tab in the T-MSIS Data Dictionary if there are questions concerning a record segment's natural key.

- RECORD-ID
- SUBMITTING-STATE
- RECORD-NUMBER
- MSIS-IDENTIFICATION-NUM / STATE-PLAN-ID-NUM / SUBMITTING-STATE-PROV-ID

Record Subject – This is the individual/entity around which the record segments in a file are built. The Medicaid/CHIP enrollee is the subject of Eligible Files. In Provider Files, the subject is the provider. The managed care entity is the subject of Managed Care Files, and third party payers and their associated beneficiaries are the subjects of TPL Files.

Overview

The complex qualifier fields are included in the T-MSIS record layouts so that a given record segment layout can be used to capture a standard set of data elements (i.e., the corresponding data elements) for a category of data (i.e., the complex qualifier field's valid values list) when more than one category may be applicable to the record subject.

The complex qualifier fields' valid values lists are not "select one value from the valid values list and provide the corresponding data element values (which is the case for simple qualifier fields)." A separate record segment should be created and fully populated for every "complex qualifier field" valid value or unique combination of "complex qualifier field" valid value and corresponding data element value (in accordance with the Record Keys & Constraints) that applies to the record subject. Table 1 illustrates what CMS is expecting, using LICENSE-TYPE in the PROV-LICENSING-INFO record segment (PRV00004) as an example.

Example Scenario

The purpose of the PROV-LICENSING-INFO segment is to capture licensing and accreditation information relevant to a provider. The valid value list for the LICENSE-TYPE data element shows the types of information that CMS is interested in collecting in this record segment:

1. State, county, or municipality professional or business license
2. DEA license
3. Professional society accreditation
4. CLIA accreditation
5. Other

For our example, assume three of these categories are applicable to provider # P0123: (a) a professional license issued by the state's Board of Physicians (valid value # 1); (b.1) a board certification from the ABMS (valid value # 3); (b.2) a board certification from the AOA (also valid value # 3); and (c) a DEA number (valid value # 2). Table 1 and 1a lists the data elements in the PRV00004 record segment, and shows the contents of each data element in the four PRV00004 segments that would be required by this example.

Table 1: Examples of fully populated record segments supplying "complex qualifier field" corresponding data. While these data elements aren't strictly "corresponding data elements," they are necessary to tie the segments to their parent segment.

Data Element Use	*Data Element*	*Physician License*	*ABMS Board Certification*	*AOA Board Certification*	*DEA Number*
Tie segments to parent segment	RECORD-ID	PRV00004	PRV00004	PRV00004	PRV00004
Tie segments to parent segment	SUBMITTING-STATE	24	24	24	24
Tie segments to parent segment	RECORD-NUMBER	4506	4507	4508	4509
Tie segments to parent segment	SUBMITTING-STATE-PROV-ID	P0123	P0123	P0123	P0123
Tie segments to parent segment	PROV-LOCATION-ID	0	0	0	0

Table 1a: Examples of fully populated record segments supplying "complex qualifier field" corresponding data.

Data Element Use	Data Element	Physician License	ABMS Board Certification	AOA Board Certification	DEA Number
Corresponding Data Element	PROV-LICENSE-EFF-DATE	19921119	20100101	20120701	20131001
Corresponding Data Element	PROV-LICENSE-END-DATE	20150930	20191231	20150630	20160930
"Complex Qualifier" Data Element	LICENSE-TYPE	1	3	3	2
Corresponding Data Element	LICENSE-ISSUING-ENTITY-ID	24	American Board of Medical Specialties	American Osteopathic Association	DEA
Corresponding Data Element	LICENSE-OR-ACCREDITATION-NUMBER	D98765	IM012345	A5546	FD1234563
NA	STATE-NOTATION	NA	NA	NA	NA
NA	FILLER	NA	NA	NA	NA

CMS Guidance

CMS is instructing States to provide information corresponding to each of a complex qualifier field's valid values to the extent that the valid value is applicable to the record subject. Additionally, States should fully populate the affected record segments.

In its first four columns, Table 2 displays the T-MSIS file name, record segment name, complex qualifier field name and the complex qualifier field's list of valid values for each of the complex qualifier fields in the T-MSIS data set. The last two columns identify the corresponding data elements (along with the file segments where they reside) that need to be populated for every applicable valid value in the "complex qualifier field's" valid value list.

Table 2: "Complex Qualifier fields" their valid values, and the corresponding data elements that need to be populated

File Name	"Complex Qualifier Field" Information: Record Segment	"Complex Qualifier Field" Information: Data Element Name	"Complex Qualifier Field" Information: Valid Value and Description	Corresponding Data Elements To Be Populated: Record Segment	Corresponding Data Elements To Be Populated: Data Element Name
ELIGIBLE	ELIGIBLE-CONTACT-INFORMATION (ELG00004)	ADDR-TYPE	01 - Primary home address and contact information (used for the eligibility determination process); 02 - Primary work address and contact information; 03 - Secondary residence and contact information; 04 - Secondary work address and contact information; 05 - Other category of address and contact information; 06 - Eligible person's official mailing address	ELIGIBLE-CONTACT-INFORMATION-ELG00004	ELIGIBLE-ADDR-LN1; ELIGIBLE-ADDR-LN2; ELIGIBLE-ADDR-LN3; ELIGIBLE-CITY; ELIGIBLE-STATE; ELIGIBLE-ZIP-CODE; ELIGIBLE-COUNTY-CODE; ELIGIBLE-PHONE-NUM; TYPE-OF-LIVING-ARRANGEMENT; ELIGIBLE-ADDR-EFF-DATE; ELIGIBLE-ADDR-END-DATE
MNGDCARE	MANAGED-CARE-MAIN (MCR00002)	MANAGED-CARE-SERVICE-AREA	1 - Statewide: The managed care entity provides services to beneficiaries throughout the entire state; 2 - County: The managed care entity provides services to beneficiaries in specified counties; 3 - City: The managed care entity provides services to beneficiaries in specified cities; 4 - Region: The managed care entity provides services to beneficiaries in specified regions, not defined by individual counties within the state ("region" is state-defined); 5 - Zip Code: The managed care entity program	MANAGED-CARE-SERVICE-AREA-MCR00004	MANAGED-CARE-SERVICE-AREA-NAME; MANAGED-CARE-SERVICE-AREA-EFF-DATE; MANAGED-CARE-SERVICE-AREA-END-DATE

File Name	"Complex Qualifier Field" Information: Record Segment	"Complex Qualifier Field" Information: Data Element Name	"Complex Qualifier Field" Information: Valid Value and Description	Corresponding Data Elements To Be Populated: Record Segment	Corresponding Data Elements To Be Populated: Data Element Name
			provides services to beneficiaries in specified zip codes; 6 - Other: The managed care entity provides services to beneficiaries in "other" area(s), not Statewide, County, City, or Region.		
MNGDCARE	MANAGED-CARE-LOCATION-AND-CONTACT-INFO (MCR00003)	MANAGED-CARE-ADDR-TYPE	1 - MCO's corporate address and contact information; 2 - MCO's mailing address; 3 - MCO's service location address; 4 - MCO's Billing address and contact information; 5 - CEO's address and contact information; 6 - CFO's address and contact information; 7 - Other	MANAGED-CARE-LOCATION-AND-CONTACT-INFO-MCR00003	MANAGED-CARE-LOCATION-ID; MANAGED-CARE-ADDR-LN1; MANAGED-CARE-ADDR-LN2; MANAGED-CARE-ADDR-LN3; MANAGED-CARE-CITY; MANAGED-CARE-STATE; MANAGED-CARE-ZIP-CODE; MANAGED-CARE-COUNTY; MANAGED-CARE-TELEPHONE; MANAGED-CARE-EMAIL; MANAGED-CARE-FAX-NUMBER; MANAGED-CARE-LOCATION-AND-CONTACT-INFO-EFF-DATE
MNGDCARE	NATIONAL-HEALTH-CARE-ENTITY-ID-INFO (MCR00008)	NATIONAL-HEALTH-CARE-ENTITY-ID-TYPE	1 - Controlling Health Plan (CHP) ID; 2 - Subhealth Plan (SHP) ID; 3 - Other Entity Identifier (OEID)	NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-MCR00008	STATE-PLAN-ID-NUM; NATIONAL-HEALTH-CARE-ENTITY-ID; NATIONAL-HEALTH-CARE-ENTITY-NAME; NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-EFF-DATE; NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-END-DATE
PROVIDER	PROV-LOCATION-AND-CONTACT-INFO (PRV00003)	ADDR-TYPE	1 - Billing Provider; 2 - Provider Mailing; 3 - Provider Practice; 4 - Provider Service Location	PROV-LOCATION-AND-CONTACT-INFO-PRV00003	PROV-LOCATION-ID; ADDR-LN1; ADDR-LN2; ADDR-LN3; ADDR-CITY; ADDR-STATE; ADDR-ZIP-CODE; ADDR-TELEPHONE; ADDR-EMAIL; ADDR-FAX-NUM; ADDR-BORDER-STATE-IND; ADDR-COUNTY; PROV-LOCATION-AND-CONTACT-INFO-EFF-DATE; PROV-LOCATION-AND-CONTACT-INFO-END-DATE
PROVIDER	PROV-LICENSING-INFO (PRV00004)	LICENSE-TYPE	1 - State, county, or municipality professional or business license; 2 -DEA license; 3- Professional society accreditation; 4 - CLIA accreditation; 5- Other	PROV-LICENSING-INFO-PRV00004	LICENSE-OR-ACCREDITATION-NUMBER; LICENSE-ISSUING-ENTITY-ID; PROV-LICENSE-EFF-DATE; PROV-LICENSE-END-DATE
PROVIDER	PROV-IDENTIFIERS (PRV00005)	PROV-IDENTIFIER-TYPE	1 - State-specific Medicaid Provider ID; 2 – NPI; 3 - Medicare ID; 4 -	PROV-IDENTIFIERS-PRV00005	PROV-IDENTIFIER; PROV-IDENTIFIER-ISSUING-ENTITY-ID; PROV-IDENTIFIER-EFF-DATE; PROV-IDENTIFIER-END-DATE

File Name	"Complex Qualifier Field" Information: Record Segment	"Complex Qualifier Field" Information: Data Element Name	"Complex Qualifier Field" Information: Valid Value and Description	Corresponding Data Elements To Be Populated: Record Segment	Corresponding Data Elements To Be Populated: Data Element Name
			NCPDP ID; 5 - Federal Tax ID; 6 - State Tax ID; 7 – SSN; 8 - Other		
PROVIDER	PROV-TAXONOMY-CLASSIFICATION (PRV00006)	PROV-CLASSIFICATION-TYPE	1 - Taxonomy code; 2 - Provider specialty code; 3 - Provider type code; 4 - Authorized category of service code	PROV-TAXONOMY-CLASSIFICATION-PRV00006	PROV-CLASSIFICATION-CODE; PROV-TAXONOMY-CLASSIFICATION-EFF-DATE; PROV-TAXONOMY-CLASSIFICATION-END-DATE
PROVIDER	PROV-AFFILIATED-PROGRAMS (PRV00009)	AFFILIATED-PROGRAM-TYPE	1 - Health Plan (NHP-ID); 2 - Health Plan (state-assigned health plan ID); 3 – Waiver; 4 - Health Home Entity; 5 - Other	PROV-AFFILIATED-PROGRAMS-PRV00009	AFFILIATED-PROGRAM-ID; PROV-AFFILIATED-PROGRAM-EFF-DATE; PROV-AFFILIATED-PROGRAM-END-DATE
TPL	TPL-ENTITY-CONTACT-INFORMATION (TPL00006)	TPL-ENTITY-ADDR-TYPE	06 - TPL-Entity Corporate Location; 07 - TPL-Entity Mailing; 08 - TPL-Entity Satellite Location; 09 - TPL-Entity Billing; 10 - TPL-Entity Correspondence; 11 - TPL-Other	TPL-ENTITY-CONTACT-INFORMATION-TPL00006	INSURANCE-CARRIER-ADDR-LN1; INSURANCE-CARRIER-ADDR-LN2; INSURANCE-CARRIER-ADDR-LN3; INSURANCE-CARRIER-CITY; INSURANCE-CARRIER-STATE; INSURANCE-CARRIER-ZIP-CODE; INSURANCE-CARRIER-PHONE-NUM; INSURANCE-CARRIER-NAIC-CODE; INSURANCE-CARRIER-NAME; NATIONAL-HEALTH-CARE-ENTITY-ID-TYPE; NATIONAL-HEALTH-CARE-ENTITY-ID; NATIONAL-HEALTH-CARE-ENTITY-NAME; TPL-ENTITY-CONTACT-INFO-EFF-DATE; TPL-ENTITY-CONTACT-INFO-END-DATE

Appendix P.06: IIFI (Inter/Intra-File Indices)

How to use this guidance document

This guidance document is intended to provide clarification on previous guidance or clarification to requirement areas that states need to assist in the development and implementation of T-MSIS file submissions.

Brief Issue Description

This document provides information about T-MSIS Inter/Intra-File Indices (IIFI) data elements and an additional set of important data elements; both comprise a subset of the overall T-MSIS data elements.

Background Discussion

The IIFI data elements are made up of three groups.

1. Ten ***Logical Record Keys*** and eleven ***File Header Keys***. ***Logical Keys*** are keys that are used in parent child relationship queries and in the creation of the logical records in the Federal T-MSIS data model. ***File Header Keys*** are keys that are required on the T-MSIS File header segments.

   Source-to-target matrices submitted by states ideally should report each of these corresponding twenty-one data elements with a Data Source Availability of "Always". We expect that 100 percent of the twenty-one group one IIFI data elements are to be reported as “Always” when CMS compares the files submitted to the State’s Source-to-Target Mapping document. CMS envisions that no problem will exist in compliance to the reporting of group one elements.

2. Twenty ***Program Specific Segment keys***. ***Program Specific Segment keys*** comprise of data elements that are keys used in identifying records uniquely in a ***Program Specific*** segment in the T-MSIS files. These are also keys are used for updating the records in the data warehouse for those ***Program specific*** segments. ***Program Specific*** data refer to whether states are participating in any of five Medicaid/CHIP program areas (1115A demonstration, Money-Follows-the-Person (MFP), Lock-In-Providers, Health Home SPAs, and Managed Care participation). There are twenty ***Program Specific segment keys*** – applicable to specific programs.

   Regarding this second group of ***Program Specific*** *data elements*, *the presence or absence of these data* elements in the State’s T-MSIS submission, of course, depends on whether the State is participating in one or more of the five Medicaid/CHIP program areas (1115A demonstration, Money-Follows-the-Person (MFP), Lock-In-Providers,

Health Home SPAs, and Managed Care participation). When States participate in one or more of the 'Medicaid/CHIP Program areas', the source-to-target matrices ideally should report each of the corresponding ***Program Specific*** data elements with a Data Source Availability of "Always" or "Sometimes".

When States do not participate in a 'program area', their source-to-target matrices ideally should report each of the corresponding ***Program Specific*** data elements with a Data Source Availability of "Never".

3. 211 ***Segment keys***. These segment keys only differ from the second group in that they are non-program specific, and are relevant to all states, regardless if they are included in the second group. ***Segment keys*** comprise of data elements that are keys used in identifying records uniquely in a segment in the T-MSIS files. These are also keys are used for updating the records in the data warehouse for those segments.

States should follow these guidelines when building records.

- States must provide primary keys (as listed below) in all segments irrespective of segment being applicable to the state.
- States are not required to code segments which are 'not applicable' for all records;

  Example – if the State does not operate a HEALTH-HOME, the State should not populate a record in the HEALTH-HOME-SPA-PARTICIPATION-INFORMATION-ELG00006 segment for each enrollee in the file.
- Coding segments which are 'not applicable' for some records and 'applicable' for other records;

  Example - when a state operates a HEALTH-HOME for **enrollees who are not enrolled** in a HEALTH-HOME - code segments which are 'not applicable';

  If the State has an approved HEALTH-HOME SPA, the State must populate one record in the HEALTH-HOME-SPA-PARTICIPATION-INFORMATION-ELG00006 segment with key values for SUBMITTING-STATE and MSIS-IDENTIFICATION-NUM and '8-fill', leave blank or space-fill all other elements in the segment. This should be completed for every enrollee in the file that is not enrolled in a HEALTH HOME.

Data Element	File
RECORD-ID	1
SUBMITTING-STATE	11
RECORD-NUMBER	1
MSIS-IDENTIFICATION-NUM	789550702245

Data Element	File
HEALTH-HOME-SPA-NAME	8-fill, leave blank or space-fill
HEALTH-HOME-ENTITY-NAME	8-fill, leave blank or space-fill
HEALTH-HOME-SPA-PARTICIPATION-EFF-DATE	8-fill, leave blank or space-fill
HEALTH-HOME-SPA-PARTICIPATION-END-DATE	8-fill, leave blank or space-fill
HEALTH-HOME-ENTITY-EFF-DATE	8-fill, leave blank or space-fill
STATE-NOTATION	8-fill, leave blank or space-fill
FILLER	N/A

Example - when a state operates a HEALTH-HOME for **enrollees who are enrolled** in a HEALTH-HOME - coding segments which are 'applicable';

If the State has an approved HEALTH-HOME SPA, the State must populate one record in the HEALTH-HOME-SPA-PARTICIPATION-INFORMATION-ELG00006 segment with key values for SUBMITTING-STATE and MSIS-IDENTIFICATION-NUM, and code all other fields appropriately with data that are applicable for the situation. This should be completed for every enrollee in the file that is enrolled in a HEALTH HOME

RECORD-ID	1
SUBMITTING-STATE	11
RECORD-NUMBER	1
MSIS-IDENTIFICATION-NUM	2335-445-07
HEALTH-HOME-SPA-NAME	Happy-Go-Lucky Inc.
HEALTH-HOME-ENTITY-NAME	Health Homes of DC.
HEALTH-HOME-SPA-PARTICIPATION-EFF-DATE	20140101
HEALTH-HOME-SPA-PARTICIPATION-END-DATE	20140131
HEALTH-HOME-ENTITY-EFF-DATE	20130701
STATE-NOTATION	N/A
FILLER	N/A

- Coding segments when segments are 'applicable' but data values are 'unknown' at certain points in time.

  If the State has an approved HEALTH-HOME SPA, the State must populate one record in the HEALTH-HOME-SPA-PARTICIPATION-INFORMATION-ELG00006 segment with key values for SUBMITTING-STATE and MSIS-IDENTIFICATION-NUM and '9-fill', leave blank

or space-fill the elements in the segment . This should be completed for every enroll in the file that is enrolled in a HEALTH HOME

RECORD-ID	1
SUBMITTING-STATE	11
RECORD-NUMBER	1
MSIS-IDENTIFICATION-NUM	789550702245
HEALTH-HOME-SPA-NAME	Golden Years HH
HEALTH-HOME-ENTITY-NAME	9-fill, leave blank or space-fill
HEALTH-HOME-SPA-PARTICIPATION-EFF-DATE	9-fill, leave blank or space-fill
HEALTH-HOME-SPA-PARTICIPATION-END-DATE	9-fill, leave blank or space-fill
HEALTH-HOME-ENTITY-EFF-DATE	9-fill, leave blank or space-fill
STATE-NOTATION	9-fill, leave blank or space-fill
FILLER	

Data Elements by File Name

Tables 1-8 below contain 448 IIFI data elements with their data element number. These tables represent a duplicated list of the IIFI data element subset found in groups 1-3. Table 9 is the unduplicated listing of 21 IIFI data elements.

Tables 10 –15 contain data elements with their data element number. This represents the 20 Program Specific data elements found in the 2nd group (***Program Specific segment keys*** subset). Table 16 is the unduplicated list of 20 Program Specific data elements.

The unique data element number (DE No), data element name, file name, and file segment are listed in each chart.

Note that data element names in these tables are duplicated on multiple file segments and multiple files.

Table	File Name
1	Eligible
2	TPL
3	Managed Care
4	Provider
5	Claim OT
6	Claim RX
7	Claim LT
8	Claim IP

Table 1: Eligible IIFI Data Elements (132 IIFIs)

DE No	Data Element Name	FILE NAME	File Segment (with Record-ID)
ELG001	RECORD-ID	ELIGIBLE	FILE-HEADER-RECORD-ELIGIBILITY-ELG00001
ELG002	DATA-DICTIONARY-VERSION	ELIGIBLE	FILE-HEADER-RECORD-ELIGIBILITY-ELG00001
ELG003	SUBMISSION-TRANSACTION-TYPE	ELIGIBLE	FILE-HEADER-RECORD-ELIGIBILITY-ELG00001
ELG004	FILE-ENCODING-SPECIFICATION	ELIGIBLE	FILE-HEADER-RECORD-ELIGIBILITY-ELG00001
ELG005	DATA-MAPPING-DOCUMENT-VERSION	ELIGIBLE	FILE-HEADER-RECORD-ELIGIBILITY-ELG00001
ELG006	FILE-NAME	ELIGIBLE	FILE-HEADER-RECORD-ELIGIBILITY-ELG00001
ELG007	SUBMITTING-STATE	ELIGIBLE	FILE-HEADER-RECORD-ELIGIBILITY-ELG00001
ELG009	START-OF-TIME-PERIOD	ELIGIBLE	FILE-HEADER-RECORD-ELIGIBILITY-ELG00001
ELG010	END-OF-TIME-PERIOD	ELIGIBLE	FILE-HEADER-RECORD-ELIGIBILITY-ELG00001
ELG011	FILE-STATUS-INDICATOR	ELIGIBLE	FILE-HEADER-RECORD-ELIGIBILITY-ELG00001
ELG012	SSN-INDICATOR	ELIGIBLE	FILE-HEADER-RECORD-ELIGIBILITY-ELG00001

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DE No	Data Element Name	FILE NAME	File Segment (with Record-ID)
ELG013	TOT-REC-CNT	ELIGIBLE	FILE-HEADER-RECORD-ELIGIBILITY-ELG00001
ELG247	SEQUENCE-NUMBER	ELIGIBLE	FILE-HEADER-RECORD-ELIGIBILITY-ELG00001
ELG016	RECORD-ID	ELIGIBLE	PRIMARY-DEMOGRAPHICS-ELIGIBILITY-ELG00002
ELG017	SUBMITTING-STATE	ELIGIBLE	PRIMARY-DEMOGRAPHICS-ELIGIBILITY-ELG00002
ELG018	RECORD-NUMBER	ELIGIBLE	PRIMARY-DEMOGRAPHICS-ELIGIBILITY-ELG00002
ELG019	MSIS-IDENTIFICATION-NUM	ELIGIBLE	PRIMARY-DEMOGRAPHICS-ELIGIBILITY-ELG00002
ELG026	PRIMARY-DEMOGRAPHIC-ELEMENT-EFF-DATE	ELIGIBLE	PRIMARY-DEMOGRAPHICS-ELIGIBILITY-ELG00002
ELG030	RECORD-ID	ELIGIBLE	VARIABLE-DEMOGRAPHICS-ELIGIBILITY-ELG00003
ELG031	SUBMITTING-STATE	ELIGIBLE	VARIABLE-DEMOGRAPHICS-ELIGIBILITY-ELG00003
ELG032	RECORD-NUMBER	ELIGIBLE	VARIABLE-DEMOGRAPHICS-ELIGIBILITY-ELG00003
ELG033	MSIS-IDENTIFICATION-NUM	ELIGIBLE	VARIABLE-DEMOGRAPHICS-ELIGIBILITY-ELG00003
ELG057	VARIABLE-DEMOGRAPHIC-ELEMENT-EFF-DATE	ELIGIBLE	VARIABLE-DEMOGRAPHICS-ELIGIBILITY-ELG00003
ELG061	RECORD-ID	ELIGIBLE	ELIGIBLE-CONTACT-INFORMATION-ELG00004
ELG062	SUBMITTING-STATE	ELIGIBLE	ELIGIBLE-CONTACT-INFORMATION-ELG00004
ELG063	RECORD-NUMBER	ELIGIBLE	ELIGIBLE-CONTACT-INFORMATION-ELG00004
ELG064	MSIS-IDENTIFICATION-NUM	ELIGIBLE	ELIGIBLE-CONTACT-INFORMATION-ELG00004
ELG065	ADDR-TYPE	ELIGIBLE	ELIGIBLE-CONTACT-INFORMATION-ELG00004
ELG075	ELIGIBLE-ADDR-EFF-DATE	ELIGIBLE	ELIGIBLE-CONTACT-INFORMATION-ELG00004
ELG079	RECORD-ID	ELIGIBLE	ELIGIBILITY-DETERMINANTS-ELG00005
ELG080	SUBMITTING-STATE	ELIGIBLE	ELIGIBILITY-DETERMINANTS-ELG00005
ELG081	RECORD-NUMBER	ELIGIBLE	ELIGIBILITY-DETERMINANTS-ELG00005
ELG082	MSIS-IDENTIFICATION-NUM	ELIGIBLE	ELIGIBILITY-DETERMINANTS-ELG00005
ELG083	MSIS-CASE-NUM	ELIGIBLE	ELIGIBILITY-DETERMINANTS-ELG00005
ELG099	ELIGIBILITY-DETERMINANT-EFF-DATE	ELIGIBLE	ELIGIBILITY-DETERMINANTS-ELG00005
ELG103	RECORD-ID	ELIGIBLE	HEALTH-HOME-SPA-PARTICIPATION-INFORMATION-ELG00006
ELG104	SUBMITTING-STATE	ELIGIBLE	HEALTH-HOME-SPA-PARTICIPATION-INFORMATION-ELG00006
ELG105	RECORD-NUMBER	ELIGIBLE	HEALTH-HOME-SPA-PARTICIPATION-INFORMATION-ELG00006
ELG106	MSIS-IDENTIFICATION-NUM	ELIGIBLE	HEALTH-HOME-SPA-PARTICIPATION-INFORMATION-ELG00006
ELG233	1115A-DEMONSTRATION-IND	ELIGIBLE	1115A-DEMONSTRATION-INFORMATION-ELG00018
ELG234	1115A-EFF-DATE	ELIGIBLE	1115A-DEMONSTRATION-INFORMATION-ELG00018
ELG132	HEALTH-HOME-CHRONIC-CONDITION-EFF-DATE	ELIGIBLE	HEALTH-HOME-CHRONIC-CONDITIONS-ELG00008
ELG114	RECORD-ID	ELIGIBLE	HEALTH-HOME-SPA-PROVIDERS-ELG00007
ELG115	SUBMITTING-STATE	ELIGIBLE	HEALTH-HOME-SPA-PROVIDERS-ELG00007
ELG116	RECORD-NUMBER	ELIGIBLE	HEALTH-HOME-SPA-PROVIDERS-ELG00007
ELG117	MSIS-IDENTIFICATION-NUM	ELIGIBLE	HEALTH-HOME-SPA-PROVIDERS-ELG00007
ELG131	HEALTH-HOME-CHRONIC-CONDITION-OTHER-EXPLANATION	ELIGIBLE	HEALTH-HOME-CHRONIC-CONDITIONS-ELG00008

DE No	Data Element Name	FILE NAME	File Segment (with Record-ID)
ELG108	HEALTH-HOME-ENTITY-NAME	ELIGIBLE	HEALTH-HOME-SPA-PARTICIPATION-INFORMATION-ELG00006
ELG119	HEALTH-HOME-ENTITY-NAME	ELIGIBLE	HEALTH-HOME-SPA-PROVIDERS-ELG00007
ELG126	RECORD-ID	ELIGIBLE	HEALTH-HOME-CHRONIC-CONDITIONS-ELG00008
ELG127	SUBMITTING-STATE	ELIGIBLE	HEALTH-HOME-CHRONIC-CONDITIONS-ELG00008
ELG128	RECORD-NUMBER	ELIGIBLE	HEALTH-HOME-CHRONIC-CONDITIONS-ELG00008
ELG129	MSIS-IDENTIFICATION-NUM	ELIGIBLE	HEALTH-HOME-CHRONIC-CONDITIONS-ELG00008
ELG120	HEALTH-HOME-PROV-NUM	ELIGIBLE	HEALTH-HOME-SPA-PROVIDERS-ELG00007
ELG107	HEALTH-HOME-SPA-NAME	ELIGIBLE	HEALTH-HOME-SPA-PARTICIPATION-INFORMATION-ELG00006
ELG118	HEALTH-HOME-SPA-NAME	ELIGIBLE	HEALTH-HOME-SPA-PROVIDERS-ELG00007
ELG130	HEALTH-HOME-CHRONIC-CONDITION	ELIGIBLE	HEALTH-HOME-CHRONIC-CONDITIONS-ELG00008
ELG136	RECORD-ID	ELIGIBLE	LOCK-IN-INFORMATION-ELG00009
ELG137	SUBMITTING-STATE	ELIGIBLE	LOCK-IN-INFORMATION-ELG00009
ELG138	RECORD-NUMBER	ELIGIBLE	LOCK-IN-INFORMATION-ELG00009
ELG139	MSIS-IDENTIFICATION-NUM	ELIGIBLE	LOCK-IN-INFORMATION-ELG00009
ELG109	HEALTH-HOME-SPA-PARTICIPATION-EFF-DATE	ELIGIBLE	HEALTH-HOME-SPA-PARTICIPATION-INFORMATION-ELG00006
ELG121	HEALTH-HOME-SPA-PROVIDER-EFF-DATE	ELIGIBLE	HEALTH-HOME-SPA-PROVIDERS-ELG00007
ELG142	LOCKIN-EFF-DATE	ELIGIBLE	LOCK-IN-INFORMATION-ELG00009
ELG146	RECORD-ID	ELIGIBLE	MFP-INFORMATION-ELG00010
ELG147	SUBMITTING-STATE	ELIGIBLE	MFP-INFORMATION-ELG00010
ELG148	RECORD-NUMBER	ELIGIBLE	MFP-INFORMATION-ELG00010
ELG149	MSIS-IDENTIFICATION-NUM	ELIGIBLE	MFP-INFORMATION-ELG00010
ELG140	LOCKIN-PROV-NUM	ELIGIBLE	LOCK-IN-INFORMATION-ELG00009
ELG159	RECORD-ID	ELIGIBLE	STATE-PLAN-OPTION-PARTICIPATION-ELG00011
ELG160	SUBMITTING-STATE	ELIGIBLE	STATE-PLAN-OPTION-PARTICIPATION-ELG00011
ELG161	RECORD-NUMBER	ELIGIBLE	STATE-PLAN-OPTION-PARTICIPATION-ELG00011
ELG162	MSIS-IDENTIFICATION-NUM	ELIGIBLE	STATE-PLAN-OPTION-PARTICIPATION-ELG00011
ELG163	STATE-PLAN-OPTION-TYPE	ELIGIBLE	STATE-PLAN-OPTION-PARTICIPATION-ELG00011
ELG164	STATE-PLAN-OPTION-EFF-DATE	ELIGIBLE	STATE-PLAN-OPTION-PARTICIPATION-ELG00011
ELG168	RECORD-ID	ELIGIBLE	WAIVER-PARTICIPATION-ELG00012
ELG169	SUBMITTING-STATE	ELIGIBLE	WAIVER-PARTICIPATION-ELG00012
ELG170	RECORD-NUMBER	ELIGIBLE	WAIVER-PARTICIPATION-ELG00012
ELG171	MSIS-IDENTIFICATION-NUM	ELIGIBLE	WAIVER-PARTICIPATION-ELG00012
ELG172	WAIVER-ID	ELIGIBLE	WAIVER-PARTICIPATION-ELG00012
ELG174	WAIVER-ENROLLMENT-EFF-DATE	ELIGIBLE	WAIVER-PARTICIPATION-ELG00012
ELG178	RECORD-ID	ELIGIBLE	LTSS-PARTICIPATION-ELG00013
ELG179	SUBMITTING-STATE	ELIGIBLE	LTSS-PARTICIPATION-ELG00013
ELG180	RECORD-NUMBER	ELIGIBLE	LTSS-PARTICIPATION-ELG00013
ELG181	MSIS-IDENTIFICATION-NUM	ELIGIBLE	LTSS-PARTICIPATION-ELG00013
ELG182	LTSS-LEVEL-CARE	ELIGIBLE	LTSS-PARTICIPATION-ELG00013
ELG183	LTSS-PROV-NUM	ELIGIBLE	LTSS-PARTICIPATION-ELG00013

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DE No	Data Element Name	FILE NAME	File Segment (with Record-ID)
ELG184	LTSS-ELIGIBILITY-EFF-DATE	ELIGIBLE	LTSS-PARTICIPATION-ELG00013
ELG188	RECORD-ID	ELIGIBLE	MANAGED-CARE-PARTICIPATION-ELG00014
ELG189	SUBMITTING-STATE	ELIGIBLE	MANAGED-CARE-PARTICIPATION-ELG00014
ELG190	RECORD-NUMBER	ELIGIBLE	MANAGED-CARE-PARTICIPATION-ELG00014
ELG191	MSIS-IDENTIFICATION-NUM	ELIGIBLE	MANAGED-CARE-PARTICIPATION-ELG00014
ELG141	LOCKED-IN-SRVCS	ELIGIBLE	LOCK-IN-INFORMATION-ELG00009
ELG196	MANAGED-CARE-PLAN-ENROLLMENT-EFF-DATE	ELIGIBLE	MANAGED-CARE-PARTICIPATION-ELG00014
ELG192	MANAGED-CARE-PLAN-ID	ELIGIBLE	MANAGED-CARE-PARTICIPATION-ELG00014
ELG155	MFP-ENROLLMENT-EFF-DATE	ELIGIBLE	MFP-INFORMATION-ELG00010
ELG200	RECORD-ID	ELIGIBLE	ETHNICITY-INFORMATION-ELG00015
ELG201	SUBMITTING-STATE	ELIGIBLE	ETHNICITY-INFORMATION-ELG00015
ELG202	RECORD-NUMBER	ELIGIBLE	ETHNICITY-INFORMATION-ELG00015
ELG203	MSIS-IDENTIFICATION-NUM	ELIGIBLE	ETHNICITY-INFORMATION-ELG00015
ELG204	ETHNICITY-CODE	ELIGIBLE	ETHNICITY-INFORMATION-ELG00015
ELG205	ETHNICITY-DECLARATION-EFF-DATE	ELIGIBLE	ETHNICITY-INFORMATION-ELG00015
ELG209	RECORD-ID	ELIGIBLE	RACE-INFORMATION-ELG00016
ELG210	SUBMITTING-STATE	ELIGIBLE	RACE-INFORMATION-ELG00016
ELG211	RECORD-NUMBER	ELIGIBLE	RACE-INFORMATION-ELG00016
ELG212	MSIS-IDENTIFICATION-NUM	ELIGIBLE	RACE-INFORMATION-ELG00016
ELG213	RACE	ELIGIBLE	RACE-INFORMATION-ELG00016
ELG214	RACE-OTHER	ELIGIBLE	RACE-INFORMATION-ELG00016
ELG216	RACE-DECLARATION-EFF-DATE	ELIGIBLE	RACE-INFORMATION-ELG00016
ELG220	RECORD-ID	ELIGIBLE	DISABILITY-INFORMATION-ELG00017
ELG221	SUBMITTING-STATE	ELIGIBLE	DISABILITY-INFORMATION-ELG00017
ELG222	RECORD-NUMBER	ELIGIBLE	DISABILITY-INFORMATION-ELG00017
ELG223	MSIS-IDENTIFICATION-NUM	ELIGIBLE	DISABILITY-INFORMATION-ELG00017
ELG224	DISABILITY-TYPE-CODE	ELIGIBLE	DISABILITY-INFORMATION-ELG00017
ELG225	DISABILITY-TYPE-EFF-DATE	ELIGIBLE	DISABILITY-INFORMATION-ELG00017
ELG229	RECORD-ID	ELIGIBLE	1115A-DEMONSTRATION-INFORMATION-ELG00018
ELG230	SUBMITTING-STATE	ELIGIBLE	1115A-DEMONSTRATION-INFORMATION-ELG00018
ELG231	RECORD-NUMBER	ELIGIBLE	1115A-DEMONSTRATION-INFORMATION-ELG00018
ELG232	MSIS-IDENTIFICATION-NUM	ELIGIBLE	1115A-DEMONSTRATION-INFORMATION-ELG00018
ELG235	1115A-END-DATE	ELIGIBLE	1115A-DEMONSTRATION-INFORMATION-ELG00018
ELG238	RECORD-ID	ELIGIBLE	HCBS-CHRONIC-CONDITIONS-NON-HEALTH-HOME-ELG00020
ELG239	SUBMITTING-STATE	ELIGIBLE	HCBS-CHRONIC-CONDITIONS-NON-HEALTH-HOME-ELG00020
ELG240	RECORD-NUMBER	ELIGIBLE	HCBS-CHRONIC-CONDITIONS-NON-HEALTH-HOME-ELG00020
ELG241	MSIS-IDENTIFICATION-NUM	ELIGIBLE	HCBS-CHRONIC-CONDITIONS-NON-HEALTH-HOME-ELG00020
ELG242	HCBS-CHRONIC-CONDITION-NON-HEALTH-HOME-CODE	ELIGIBLE	HCBS-CHRONIC-CONDITIONS-NON-HEALTH-HOME-ELG00020
ELG243	HCBS-CHRONIC-CONDITION-NON-HEALTH-HOME-EFF-DATE	ELIGIBLE	HCBS-CHRONIC-CONDITIONS-NON-HEALTH-HOME-ELG00020
ELG248	RECORD-ID	ELIGIBLE	ENROLLMENT-TIME-SPAN-SEGMENT-ELG00021
ELG249	SUBMITTING-STATE	ELIGIBLE	ENROLLMENT-TIME-SPAN-SEGMENT-ELG00021
ELG250	RECORD-NUMBER	ELIGIBLE	ENROLLMENT-TIME-SPAN-SEGMENT-ELG00021

DE No	Data Element Name	FILE NAME	File Segment (with Record-ID)
ELG251	MSIS-IDENTIFICATION-NUM	ELIGIBLE	ENROLLMENT-TIME-SPAN-SEGMENT-ELG00021
ELG252	ENROLLMENT-TYPE	ELIGIBLE	ENROLLMENT-TIME-SPAN-SEGMENT-ELG00021
ELG253	ENROLLMENT-EFF-DATE	ELIGIBLE	ENROLLMENT-TIME-SPAN-SEGMENT-ELG00021

Table 2: TPL IIFI Data Elements (47 IIFIs)

DE No	Data Element Name	FILE NAME	File Segment (with Record-ID)
TPL001	RECORD-ID	TPL	FILE-HEADER-RECORD-TPL-TPL00001
TPL002	DATA-DICTIONARY-VERSION	TPL	FILE-HEADER-RECORD-TPL-TPL00001
TPL003	SUBMISSION-TRANSACTION-TYPE	TPL	FILE-HEADER-RECORD-TPL-TPL00001
TPL004	FILE-ENCODING-SPECIFICATION	TPL	FILE-HEADER-RECORD-TPL-TPL00001
TPL005	DATA-MAPPING-DOCUMENT-VERSION	TPL	FILE-HEADER-RECORD-TPL-TPL00001
TPL006	FILE-NAME	TPL	FILE-HEADER-RECORD-TPL-TPL00001
TPL007	SUBMITTING-STATE	TPL	FILE-HEADER-RECORD-TPL-TPL00001
TPL009	START-OF-TIME-PERIOD	TPL	FILE-HEADER-RECORD-TPL-TPL00001
TPL010	END-OF-TIME-PERIOD	TPL	FILE-HEADER-RECORD-TPL-TPL00001
TPL011	FILE-STATUS-INDICATOR	TPL	FILE-HEADER-RECORD-TPL-TPL00001
TPL012	SSN-INDICATOR	TPL	FILE-HEADER-RECORD-TPL-TPL00001
TPL013	TOT-REC-CNT	TPL	FILE-HEADER-RECORD-TPL-TPL00001
TPL088	SEQUENCE-NUMBER	TPL	FILE-HEADER-RECORD-TPL-TPL00001
TPL016	RECORD-ID	TPL	TPL-MEDICAID-ELIGIBLE-PERSON-MAIN-TPL00002
TPL017	SUBMITTING-STATE	TPL	TPL-MEDICAID-ELIGIBLE-PERSON-MAIN-TPL00002
TPL018	RECORD-NUMBER	TPL	TPL-MEDICAID-ELIGIBLE-PERSON-MAIN-TPL00002
TPL019	MSIS-IDENTIFICATION-NUM	TPL	TPL-MEDICAID-ELIGIBLE-PERSON-MAIN-TPL00002
TPL025	ELIG-PRSN-MAIN-EFF-DATE	TPL	TPL-MEDICAID-ELIGIBLE-PERSON-MAIN-TPL00002
TPL029	RECORD-ID	TPL	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO-TPL00003
TPL030	SUBMITTING-STATE	TPL	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO-TPL00003
TPL031	RECORD-NUMBER	TPL	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO-TPL00003
TPL032	MSIS-IDENTIFICATION-NUM	TPL	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO-TPL00003
TPL033	INSURANCE-CARRIER-ID-NUM	TPL	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO-TPL00003
TPL034	INSURANCE-PLAN-ID	TPL	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO-TPL00003
TPL035	GROUP-NUM	TPL	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO-TPL00003
TPL036	MEMBER-ID	TPL	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO-TPL00003
TPL089	COVERAGE-TYPE	TPL	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO-TPL00003
TPL048	INSURANCE-COVERAGE-EFF-DATE	TPL	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-INFO-TPL00003
TPL052	RECORD-ID	TPL	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-CATEGORIES-TPL00004
TPL053	SUBMITTING-STATE	TPL	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-CATEGORIES-TPL00004
TPL054	RECORD-NUMBER	TPL	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-

DE No	Data Element Name	FILE NAME	File Segment (with Record-ID)
			CATEGORIES-TPL00004
TPL055	INSURANCE-CARRIER-ID-NUM	TPL	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-CATEGORIES-TPL00004
TPL056	INSURANCE-PLAN-ID	TPL	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-CATEGORIES-TPL00004
TPL058	COVERAGE-TYPE	TPL	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-CATEGORIES-TPL00004
TPL059	INSURANCE-CATEGORIES-EFF-DATE	TPL	TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-CATEGORIES-TPL00004
TPL063	RECORD-ID	TPL	TPL-MEDICAID-ELIGIBLE-OTHER-THIRD-PARTY-COVERAGE-INFORMATION-TPL00005
TPL064	SUBMITTING-STATE	TPL	TPL-MEDICAID-ELIGIBLE-OTHER-THIRD-PARTY-COVERAGE-INFORMATION-TPL00005
TPL065	RECORD-NUMBER	TPL	TPL-MEDICAID-ELIGIBLE-OTHER-THIRD-PARTY-COVERAGE-INFORMATION-TPL00005
TPL066	MSIS-IDENTIFICATION-NUM	TPL	TPL-MEDICAID-ELIGIBLE-OTHER-THIRD-PARTY-COVERAGE-INFORMATION-TPL00005
TPL067	TYPE-OF-OTHER-THIRD-PARTY-LIABILITY	TPL	TPL-MEDICAID-ELIGIBLE-OTHER-THIRD-PARTY-COVERAGE-INFORMATION-TPL00005
TPL068	OTHER-TPL-EFF-DATE	TPL	TPL-MEDICAID-ELIGIBLE-OTHER-THIRD-PARTY-COVERAGE-INFORMATION-TPL00005
TPL072	RECORD-ID	TPL	TPL-ENTITY-CONTACT-INFORMATION-TPL00006
TPL073	SUBMITTING-STATE	TPL	TPL-ENTITY-CONTACT-INFORMATION-TPL00006
TPL074	RECORD-NUMBER	TPL	TPL-ENTITY-CONTACT-INFORMATION-TPL00006
TPL075	INSURANCE-CARRIER-ID-NUM	TPL	TPL-ENTITY-CONTACT-INFORMATION-TPL00006
TPL076	TPL-ENTITY-ADDR-TYPE	TPL	TPL-ENTITY-CONTACT-INFORMATION-TPL00006
TPL084	TPL-ENTITY-CONTACT-INFO-EFF-DATE	TPL	TPL-ENTITY-CONTACT-INFORMATION-TPL00006

Table 3: Managed Care IIFI Data Elements (62 IIFI)

DE No	Data Element Name	FILE NAME	File Segment (with Record-ID)
MCR001	RECORD-ID	MNGDCARE	FILE-HEADER-RECORD-MANAGED-CARE-MCR00001
MCR002	DATA-DICTIONARY-VERSION	MNGDCARE	FILE-HEADER-RECORD-MANAGED-CARE-MCR00001
MCR003	SUBMISSION-TRANSACTION-TYPE	MNGDCARE	FILE-HEADER-RECORD-MANAGED-CARE-MCR00001
MCR004	FILE-ENCODING-SPECIFICATION	MNGDCARE	FILE-HEADER-RECORD-MANAGED-CARE-MCR00001
MCR005	DATA-MAPPING-DOCUMENT-VERSION	MNGDCARE	FILE-HEADER-RECORD-MANAGED-CARE-MCR00001
MCR006	FILE-NAME	MNGDCARE	FILE-HEADER-RECORD-MANAGED-CARE-MCR00001
MCR007	SUBMITTING-STATE	MNGDCARE	FILE-HEADER-RECORD-MANAGED-CARE-MCR00001
MCR009	START-OF-TIME-PERIOD	MNGDCARE	FILE-HEADER-RECORD-MANAGED-CARE-MCR00001
MCR010	END-OF-TIME-PERIOD	MNGDCARE	FILE-HEADER-RECORD-MANAGED-CARE-MCR00001
MCR011	FILE-STATUS-INDICATOR	MNGDCARE	FILE-HEADER-RECORD-MANAGED-CARE-MCR00001
MCR013	TOT-REC-CNT	MNGDCARE	FILE-HEADER-RECORD-MANAGED-CARE-MCR00001
MCR112	SEQUENCE-NUMBER	MNGDCARE	FILE-HEADER-RECORD-MANAGED-CARE-MCR00001
MCR01	RECORD-ID	MNGDCARE	MANAGED-CARE-MAIN-MCR00002

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DE No	Data Element Name	FILE NAME	File Segment (with Record-ID)
6			
MCR017	SUBMITTING-STATE	MNGDCARE	MANAGED-CARE-MAIN-MCR00002
MCR018	RECORD-NUMBER	MNGDCARE	MANAGED-CARE-MAIN-MCR00002
MCR019	STATE-PLAN-ID-NUM	MNGDCARE	MANAGED-CARE-MAIN-MCR00002
MCR030	MANAGED-CARE-MAIN-REC-EFF-DATE	MNGDCARE	MANAGED-CARE-MAIN-MCR00002
MCR034	RECORD-ID	MNGDCARE	MANAGED-CARE-LOCATION-AND-CONTACT-INFO-MCR00003
MCR035	SUBMITTING-STATE	MNGDCARE	MANAGED-CARE-LOCATION-AND-CONTACT-INFO-MCR00003
MCR036	RECORD-NUMBER	MNGDCARE	MANAGED-CARE-LOCATION-AND-CONTACT-INFO-MCR00003
MCR037	STATE-PLAN-ID-NUM	MNGDCARE	MANAGED-CARE-LOCATION-AND-CONTACT-INFO-MCR00003
MCR038	MANAGED-CARE-LOCATION-ID	MNGDCARE	MANAGED-CARE-LOCATION-AND-CONTACT-INFO-MCR00003
MCR039	MANAGED-CARE-LOCATION-AND-CONTACT-INFO-EFF-DATE	MNGDCARE	MANAGED-CARE-LOCATION-AND-CONTACT-INFO-MCR00003
MCR041	MANAGED-CARE-ADDR-TYPE	MNGDCARE	MANAGED-CARE-LOCATION-AND-CONTACT-INFO-MCR00003
MCR054	RECORD-ID	MNGDCARE	MANAGED-CARE-SERVICE-AREA-MCR00004
MCR055	SUBMITTING-STATE	MNGDCARE	MANAGED-CARE-SERVICE-AREA-MCR00004
MCR056	RECORD-NUMBER	MNGDCARE	MANAGED-CARE-SERVICE-AREA-MCR00004
MCR057	STATE-PLAN-ID-NUM	MNGDCARE	MANAGED-CARE-SERVICE-AREA-MCR00004
MCR058	MANAGED-CARE-SERVICE-AREA-NAME	MNGDCARE	MANAGED-CARE-SERVICE-AREA-MCR00004
MCR059	MANAGED-CARE-SERVICE-AREA-EFF-DATE	MNGDCARE	MANAGED-CARE-SERVICE-AREA-MCR00004
MCR063	RECORD-ID	MNGDCARE	MANAGED-CARE-OPERATING-AUTHORITY-MCR00005
MCR064	SUBMITTING-STATE	MNGDCARE	MANAGED-CARE-OPERATING-AUTHORITY-MCR00005
MCR065	RECORD-NUMBER	MNGDCARE	MANAGED-CARE-OPERATING-AUTHORITY-MCR00005
MCR066	STATE-PLAN-ID-NUM	MNGDCARE	MANAGED-CARE-OPERATING-AUTHORITY-MCR00005
MCR067	OPERATING-AUTHORITY	MNGDCARE	MANAGED-CARE-OPERATING-AUTHORITY-MCR00005
MCR069	MANAGED-CARE-OP-AUTHORITY-EFF-DATE	MNGDCARE	MANAGED-CARE-OPERATING-AUTHORITY-MCR00005
MCR073	RECORD-ID	MNGDCARE	MANAGED-CARE-PLAN-POPULATION-ENROLLED-MCR00006
MCR074	SUBMITTING-STATE	MNGDCARE	MANAGED-CARE-PLAN-POPULATION-ENROLLED-MCR00006
MCR075	RECORD-NUMBER	MNGDCARE	MANAGED-CARE-PLAN-POPULATION-ENROLLED-MCR00006
MCR076	STATE-PLAN-ID-NUM	MNGDCARE	MANAGED-CARE-PLAN-POPULATION-ENROLLED-MCR00006
MCR077	MANAGED-CARE-PLAN-POP	MNGDCARE	MANAGED-CARE-PLAN-POPULATION-ENROLLED-MCR00006
MCR078	MANAGED-CARE-PLAN-POP-EFF-DATE	MNGDCARE	MANAGED-CARE-PLAN-POPULATION-ENROLLED-MCR00006
MCR082	RECORD-ID	MNGDCARE	MANAGED- CARE-ACCREDITATION-ORGANIZATION-MCR00007
MCR083	SUBMITTING-STATE	MNGDCARE	MANAGED- CARE-ACCREDITATION-ORGANIZATION-MCR00007

DE No	Data Element Name	FILE NAME	File Segment (with Record-ID)
MCR084	RECORD-NUMBER	MNGDCARE	MANAGED- CARE-ACCREDITATION-ORGANIZATION-MCR00007
MCR085	STATE-PLAN-ID-NUM	MNGDCARE	MANAGED- CARE-ACCREDITATION-ORGANIZATION-MCR00007
MCR086	ACCREDITATION-ORGANIZATION	MNGDCARE	MANAGED- CARE-ACCREDITATION-ORGANIZATION-MCR00007
MCR087	DATE-ACCREDITATION-ACHIEVED	MNGDCARE	MANAGED- CARE-ACCREDITATION-ORGANIZATION-MCR00007
MCR091	RECORD-ID	MNGDCARE	NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-MCR00008
MCR092	SUBMITTING-STATE	MNGDCARE	NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-MCR00008
MCR093	RECORD-NUMBER	MNGDCARE	NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-MCR00008
MCR094	STATE-PLAN-ID-NUM	MNGDCARE	NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-MCR00008
MCR095	NATIONAL-HEALTH-CARE-ENTITY-ID	MNGDCARE	NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-MCR00008
MCR096	NATIONAL-HEALTH-CARE-ENTITY-ID-TYPE	MNGDCARE	NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-MCR00008
MCR098	NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-EFF-DATE	MNGDCARE	NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-MCR00008
MCR102	RECORD-ID	MNGDCARE	CHPID-SHPID-RELATIONSHIPS-MCR00009
MCR103	SUBMITTING-STATE	MNGDCARE	CHPID-SHPID-RELATIONSHIPS-MCR00009
MCR104	RECORD-NUMBER	MNGDCARE	CHPID-SHPID-RELATIONSHIPS-MCR00009
MCR105	STATE-PLAN-ID-NUM	MNGDCARE	CHPID-SHPID-RELATIONSHIPS-MCR00009
MCR106	CHPID	MNGDCARE	CHPID-SHPID-RELATIONSHIPS-MCR00009
MCR107	SHPID	MNGDCARE	CHPID-SHPID-RELATIONSHIPS-MCR00009
MCR108	CHPID-SHPID-RELATIONSHIP-EFF-DATE	MNGDCARE	CHPID-SHPID-RELATIONSHIPS-MCR00009

Table 4: Provider IIFI Data Elements (74 IIFIs)

DE No	Data Element Name	FILE NAME	File Segment (with Record-ID)
PRV001	RECORD-ID	PROVIDER	FILE-HEADER-RECORD-PROVIDER-PRV00001
PRV002	DATA-DICTIONARY-VERSION	PROVIDER	FILE-HEADER-RECORD-PROVIDER-PRV00001
PRV003	SUBMISSION-TRANSACTION-TYPE	PROVIDER	FILE-HEADER-RECORD-PROVIDER-PRV00001
PRV004	FILE-ENCODING-SPECIFICATION	PROVIDER	FILE-HEADER-RECORD-PROVIDER-PRV00001
PRV005	DATA-MAPPING-DOCUMENT-VERSION	PROVIDER	FILE-HEADER-RECORD-PROVIDER-PRV00001
PRV006	FILE-NAME	PROVIDER	FILE-HEADER-RECORD-PROVIDER-PRV00001
PRV007	SUBMITTING-STATE	PROVIDER	FILE-HEADER-RECORD-PROVIDER-PRV00001
PRV009	START-OF-TIME-PERIOD	PROVIDER	FILE-HEADER-RECORD-PROVIDER-PRV00001
PRV010	END-OF-TIME-PERIOD	PROVIDER	FILE-HEADER-RECORD-PROVIDER-PRV00001
PRV011	FILE-STATUS-INDICATOR	PROVIDER	FILE-HEADER-RECORD-PROVIDER-PRV00001
PRV013	TOT-REC-CNT	PROVIDER	FILE-HEADER-RECORD-PROVIDER-PRV00001
PRV138	SEQUENCE-NUMBER	PROVIDER	FILE-HEADER-RECORD-PROVIDER-PRV00001
PRV016	RECORD-ID	PROVIDER	PROV-ATTRIBUTES-MAIN-PRV00002
PRV017	SUBMITTING-STATE	PROVIDER	PROV-ATTRIBUTES-MAIN-PRV00002

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DE No	Data Element Name	FILE NAME	File Segment (with Record-ID)
PRV018	RECORD-NUMBER	PROVIDER	PROV-ATTRIBUTES-MAIN-PRV00002
PRV019	SUBMITTING-STATE-PROV-ID	PROVIDER	PROV-ATTRIBUTES-MAIN-PRV00002
PRV020	PROV-ATTRIBUTES-EFF-DATE	PROVIDER	PROV-ATTRIBUTES-MAIN-PRV00002
PRV039	RECORD-ID	PROVIDER	PROV-LOCATION-AND-CONTACT-INFO-PRV00003
PRV040	SUBMITTING-STATE	PROVIDER	PROV-LOCATION-AND-CONTACT-INFO-PRV00003
PRV041	RECORD-NUMBER	PROVIDER	PROV-LOCATION-AND-CONTACT-INFO-PRV00003
PRV042	SUBMITTING-STATE-PROV-ID	PROVIDER	PROV-LOCATION-AND-CONTACT-INFO-PRV00003
PRV043	PROV-LOCATION-ID	PROVIDER	PROV-LOCATION-AND-CONTACT-INFO-PRV00003
PRV044	PROV-LOCATION-AND-CONTACT-INFO-EFF-DATE	PROVIDER	PROV-LOCATION-AND-CONTACT-INFO-PRV00003
PRV046	ADDR-TYPE	PROVIDER	PROV-LOCATION-AND-CONTACT-INFO-PRV00003
PRV060	RECORD-ID	PROVIDER	PROV-LICENSING-INFO-PRV00004
PRV061	SUBMITTING-STATE	PROVIDER	PROV-LICENSING-INFO-PRV00004
PRV062	RECORD-NUMBER	PROVIDER	PROV-LICENSING-INFO-PRV00004
PRV063	SUBMITTING-STATE-PROV-ID	PROVIDER	PROV-LICENSING-INFO-PRV00004
PRV064	PROV-LOCATION-ID	PROVIDER	PROV-LICENSING-INFO-PRV00004
PRV065	PROV-LICENSE-EFF-DATE	PROVIDER	PROV-LICENSING-INFO-PRV00004
PRV067	LICENSE-TYPE	PROVIDER	PROV-LICENSING-INFO-PRV00004
PRV068	LICENSE-ISSUING-ENTITY-ID	PROVIDER	PROV-LICENSING-INFO-PRV00004
PRV072	RECORD-ID	PROVIDER	PROV-IDENTIFIERS-PRV00005
PRV073	SUBMITTING-STATE	PROVIDER	PROV-IDENTIFIERS-PRV00005
PRV074	RECORD-NUMBER	PROVIDER	PROV-IDENTIFIERS-PRV00005
PRV075	SUBMITTING-STATE-PROV-ID	PROVIDER	PROV-IDENTIFIERS-PRV00005
PRV076	PROV-LOCATION-ID	PROVIDER	PROV-IDENTIFIERS-PRV00005
PRV077	PROV-IDENTIFIER-TYPE	PROVIDER	PROV-IDENTIFIERS-PRV00005
PRV078	PROV-IDENTIFIER-ISSUING-ENTITY-ID	PROVIDER	PROV-IDENTIFIERS-PRV00005
PRV079	PROV-IDENTIFIER-EFF-DATE	PROVIDER	PROV-IDENTIFIERS-PRV00005
PRV081	PROV-IDENTIFIER	PROVIDER	PROV-IDENTIFIERS-PRV00005
PRV084	RECORD-ID	PROVIDER	PROV-TAXONOMY-CLASSIFICATION-PRV00006
PRV085	SUBMITTING-STATE	PROVIDER	PROV-TAXONOMY-CLASSIFICATION-PRV00006
PRV086	RECORD-NUMBER	PROVIDER	PROV-TAXONOMY-CLASSIFICATION-PRV00006
PRV087	SUBMITTING-STATE-PROV-ID	PROVIDER	PROV-TAXONOMY-CLASSIFICATION-PRV00006
PRV088	PROV-CLASSIFICATION-TYPE	PROVIDER	PROV-TAXONOMY-CLASSIFICATION-PRV00006
PRV089	PROV-CLASSIFICATION-CODE	PROVIDER	PROV-TAXONOMY-CLASSIFICATION-PRV00006
PRV090	PROV-TAXONOMY-CLASSIFICATION-EFF-DATE	PROVIDER	PROV-TAXONOMY-CLASSIFICATION-PRV00006
PRV094	RECORD-ID	PROVIDER	PROV-MEDICAID-ENROLLMENT-PRV00007
PRV095	SUBMITTING-STATE	PROVIDER	PROV-MEDICAID-ENROLLMENT-PRV00007
PRV096	RECORD-NUMBER	PROVIDER	PROV-MEDICAID-ENROLLMENT-PRV00007
PRV097	SUBMITTING-STATE-PROV-ID	PROVIDER	PROV-MEDICAID-ENROLLMENT-PRV00007
PRV098	PROV-MEDICAID-EFF-DATE	PROVIDER	PROV-MEDICAID-ENROLLMENT-PRV00007
PRV100	PROV-MEDICAID-ENROLLMENT-STATUS-CODE	PROVIDER	PROV-MEDICAID-ENROLLMENT-PRV00007
PRV106	RECORD-ID	PROVIDER	PROV-AFFILIATED-GROUPS-PRV00008

DE No	Data Element Name	FILE NAME	File Segment (with Record-ID)
PRV107	SUBMITTING-STATE	PROVIDER	PROV-AFFILIATED-GROUPS-PRV00008
PRV108	RECORD-NUMBER	PROVIDER	PROV-AFFILIATED-GROUPS-PRV00008
PRV109	SUBMITTING-STATE-PROV-ID	PROVIDER	PROV-AFFILIATED-GROUPS-PRV00008
PRV110	SUBMITTING-STATE-PROV-ID-OF-AFFILIATED-ENTITY	PROVIDER	PROV-AFFILIATED-GROUPS-PRV00008
PRV111	PROV-AFFILIATED-GROUP-EFF-DATE	PROVIDER	PROV-AFFILIATED-GROUPS-PRV00008
PRV115	RECORD-ID	PROVIDER	PROV-AFFILIATED-PROGRAMS-PRV00009
PRV116	SUBMITTING-STATE	PROVIDER	PROV-AFFILIATED-PROGRAMS-PRV00009
PRV117	RECORD-NUMBER	PROVIDER	PROV-AFFILIATED-PROGRAMS-PRV00009
PRV118	SUBMITTING-STATE-PROV-ID	PROVIDER	PROV-AFFILIATED-PROGRAMS-PRV00009
PRV119	AFFILIATED-PROGRAM-TYPE	PROVIDER	PROV-AFFILIATED-PROGRAMS-PRV00009
PRV120	AFFILIATED-PROGRAM-ID	PROVIDER	PROV-AFFILIATED-PROGRAMS-PRV00009
PRV121	PROV-AFFILIATED-PROGRAM-EFF-DATE	PROVIDER	PROV-AFFILIATED-PROGRAMS-PRV00009
PRV125	RECORD-ID	PROVIDER	PROV-BED-TYPE-INFO-PRV00010
PRV126	SUBMITTING-STATE	PROVIDER	PROV-BED-TYPE-INFO-PRV00010
PRV127	RECORD-NUMBER	PROVIDER	PROV-BED-TYPE-INFO-PRV00010
PRV128	SUBMITTING-STATE-PROV-ID	PROVIDER	PROV-BED-TYPE-INFO-PRV00010
PRV129	PROV-LOCATION-ID	PROVIDER	PROV-BED-TYPE-INFO-PRV00010
PRV130	BED-TYPE-EFF-DATE	PROVIDER	PROV-BED-TYPE-INFO-PRV00010
PRV134	BED-TYPE-CODE	PROVIDER	PROV-BED-TYPE-INFO-PRV00010

Table 5: Claim OT IIFI Data Elements (34 IIFIs)

DE No	Data Element Name	FILE NAME	File Segment (with Record-ID)
COT001	RECORD-ID	CLAIMOT	FILE-HEADER-RECORD-OT-COT00001
COT002	DATA-DICTIONARY-VERSION	CLAIMOT	FILE-HEADER-RECORD-OT-COT00001
COT003	SUBMISSION-TRANSACTION-TYPE	CLAIMOT	FILE-HEADER-RECORD-OT-COT00001
COT004	FILE-ENCODING-SPECIFICATION	CLAIMOT	FILE-HEADER-RECORD-OT-COT00001
COT005	DATA-MAPPING-DOCUMENT-VERSION	CLAIMOT	FILE-HEADER-RECORD-OT-COT00001
COT006	FILE-NAME	CLAIMOT	FILE-HEADER-RECORD-OT-COT00001
COT007	SUBMITTING-STATE	CLAIMOT	FILE-HEADER-RECORD-OT-COT00001
COT009	START-OF-TIME-PERIOD	CLAIMOT	FILE-HEADER-RECORD-OT-COT00001
COT010	END-OF-TIME-PERIOD	CLAIMOT	FILE-HEADER-RECORD-OT-COT00001
COT011	FILE-STATUS-INDICATOR	CLAIMOT	FILE-HEADER-RECORD-OT-COT00001
COT012	SSN-INDICATOR	CLAIMOT	FILE-HEADER-RECORD-OT-COT00001
COT013	TOT-REC-CNT	CLAIMOT	FILE-HEADER-RECORD-OT-COT00001
COT216	SEQUENCE-NUMBER	CLAIMOT	FILE-HEADER-RECORD-OT-COT00001
COT016	RECORD-ID	CLAIMOT	CLAIM-HEADER-RECORD-OT-COT00002
COT017	SUBMITTING-STATE	CLAIMOT	CLAIM-HEADER-RECORD-OT-COT00002
COT018	RECORD-NUMBER	CLAIMOT	CLAIM-HEADER-RECORD-OT-COT00002
COT019	ICN-ORIG	CLAIMOT	CLAIM-HEADER-RECORD-OT-COT00002
COT020	ICN-ADJ	CLAIMOT	CLAIM-HEADER-RECORD-OT-COT00002

DE No	Data Element Name	FILE NAME	File Segment (with Record-ID)
COT025	ADJUSTMENT-IND	CLAIMOT	CLAIM-HEADER-RECORD-OT-COT00002
COT033	BEGINNING-DATE-OF-SERVICE	CLAIMOT	CLAIM-HEADER-RECORD-OT-COT00002
COT035	ADJUDICATION-DATE	CLAIMOT	CLAIM-HEADER-RECORD-OT-COT00002
COT040	CLAIM-STATUS-CATEGORY	CLAIMOT	CLAIM-HEADER-RECORD-OT-COT00002
COT112	BILLING-PROV-NUM	CLAIMOT	CLAIM-HEADER-RECORD-OT-COT00002
COT117	REFERRING-PROV-NUM	CLAIMOT	CLAIM-HEADER-RECORD-OT-COT00002
COT154	RECORD-ID	CLAIMOT	CLAIM-LINE-RECORD-OT-COT00003
COT155	SUBMITTING-STATE	CLAIMOT	CLAIM-LINE-RECORD-OT-COT00003
COT156	RECORD-NUMBER	CLAIMOT	CLAIM-LINE-RECORD-OT-COT00003
COT158	ICN-ORIG	CLAIMOT	CLAIM-LINE-RECORD-OT-COT00003
COT159	ICN-ADJ	CLAIMOT	CLAIM-LINE-RECORD-OT-COT00003
COT160	LINE-NUM-ORIG	CLAIMOT	CLAIM-LINE-RECORD-OT-COT00003
COT161	LINE-NUM-ADJ	CLAIMOT	CLAIM-LINE-RECORD-OT-COT00003
COT166	BEGINNING-DATE-OF-SERVICE	CLAIMOT	CLAIM-LINE-RECORD-OT-COT00003
COT189	SERVICING-PROV-NUM	CLAIMOT	CLAIM-LINE-RECORD-OT-COT00003
COT221	ADJUDICATION-DATE	CLAIMOT	CLAIM-LINE-RECORD-OT-COT00003

Table 6: Claim RX IIFI Data Elements (32 IIFIs)

DE No	Data Element Name	FILE NAME	File Segment (with Record-ID)
CRX001	RECORD-ID	CLAIMRX	FILE-HEADER-RECORD-RX-CRX00001
CRX002	DATA-DICTIONARY-VERSION	CLAIMRX	FILE-HEADER-RECORD-RX-CRX00001
CRX003	SUBMISSION-TRANSACTION-TYPE	CLAIMRX	FILE-HEADER-RECORD-RX-CRX00001
CRX004	FILE-ENCODING-SPECIFICATION	CLAIMRX	FILE-HEADER-RECORD-RX-CRX00001
CRX005	DATA-MAPPING-DOCUMENT-VERSION	CLAIMRX	FILE-HEADER-RECORD-RX-CRX00001
CRX006	FILE-NAME	CLAIMRX	FILE-HEADER-RECORD-RX-CRX00001
CRX007	SUBMITTING-STATE	CLAIMRX	FILE-HEADER-RECORD-RX-CRX00001
CRX009	START-OF-TIME-PERIOD	CLAIMRX	FILE-HEADER-RECORD-RX-CRX00001
CRX010	END-OF-TIME-PERIOD	CLAIMRX	FILE-HEADER-RECORD-RX-CRX00001
CRX011	FILE-STATUS-INDICATOR	CLAIMRX	FILE-HEADER-RECORD-RX-CRX00001
CRX012	SSN-INDICATOR	CLAIMRX	FILE-HEADER-RECORD-RX-CRX00001
CRX013	TOT-REC-CNT	CLAIMRX	FILE-HEADER-RECORD-RX-CRX00001
CRX155	SEQUENCE-NUMBER	CLAIMRX	FILE-HEADER-RECORD-RX-CRX00001
CRX016	RECORD-ID	CLAIMRX	CLAIM-HEADER-RECORD-RX-CRX00002
CRX017	SUBMITTING-STATE	CLAIMRX	CLAIM-HEADER-RECORD-RX-CRX00002
CRX018	RECORD-NUMBER	CLAIMRX	CLAIM-HEADER-RECORD-RX-CRX00002
CRX019	ICN-ORIG	CLAIMRX	CLAIM-HEADER-RECORD-RX-CRX00002
CRX020	ICN-ADJ	CLAIMRX	CLAIM-HEADER-RECORD-RX-CRX00002
CRX025	ADJUSTMENT-IND	CLAIMRX	CLAIM-HEADER-RECORD-RX-CRX00002
CRX027	ADJUDICATION-DATE	CLAIMRX	CLAIM-HEADER-RECORD-RX-CRX00002
CRX031	CLAIM-STATUS-CATEGORY	CLAIMRX	CLAIM-HEADER-RECORD-RX-CRX00002
CRX070	BILLING-PROV-NUM	CLAIMRX	CLAIM-HEADER-RECORD-RX-CRX00002
CRX074	PRESCRIBING-PROV-NUM	CLAIMRX	CLAIM-HEADER-RECORD-RX-CRX00002
CRX156	DISPENSING-PRESCRIPTION-DRUG-PROV-NUM	CLAIMRX	CLAIM-HEADER-RECORD-RX-CRX00002
CRX108	RECORD-ID	CLAIMRX	CLAIM-LINE-RECORD-RX-CRX00003

DE No	Data Element Name	FILE NAME	File Segment (with Record-ID)
CRX109	SUBMITTING-STATE	CLAIMRX	CLAIM-LINE-RECORD-RX-CRX00003
CRX110	RECORD-NUMBER	CLAIMRX	CLAIM-LINE-RECORD-RX-CRX00003
CRX112	ICN-ORIG	CLAIMRX	CLAIM-LINE-RECORD-RX-CRX00003
CRX113	ICN-ADJ	CLAIMRX	CLAIM-LINE-RECORD-RX-CRX00003
CRX114	LINE-NUM-ORIG	CLAIMRX	CLAIM-LINE-RECORD-RX-CRX00003
CRX115	LINE-NUM-ADJ	CLAIMRX	CLAIM-LINE-RECORD-RX-CRX00003
CRX157	ADJUDICATION-DATE	CLAIMRX	CLAIM-LINE-RECORD-RX-CRX00003

Table 7: Claim LT IIFI Data Elements (34 IIFIs)

DE No	Data Element Name	FILE NAME	File Segment (with Record-ID)
CLT001	RECORD-ID	CLAIMLT	FILE-HEADER-RECORD-LT-CLT00001
CLT002	DATA-DICTIONARY-VERSION	CLAIMLT	FILE-HEADER-RECORD-LT-CLT00001
CLT003	SUBMISSION-TRANSACTION-TYPE	CLAIMLT	FILE-HEADER-RECORD-LT-CLT00001
CLT004	FILE-ENCODING-SPECIFICATION	CLAIMLT	FILE-HEADER-RECORD-LT-CLT00001
CLT005	DATA-MAPPING-DOCUMENT-VERSION	CLAIMLT	FILE-HEADER-RECORD-LT-CLT00001
CLT006	FILE-NAME	CLAIMLT	FILE-HEADER-RECORD-LT-CLT00001
CLT007	SUBMITTING-STATE	CLAIMLT	FILE-HEADER-RECORD-LT-CLT00001
CLT009	START-OF-TIME-PERIOD	CLAIMLT	FILE-HEADER-RECORD-LT-CLT00001
CLT010	END-OF-TIME-PERIOD	CLAIMLT	FILE-HEADER-RECORD-LT-CLT00001
CLT011	FILE-STATUS-INDICATOR	CLAIMLT	FILE-HEADER-RECORD-LT-CLT00001
CLT012	SSN-INDICATOR	CLAIMLT	FILE-HEADER-RECORD-LT-CLT00001
CLT013	TOT-REC-CNT	CLAIMLT	FILE-HEADER-RECORD-LT-CLT00001
CLT227	SEQUENCE-NUMBER	CLAIMLT	FILE-HEADER-RECORD-LT-CLT00001
CLT016	RECORD-ID	CLAIMLT	CLAIM-HEADER-RECORD-LT-CLT00002
CLT017	SUBMITTING-STATE	CLAIMLT	CLAIM-HEADER-RECORD-LT-CLT00002
CLT018	RECORD-NUMBER	CLAIMLT	CLAIM-HEADER-RECORD-LT-CLT00002
CLT019	ICN-ORIG	CLAIMLT	CLAIM-HEADER-RECORD-LT-CLT00002
CLT020	ICN-ADJ	CLAIMLT	CLAIM-HEADER-RECORD-LT-CLT00002
CLT025	ADJUSTMENT-IND	CLAIMLT	CLAIM-HEADER-RECORD-LT-CLT00002
CLT048	BEGINNING-DATE-OF-SERVICE	CLAIMLT	CLAIM-HEADER-RECORD-LT-CLT00002
CLT050	ADJUDICATION-DATE	CLAIMLT	CLAIM-HEADER-RECORD-LT-CLT00002
CLT055	CLAIM-STATUS-CATEGORY	CLAIMLT	CLAIM-HEADER-RECORD-LT-CLT00002
CLT130	BILLING-PROV-NUM	CLAIMLT	CLAIM-HEADER-RECORD-LT-CLT00002
CLT135	REFERRING-PROV-NUM	CLAIMLT	CLAIM-HEADER-RECORD-LT-CLT00002
CLT184	RECORD-ID	CLAIMLT	CLAIM-LINE-RECORD-LT-CLT00003
CLT185	SUBMITTING-STATE	CLAIMLT	CLAIM-LINE-RECORD-LT-CLT00003
CLT186	RECORD-NUMBER	CLAIMLT	CLAIM-LINE-RECORD-LT-CLT00003
CLT188	ICN-ORIG	CLAIMLT	CLAIM-LINE-RECORD-LT-CLT00003
CLT189	ICN-ADJ	CLAIMLT	CLAIM-LINE-RECORD-LT-CLT00003
CLT190	LINE-NUM-ORIG	CLAIMLT	CLAIM-LINE-RECORD-LT-CLT00003
CLT191	LINE-NUM-ADJ	CLAIMLT	CLAIM-LINE-RECORD-LT-CLT00003
CLT196	BEGINNING-DATE-OF-SERVICE	CLAIMLT	CLAIM-LINE-RECORD-LT-CLT00003

DE No	Data Element Name	FILE NAME	File Segment (with Record-ID)
CLT212	SERVICING-PROV-NUM	CLAIMLT	CLAIM-LINE-RECORD-LT-CLT00003
CLT233	ADJUDICATION-DATE	CLAIMLT	CLAIM-LINE-RECORD-LT-CLT00003

Table 8: Claim IP IIFI Data Elements (33 IIFIs)

DE No	Data Element Name	FILE NAME	File Segment (with Record-ID)
CIP001	RECORD-ID	CLAIMIP	FILE-HEADER-RECORD-IP-CIP00001
CIP002	DATA-DICTIONARY-VERSION	CLAIMIP	FILE-HEADER-RECORD-IP-CIP00001
CIP003	SUBMISSION-TRANSACTION-TYPE	CLAIMIP	FILE-HEADER-RECORD-IP-CIP00001
CIP004	FILE-ENCODING-SPECIFICATION	CLAIMIP	FILE-HEADER-RECORD-IP-CIP00001
CIP005	DATA-MAPPING-DOCUMENT-VERSION	CLAIMIP	FILE-HEADER-RECORD-IP-CIP00001
CIP006	FILE-NAME	CLAIMIP	FILE-HEADER-RECORD-IP-CIP00001
CIP007	SUBMITTING-STATE	CLAIMIP	FILE-HEADER-RECORD-IP-CIP00001
CIP009	START-OF-TIME-PERIOD	CLAIMIP	FILE-HEADER-RECORD-IP-CIP00001
CIP010	END-OF-TIME-PERIOD	CLAIMIP	FILE-HEADER-RECORD-IP-CIP00001
CIP011	FILE-STATUS-INDICATOR	CLAIMIP	FILE-HEADER-RECORD-IP-CIP00001
CIP012	SSN-INDICATOR	CLAIMIP	FILE-HEADER-RECORD-IP-CIP00001
CIP013	TOT-REC-CNT	CLAIMIP	FILE-HEADER-RECORD-IP-CIP00001
CIP275	SEQUENCE-NUMBER	CLAIMIP	FILE-HEADER-RECORD-IP-CIP00001
CIP016	RECORD-ID	CLAIMIP	CLAIM-HEADER-RECORD-IP-CIP00002
CIP017	SUBMITTING-STATE	CLAIMIP	CLAIM-HEADER-RECORD-IP-CIP00002
CIP018	RECORD-NUMBER	CLAIMIP	CLAIM-HEADER-RECORD-IP-CIP00002
CIP019	ICN-ORIG	CLAIMIP	CLAIM-HEADER-RECORD-IP-CIP00002
CIP020	ICN-ADJ	CLAIMIP	CLAIM-HEADER-RECORD-IP-CIP00002
CIP026	ADJUSTMENT-IND	CLAIMIP	CLAIM-HEADER-RECORD-IP-CIP00002
CIP098	ADJUDICATION-DATE	CLAIMIP	CLAIM-HEADER-RECORD-IP-CIP00002
CIP103	CLAIM-STATUS-CATEGORY	CLAIMIP	CLAIM-HEADER-RECORD-IP-CIP00002
CIP179	BILLING-PROV-NUM	CLAIMIP	CLAIM-HEADER-RECORD-IP-CIP00002
CIP189	REFERRING-PROV-NUM	CLAIMIP	CLAIM-HEADER-RECORD-IP-CIP00002
CIP231	RECORD-ID	CLAIMIP	CLAIM-LINE-RECORD-IP-CIP00003
CIP232	SUBMITTING-STATE	CLAIMIP	CLAIM-LINE-RECORD-IP-CIP00003
CIP233	RECORD-NUMBER	CLAIMIP	CLAIM-LINE-RECORD-IP-CIP00003
CIP235	ICN-ORIG	CLAIMIP	CLAIM-LINE-RECORD-IP-CIP00003
CIP236	ICN-ADJ	CLAIMIP	CLAIM-LINE-RECORD-IP-CIP00003
CIP237	LINE-NUM-ORIG	CLAIMIP	CLAIM-LINE-RECORD-IP-CIP00003
CIP238	LINE-NUM-ADJ	CLAIMIP	CLAIM-LINE-RECORD-IP-CIP00003
CIP243	BEGINNING-DATE-OF-SERVICE	CLAIMIP	CLAIM-LINE-RECORD-IP-CIP00003
CIP260	SERVICING-PROV-NUM	CLAIMIP	CLAIM-LINE-RECORD-IP-CIP00003
CIP286	ADJUDICATION-DATE	CLAIMIP	CLAIM-LINE-RECORD-IP-CIP00003

IIFI Data Element Names

Table 9 contains a listing of unique data element names that represent the IIFI subset. While 448 total IIFI data elements exist, only 122 unique data element names exist. This data element name duplication

is due to data element names that are required in each file segment, such as 'Submitting-State' and 'Record-Number'.

Table 9: Unique IIFI Data Elements (122)

Data Element Name
1115A-DEMONSTRATION-IND
1115A-EFF-DATE
ACCREDITATION-ORGANIZATION
ADDR-TYPE
ADJUDICATION-DATE
ADJUSTMENT-IND
AFFILIATED-PROGRAM-ID
AFFILIATED-PROGRAM-TYPE
BED-TYPE-CODE
BED-TYPE-EFF-DATE
BEGINNING-DATE-OF-SERVICE
BILLING-PROV-NUM
CHPID
CHPID-SHPID-RELATIONSHIP-EFF-DATE
CLAIM-STATUS-CATEGORY
COVERAGE-TYPE
DATA-DICTIONARY-VERSION
DATA-MAPPING-DOCUMENT-VERSION
DATE-ACCREDITATION-ACHIEVED
DISABILITY-TYPE-CODE
DISABILITY-TYPE-EFF-DATE
DISPENSING-PRESCRIPTION-DRUG-PROV-NUM
ELIGIBILITY-DETERMINANT-EFF-DATE
ELIGIBLE-ADDR-EFF-DATE
ELIG-PRSN-MAIN-EFF-DATE
END-OF-TIME-PERIOD
ENROLLMENT-EFF-DATE
ENROLLMENT-TYPE
ETHNICITY-CODE
ETHNICITY-DECLARATION-EFF-DATE
FILE-ENCODING-SPECIFICATION
FILE-NAME
FILE-STATUS-INDICATOR
GROUP-NUM
HCBS-CHRONIC-CONDITION-NON-HEALTH-HOME-CODE
HCBS-CHRONIC-CONDITION-NON-HEALTH-HOME-EFF-DATE
HEALTH-HOME-CHRONIC-CONDITION

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Data Element Name
HEALTH-HOME-CHRONIC-CONDITION-EFF-DATE
HEALTH-HOME-CHRONIC-CONDITION-OTHER-EXPLANATION
HEALTH-HOME-ENTITY-NAME
HEALTH-HOME-PROV-NUM
HEALTH-HOME-SPA-NAME
HEALTH-HOME-SPA-PARTICIPATION-EFF-DATE
HEALTH-HOME-SPA-PROVIDER-EFF-DATE
ICN-ADJ
ICN-ORIG
INSURANCE-CARRIER-ID-NUM
INSURANCE-CATEGORIES-EFF-DATE
INSURANCE-COVERAGE-EFF-DATE
INSURANCE-PLAN-ID
LICENSE-ISSUING-ENTITY-ID
LICENSE-TYPE
LINE-NUM-ADJ
LINE-NUM-ORIG
LOCKIN-EFF-DATE
LOCKIN-PROV-NUM
LOCKED-IN-SRVCS
LTSS-ELIGIBILITY-EFF-DATE
LTSS-LEVEL-CARE
LTSS-PROV-NUM
MANAGED-CARE-ADDR-TYPE
MANAGED-CARE-LOCATION-AND-CONTACT-INFO-EFF-DATE
MANAGED-CARE-LOCATION-ID
MANAGED-CARE-MAIN-REC-EFF-DATE
MANAGED-CARE-OP-AUTHORITY-EFF-DATE
MANAGED-CARE-PLAN-ENROLLMENT-EFF-DATE
MANAGED-CARE-PLAN-ID
MANAGED-CARE-PLAN-POP
MANAGED-CARE-PLAN-POP-EFF-DATE
MANAGED-CARE-SERVICE-AREA-EFF-DATE
MANAGED-CARE-SERVICE-AREA-NAME
MEMBER-ID
MFP-ENROLLMENT-EFF-DATE
MSIS-CASE-NUM
MSIS-IDENTIFICATION-NUM
NATIONAL-HEALTH-CARE-ENTITY-ID

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Data Element Name
NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-EFF-DATE
NATIONAL-HEALTH-CARE-ENTITY-ID-TYPE
OPERATING-AUTHORITY
OTHER-TPL-EFF-DATE
PRESCRIBING-PROV-NUM
PRIMARY-DEMOGRAPHIC-ELEMENT-EFF-DATE
PROV-AFFILIATED-GROUP-EFF-DATE
PROV-AFFILIATED-PROGRAM-EFF-DATE
PROV-ATTRIBUTES-EFF-DATE
PROV-CLASSIFICATION-CODE
PROV-CLASSIFICATION-TYPE
PROV-IDENTIFIER
PROV-IDENTIFIER-EFF-DATE
PROV-IDENTIFIER-ISSUING-ENTITY-ID
PROV-IDENTIFIER-TYPE
PROV-LICENSE-EFF-DATE
PROV-LOCATION-AND-CONTACT-INFO-EFF-DATE
PROV-LOCATION-ID
PROV-MEDICAID-EFF-DATE
PROV-MEDICAID-ENROLLMENT-STATUS-CODE
PROV-TAXONOMY-CLASSIFICATION-EFF-DATE
RACE
RACE-DECLARATION-EFF-DATE
RACE-OTHER
RECORD-ID
RECORD-NUMBER
REFERRING-PROV-NUM
SEQUENCE-NUMBER
SERVICING-PROV-NUM
SHPID
SSN-INDICATOR
START-OF-TIME-PERIOD
STATE-PLAN-ID-NUM
STATE-PLAN-OPTION-EFF-DATE
STATE-PLAN-OPTION-TYPE
SUBMISSION-TRANSACTION-TYPE
SUBMITTING-STATE
SUBMITTING-STATE-PROV-ID
SUBMITTING-STATE-PROV-ID-OF-AFFILIATED-ENTITY
TOT-REC-CNT

Data Element Name
TPL-ENTITY-ADDR-TYPE
TPL-ENTITY-CONTACT-INFO-EFF-DATE
TYPE-OF-OTHER-THIRD-PARTY-LIABILITY
VARIABLE-DEMOGRAPHIC-ELEMENT-EFF-DATE
WAIVER-ENROLLMENT-EFF-DATE
WAIVER-ID

Program Specific Data Elements

Table 10: Eligible – 1115 Demonstration – (2 Program Specific Data Elements)

DE No	Data Element Name	FILE NAME	File Segment (with Record-ID)
ELG233	1115A-DEMONSTRATION-IND	ELIGIBLE	1115A-DEMONSTRATION-INFORMATION-ELG00018
ELG234	1115A-EFF-DATE	ELIGIBLE	1115A-DEMONSTRATION-INFORMATION-ELG00018

Table 11: Eligible – Health Home – (9 Program Specific Data Elements)

DE No	Data Element Name	FILE NAME	File Segment (with Record-ID)
ELG132	HEALTH-HOME-CHRONIC-CONDITION-EFF-DATE	ELIGIBLE	HEALTH-HOME-CHRONIC-CONDITIONS-ELG00008
ELG131	HEALTH-HOME-CHRONIC-CONDITION-OTHER-EXPLANATION	ELIGIBLE	HEALTH-HOME-CHRONIC-CONDITIONS-ELG00008
ELG108	HEALTH-HOME-ENTITY-NAME	ELIGIBLE	HEALTH-HOME-SPA-PARTICIPATION-INFORMATION-ELG00006
ELG107	HEALTH-HOME-SPA-NAME	ELIGIBLE	HEALTH-HOME-SPA-PARTICIPATION-INFORMATION-ELG00006
ELG109	HEALTH-HOME-SPA-PARTICIPATION-EFF-DATE	ELIGIBLE	HEALTH-HOME-SPA-PARTICIPATION-INFORMATION-ELG00006
ELG119	HEALTH-HOME-ENTITY-NAME	ELIGIBLE	HEALTH-HOME-SPA-PROVIDERS-ELG00007
ELG120	HEALTH-HOME-PROV-NUM	ELIGIBLE	HEALTH-HOME-SPA-PROVIDERS-ELG00007
ELG118	HEALTH-HOME-SPA-NAME	ELIGIBLE	HEALTH-HOME-SPA-PROVIDERS-ELG00007
ELG121	HEALTH-HOME-SPA-PROVIDER-EFF-DATE	ELIGIBLE	HEALTH-HOME-SPA-PROVIDERS-ELG00007

Table 12: Eligible – Lock-In Provider – (3 Program Specific Data Elements)

DE No	Data Element Name	FILE NAME	File Segment (with Record-ID)
ELG142	LOCKIN-EFF-DATE	ELIGIBLE	LOCK-IN-INFORMATION-ELG00009
ELG140	LOCKIN-PROV-NUM	ELIGIBLE	LOCK-IN-INFORMATION-ELG00009
ELG141	LOCKED-IN-SRVCS	ELIGIBLE	LOCK-IN-INFORMATION-ELG00009

Table 13: Eligible – Managed-Care-Participation – (2 Program Specific Data Elements)

DE No	Data Element Name	FILE NAME	File Segment (with Record-ID)
ELG196	MANAGED-CARE-PLAN-ENROLLMENT-EFF-DATE	ELIGIBLE	MANAGED-CARE-PARTICIPATION-ELG00014
ELG192	MANAGED-CARE-PLAN-ID	ELIGIBLE	MANAGED-CARE-PARTICIPATION-ELG00014

Table 14: Eligible – Money Follows the Person – (1 Program Specific Data Element)

DE No	Data Element Name	FILE NAME	File Segment (with Record-ID)
ELG155	MFP-ENROLLMENT-EFF-DATE	ELIGIBLE	MFP-INFORMATION-ELG00010

Table 15: Managed Care – (3 Program Specific Data Elements)

DE No	Data Element Name	FILE NAME	File Segment (with Record-ID)
MCR095	NATIONAL-HEALTH-CARE-ENTITY-ID	MNGDCARE	NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-MCR00008
MCR096	NATIONAL-HEALTH-CARE-ENTITY-ID-TYPE	MNGDCARE	NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-MCR00008
MCR098	NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-EFF-DATE	MNGDCARE	NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-MCR00008

Program Specific Data Element Names

The following table contains a listing of 20 unique data element names that represent the Program Specific data element subset.

Table 16: Unique Program Specific Data Elements (20)

Data Element Name
1115A-DEMONSTRATION-IND
1115A-EFF-DATE
HEALTH-HOME-CHRONIC-CONDITION-EFF-DATE
HEALTH-HOME-CHRONIC-CONDITION-OTHER-EXPLANATION
HEALTH-HOME-ENTITY-NAME
HEALTH-HOME-ENTITY-NAME
HEALTH-HOME-PROV-NUM
HEALTH-HOME-SPA-NAME
HEALTH-HOME-SPA-NAME
HEALTH-HOME-SPA-PARTICIPATION-EFF-DATE
HEALTH-HOME-SPA-PROVIDER-EFF-DATE
LOCKIN-EFF-DATE
LOCKIN-PROV-NUM
LOCKED-IN-SRVCS
MANAGED-CARE-PLAN-ENROLLMENT-EFF-DATE
MANAGED-CARE-PLAN-ID
MFP-ENROLLMENT-EFF-DATE
NATIONAL-HEALTH-CARE-ENTITY-ID
NATIONAL-HEALTH-CARE-ENTITY-ID-TYPE
NATIONAL-HEALTH-CARE-ENTITY-ID-INFO-EFF-DATE

CMS Guidance

Since the IIFI and Program Specific data elements are of such fundamental importance to file integrity and data analysis, the state will be asked to review how IIFI and Program Specific data elements marked with “never” or “sometimes” availability can be upgraded to “always”(when applicable). Therefore, states should review each IIFI and Program Specific (when applicable) data element and reevaluate its ability to provide these data elements in its final consolidated 8 file submission.

Appendix P.07: Finding Provider Roles on STD Transactions

How to use this guidance document

This guidance document is not intended to slow down or derail existing state development initiatives. The intent is to provide clarification and standardization across the nation in key areas raised by state partners. Should guidance introduce rework in ongoing development, please bring this to the attention of your TA and CMS analyst to direct you to the most appropriate path that minimizes impact to your progress.

Brief Issue Description

Some States have requested assistance with identifying where to find in the X-12 claim transaction sets the NPIs and taxonomy codes of providers who performed various roles associated with the claim/encounter.

Background Discussion

Definitions

Provider role – The function that a specific provider performed for a particular patient on specified dates of service, and which are contained on fee-for-service claims or reported on encounter records. The particular roles that CMS would like to track on T-MSIS claims are:

- Admitting (attending) provider
- Billing provider
- Dispensing provider
- Operating provider
- Prescribing provider
- Referring provider
- Servicing (rendering) provider
- Under supervision of provider

Provider role information needed for the T-MSIS claim files can be extracted from the standard X-12 transactions. The five tables in the "CMS Guidance" section of this document provide T-MSIS-toX-12 crosswalks for each provider role. The five tables are:

Table A: Provider roles on T-MSIS CLAIMIP files and their corresponding locations on the X-12 transactions

Table B: Provider roles on T-MSIS CLAIMLT files and their corresponding locations on the X-12 transactions

Table C: Provider roles on T-MSIS CLAIMOT (*facility claims*) files and their corresponding locations on the X-12 transactions

Table D: Provider roles on T-MSIS CLAIMOT (*professional claims*) files and their corresponding locations on the X-12 transactions

Table E: Provider roles on T-MSIS CLAIMOT (*dental claims*) files and their corresponding locations on the X-12 transactions

Table F: Provider roles on T-MSIS CLAIMRX files and their corresponding locations on the X-12 transactions

In each table, the first column identifies the provider role. The second and third columns identify the specific T-MSIS record segments and data elements used to capture the NPI and taxonomy of the provider performing the specified role. The fourth, fifth, sixth, and seventh columns in tables "A" through "E" provide the X-12 transaction name, data element identifier, data element description and loop id that map to the T-MSIS data element. The fourth, fifth, sixth, and seventh columns in table "F" provide the segment name, field identifier, field name and definition of the applicable NCPDP D.0 data set fields.

CMS Guidance

Use tables "A" through "F" to map the provider roles that are contained in the T-MSIS claim record layouts to their corresponding X-12 standard transaction data elements.
If the T-MSIS data element does not exist in the X-12 transaction set (shown as "N/A" in the tables below), 8-fill, leave blank or space-fill the T-MSIS data element when building T-MSIS claim files.

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Table A: Provider roles on T-MSIS CLAIMIP files and their corresponding locations on the X-12 transactions

Provider Role	IP-T-MSIS Data Element	IP-T-MSIS Record Segment	X-12 Transaction	X-12 Element Identifier	X-12 Description	X-12 Loop	Conditional Rules
Admitting (Attending)	ADMITTING-PROV-NPI-NUM	CLAIM-HEADER-RECORD-IP-CIP00002	5010 A2 837-I Institutional Claim	NM109	Attending Provider Identifier	2310A	N/A
Billing	ADMITTING-PROV-TAXONOMY	CLAIM-HEADER-RECORD-IP-CIP00002	5010 A2 837-I Institutional Claim	PRV03	Provider Taxonomy Code	2310A	
	BILLING-PROV-NPI-NUM	CLAIM-HEADER-RECORD-IP-CIP00002	5010 A2 837-I Institutional Claim	NM109	Billing Provider Identifier	2010AA	N/A
Operating	BILLING-PROV-TAXONOMY	CLAIM-HEADER-RECORD-IP-CIP00002	5010 A2 837-I Institutional Claim	PRV03	Provider Taxonomy Code	2000A	
	OPERATING-PROV-NPI-NUM	CLAIM-LINE-RECORD-IP-CIP00003	5010 A2 837-I Institutional Claim	NM109	Operating Physician Identifier	2310B or 2420A	The identifier in the 837i loop 2310B could be applied to each line in T-MSIS except for lines where there is a different identifier in loop 2420A at the line level of the 837i. If there is a different identifier in 837i loop 2420A then the identifier from loop 2420A should be reported as the operating provider identifier.
Referring	OPERATING-PROV-TAXONOMY	CLAIM-HEADER-RECORD-IP-CIP00002	N/A	N/A	N/A	N/A	
	REFERRING-PROV-NPI-NUM	CLAIM-HEADER-RECORD-IP-CIP00002	5010 A2 837-I Institutional Claim	NM109	Referring Provider Identifier	2310F or 2420D	The identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier.
Servicing (Rendering)	REFERRING-PROV-TAXONOMY	CLAIM-HEADER-RECORD-IP-CIP00002	N/A	N/A	N/A	N/A	
	SERVICING-PROV-NPI-NUM	CLAIM-LINE-RECORD-IP-CIP00003	5010 A2 837-I Institutional Claim	NM109	Rendering Provider Identifier	2310D or 2420C	The identifier in the 837i loop 2310D could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420C at the line level of the 837i. If there is a different identifier in 837i loop 2420C then the identifier from loop 2420C should be reported as the servicing/rendering provider identifier.
Under-Direction-of	SERVICING-PROV-TAXONOMY	CLAIM-LINE-RECORD-IP-CIP00003	N/A	N/A	N/A	N/A	N/A
	UNDER-DIRECTION-OF-PROV-NPI	CLAIM-HEADER-RECORD-IP-CIP00002	N/A	N/A	N/A	N/A	N/A

Provider Role	IP-T-MSIS Data Element	IP-T-MSIS Record Segment	X-12 Transaction	X-12 Element Identifier	X-12 Description	X-12 Loop	Conditional Rules
Under-Supervision-of	UNDER-DIRECTION-OF-PROV-TAXONOMY	CLAIM-HEADER-RECORD-IP-CIP00002	N/A	N/A	N/A	N/A	N/A
	UNDER-SUPERVISION-OF-PROV-NPI	CLAIM-HEADER-RECORD-IP-CIP00002	N/A	N/A	N/A	N/A	N/A
	UNDER-SUPERVISION-OF-PROV-TAXONOMY	CLAIM-HEADER-RECORD-IP-CIP00002	N/A	N/A	N/A	N/A	N/A

Table B: Provider roles on T-MSIS CLAIMLT files and their corresponding locations on the X-12 transactions

Provider Role	LT-T-MSIS Data Element	LT-T-MSIS Record Segment	X-12 Transaction	X-12 Element Identifier	X-12 Description	X-12 Loop	Conditional Rules
Admitting (Attending)	ADMITTING-PROV-NPI-NUM	CLAIM-HEADER-RECORD-LT-CLT00002	5010 A2 837-I Institutional Claim	NM109	Attending Provider Identifier	2310A	
	ADMITTING-PROV-TAXONOMY	CLAIM-HEADER-RECORD-LT-CLT00002		PRV03	Provider Taxonomy Code	2310A	
Billing	BILLING-PROV-NPI-NUM	CLAIM-HEADER-RECORD-LT-CLT00002	5010 A2 837-I Institutional Claim	NM109	Billing Provider Identifier	2010AA	
	BILLING-PROV-TAXONOMY	CLAIM-HEADER-RECORD-LT-CLT00002		PRV03	Provider Taxonomy Code	2000A	
Referring	REFERRING-PROV-NPI-NUM	CLAIM-HEADER-RECORD-LT-CLT00002	5010 A2 837-I Institutional Claim	NM109	Referring Provider Identifier	2310F or 2420D	The identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop 2420D then the identifier from 2420D should be reported as the referring provider identifier.
	REFERRING-PROV-TAXONOMY	CLAIM-HEADER-RECORD-LT-CLT00002	N/A	N/A	N/A	N/A	
Servicing (Rendering)	SERVICING-PROV-NPI-NUM	CLAIM-LINE-RECORD-LT-CLT00003	5010 A2 837-I Institutional Claim	NM109	Rendering Provider Identifier	2310D or 2420C	The identifier in the 837i loop 2310D could be applied to each line in T-MSIS except for lines where there is a different identifier in loop 2420C at the line level of the

Provider Role	LT-T-MSIS Data Element	LT-T-MSIS Record Segment	X-12 Transaction	X-12 Element Identifier	X-12 Description	X-12 Loop	Conditional Rules
							837i. If there is a different identifier in 837i loop 2420C then the identifier from loop 2420C should be reported as the servicing/rendering provider identifier.
	SERVICING-PROV-TAXONOMY	CLAIM-LINE-RECORD-LT-CLT00003	N/A	N/A	N/A	N/A	
	UNDER-DIRECTION-OF-PROV-NPI	CLAIM-HEADER-RECORD-LT-CLT00002	N/A	N/A	N/A	N/A	
Under-Direction-of	UNDER-DIRECTION-OF-PROV-TAXONOMY	CLAIM-HEADER-RECORD-LT-CLT00002	N/A	N/A	N/A	N/A	
Under-Supervision-of	UNDER-SUPERVISION-OF-PROV-NPI	CLAIM-HEADER-RECORD-LT-CLT00002	N/A	N/A	N/A	N/A	
	UNDER-SUPERVISION-OF-PROV-TAXONOMY	CLAIM-HEADER-RECORD-LT-CLT00002	N/A	N/A	N/A	N/A	

Table C: Provider roles on T-MSIS CLAIMOT (facility claims) files and their corresponding locations on the X-12 transactions

Provider Role	OT (facility)-T-MSIS Data Element	OT (facility)-T-MSIS Record Segment	X-12 Transaction	X-12 Element Identifier	X-12 Description	X-12 Loop	Conditional Rules
Billing	BILLING-PROV-NPI-NUM	CLAIM-HEADER-RECORD-OT-COT00002	5010 A2 837-I Institutional Claim	NM109	Billing Provider Identifier	2010AA	
	BILLING-PROV-TAXONOMY	CLAIM-HEADER-RECORD-OT-COT00002	5010 A2 837-I Institutional Claim	PRV03	Provider Taxonomy Code	2000A	
Referring	REFERRING-PROV-NPI-NUM	CLAIM-HEADER-RECORD-OT-COT00002	5010 A2 837-I Institutional Claim	NM109	Referring Provider Identifier	2310F or 2420D	The identifier in the 837i loop 2310F could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420D at the line level of the 837i. If there is a different identifier in 837i loop

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Provider Role	OT (facility)-T-MSIS Data Element	OT (facility)-T-MSIS Record Segment	X-12 Transaction	X-12 Element Identifier	X-12 Description	X-12 Loop	Conditional Rules
							2420D then the identifier from 2420D should be reported as the referring provider identifier.
Servicing (Rendering)	REFERRING-PROV-TAXONOMY SERVICING-PROV-NPI-NUM	CLAIM-HEADER-RECORD-OT-COT00002 CLAIM-LINE-RECORD-OT-COT00003	N/A 5010 A2 837-I Institutional Claim	N/A NM109	N/A Attending Provider Identifier Or Rendering Provider Identifier	N/A 2310A Or 2310D or 2420C	The identifier in the 837i loop 2310D could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420C at the line level of the 837i. If there is a different identifier in 837i loop 2420C then the identifier from loop 2420C should be reported as the servicing/rendering provider identifier.
	SERVICING-PROV-TAXONOMY	CLAIM-LINE-RECORD-OT-COT00003	N/A	N/A	N/A	N/A	
Under-Direction-of	UNDER-DIRECTION-OF-PROV-NPI	CLAIM-HEADER-RECORD-OT-COT00002	N/A	N/A	N/A	N/A	
	UNDER-DIRECTION-OF-PROV-TAXONOMY	CLAIM-HEADER-RECORD-OT-COT00002	N/A	N/A	N/A	N/A	
Under-Supervision-of	UNDER-SUPERVISION-OF-PROV-NPI	CLAIM-HEADER-RECORD-OT-COT00002	N/A	N/A	N/A	N/A	
	UNDER-SUPERVISION-OF-PROV-TAXONOMY	CLAIM-HEADER-RECORD-OT-COT00002	N/A	N/A	N/A	N/A	

Table D: Provider roles on T-MSIS CLAIMOT (professional claims) files and their corresponding locations on the X-12 transactions

Provider Role	OT (professional)-T-MSIS Data Element	OT (professional)-T-MSIS Record Segment	X-12 Transaction	X-12 Element Identifier	X-12 Description	X-12 Loop	Conditional Rules
Billing	BILLING-PROV-NPI-NUM	CLAIM-HEADER-RECORD-OT-COT00002	5010 A1 837-P Professional Claim	NM109	Billing Provider Identifier	2010AA	
	BILLING-PROV-TAXONOMY	CLAIM-HEADER-RECORD-OT-COT00002	5010 A1 837-P Professional Claim	PRV03	Provider Taxonomy Code	2000A	
Referring	REFERRING-PROV-NPI-NUM	CLAIM-HEADER-RECORD-OT-COT00002	5010 A1 837-P Professional Claim	NM109	Referring Provider Identifier	2310A or 2420F	The identifier in the 837p loop 2310A could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420F at the line level of the 837p. If there is a different identifier in 837p loop 2420F then the identifier from 2420F should be reported as the referring provider identifier.
	REFERRING-PROV-TAXONOMY	CLAIM-HEADER-RECORD-OT-COT00002	N/A	N/A	N/A	N/A	
Servicing (Rendering)	SERVICING-PROV-NPI-NUM	CLAIM-LINE-RECORD-OT-COT00003	5010 A1 837-P Professional Claim	NM109	Rendering Provider Identifier	2310B or 2420A	The identifier in the 837p loop 2310B could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420A at the line level of the 837p. If there is a different identifier in 837p loop 2420A then the identifier from 2420A should be reported as the servicing/rendering provider identifier.
	SERVICING-PROV-TAXONOMY	CLAIM-LINE-RECORD-OT-COT00003	5010 A1 837-P Professional Claim	PRV03	Provider Taxonomy Code	2310B or 2420A	The taxonomy in the 837p loop 2310B could be applied to each line in T-MSIS except for lines where there is a different taxonomy in 2420A at the line level of the 837p. If there is a different taxonomy in 837p loop 2420A then the taxonomy from 2420A should be reported as the

Provider Role	OT (professional)-T-MSIS Data Element	OT (professional)-T-MSIS Record Segment	X-12 Transaction	X-12 Element Identifier	X-12 Description	X-12 Loop	Conditional Rules
							servicing/rendering provider taxonomy.
Under-Direction-of	UNDER-DIRECTION-OF-PROV-NPI	CLAIM-HEADER-RECORD-OT-COT00002	N/A	N/A	N/A	N/A	
	UNDER-DIRECTION-OF-PROV-TAXONOMY	CLAIM-HEADER-RECORD-OT-COT00002	N/A	N/A	N/A	N/A	
Under-Supervision-of	UNDER-SUPERVISION-OF-PROV-NPI	CLAIM-HEADER-RECORD-OT-COT00002	5010 A1 837-P Professional Claim	NM109	Supervising Provider Identifier	2310D or 2420D	The identifier in the 837p loop 2310D could be applied to each line in T-MSIS except for lines where there is a different identifier in loop 2420D at the line level of the 837p. If there is a different identifier in loop 2420D then the identifier from loop 2420D should be reported as the under-supervision-of provider identifier.
	UNDER-SUPERVISION-OF-PROV-TAXONOMY	CLAIM-HEADER-RECORD-OT-COT00002	N/A	N/A	N/A	N/A	

Table E: Provider roles on T-MSIS CLAIMOT (dental claims) files and their corresponding locations on the X-12 transactions

Provider Role	OT (dental)-T-MSIS Data Element	OT (dental)-T-MSIS Record Segment	X-12 Transaction	X-12 Element Identifier	X-12 Description	X-12 Loop	Conditional Rules
Billing	BILLING-PROV-NPI-NUM	CLAIM-HEADER-RECORD-OT-COT00002	5010 A1 837-D Dental Claim	NM109	Billing Provider Identifier	2010AA	
	BILLING-PROV-TAXONOMY	CLAIM-HEADER-RECORD-OT-COT00002	5010 A1 837-D Dental Claim	PRV03	Provider Taxonomy Code	2000A	
Referring	REFERRING-PROV-NPI-NUM	CLAIM-HEADER-RECORD-OT-COT00002	5010 A1 837-D Dental Claim	NM109	Referring Provider Identifier	2310A	
	REFERRING-PROV-TAXONOMY	CLAIM-HEADER-RECORD-OT-COT00002	N/A	N/A	N/A	N/A	

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Provider Role	OT (dental)-T-MSIS Data Element	OT (dental)-T-MSIS Record Segment	X-12 Transaction	X-12 Element Identifier	X-12 Description	X-12 Loop	Conditional Rules
Servicing (Rendering)	SERVICING-PROV-NPI-NUM	CLAIM-LINE-RECORD-OT-COT00003	5010 A1 837-D Dental Claim	NM109	Rendering Provider Identifier	2310B or 2420A	The identifier in 837d loop 2310B could be applied to each line in T-MSIS except for lines where there is a different identifier in 2420A at the line level of the 837d. If there is a different identifier in 837d) loop 2420A then the identifier from 2420A should be reported as the servicing/rendering provider identifier.
	SERVICING-PROV-TAXONOMY	CLAIM-LINE-RECORD-OT-COT00003	5010 A1 837-D Dental Claim	PRV03	Provider Taxonomy Code	2310B or 2420A	The taxonomy in the 837d loop 2310B could be applied to each line in T-MSIS except for lines where there is a different taxonomy in 2420A at the line level of the 837p. If there is a different taxonomy in 837p loop 2420A then the taxonomy from 2420A should be reported as the servicing/rendering provider taxonomy.
Under-Direction-of	UNDER-DIRECTION-OF-PROV-NPI	CLAIM-HEADER-RECORD-OT-COT00002	N/A	N/A	N/A	N/A	
	UNDER-DIRECTION-OF-PROV-TAXONOMY	CLAIM-HEADER-RECORD-OT-COT00002	N/A	N/A	N/A	N/A	
Under-Supervision-of	UNDER-SUPERVISION-OF-PROV-NPI	CLAIM-HEADER-RECORD-OT-COT00002	5010 A1 837-D Dental Claim	NM109	Supervising Provider Identifier	2310E or 2420C	The identifier in the 837d loop 2310E could be applied to each line in T-MSIS except for lines where there is a different identifier in loop 2420C at the line level of the 837d. If there is a different identifier in loop 2420C then the identifier from loop 2420C should be reported as the under-supervision-of provider identifier.
	UNDER-SUPERVISION-OF-PROV-TAXONOMY	CLAIM-HEADER-RECORD-OT-COT00002	N/A	N/A	N/A	N/A	

Table F: Provider roles on T-MSIS CLAIMRX (prescription drug) files and their corresponding locations on the X-12 transactions

Provider Role	RX-T-MSIS Data Element	RX-T-MSIS Record Segment	X-12 Segment	X-12 Field	X-12 Field Name	X-12 Definition
Billing	BILLING-PROV-NPI-NUM	CLAIM-HEADER-RECORD-RX-CRX00002	NCPDP D.0 - Transaction Header Segment	201-B1	Service Provider ID	ID assigned to a pharmacy or provider

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Provider Role	RX-T-MSIS Data Element	RX-T-MSIS Record Segment	X-12 Segment	X-12 Field	X-12 Field Name	X-12 Definition
	BILLING-PROV-TAXONOMY	CLAIM-HEADER-RECORD-RX-CRX00002	N/A	N/A	N/A	N/A
Dispensing	DISPENSING-PRESCRIPTION-DRUG-PROV-NPI	CLAIM-HEADER-RECORD-RX-CRX00002	NCPDP D.0 - Pharmacy Provider Segment	444-E9	Provider ID	ID assigned to a pharmacy or provider individual responsible for dispensing the prescription
	DISPENSING-PRESCRIPTION-DRUG-PROV-TAXONOMY	CLAIM-HEADER-RECORD-RX-CRX00002	N/A	N/A	N/A	N/A
Prescribing	PRESCRIBING-PROV-NPI-NUM	CLAIM-HEADER-RECORD-RX-CRX00002	NCPDP D.0 - Prescriber Segment	411-DB	Prescriber ID	ID assigned to the prescriber
	PRESCRIBING-PROV-TAXONOMY	CLAIM-HEADER-RECORD-RX-CRX00002	N/A	N/A	N/A	N/A

Appendix Q: Terms and Abbreviations

Definitions

Acronym/Abbreviation	Description
AAAHC	Accreditation Association for Ambulatory Health Care, Inc.
ABD	Aged, Blind and Disabled
ACA	Affordable Care Act
ADA	American Dental Association
ADDR	Address
AFDC	Aid to Families with Dependent Children
AIDS	Acquired Immunodeficiency Syndrome
AMT	Amount
ANSI	American National Standards Institute
APC	Ambulatory payment classifications
APPL	Application
ARNP	Advanced Registered Nurse Practitioner
ASC	Ambulatory Surgical Center
ASCII	American Standard Code for Information Interchange
ATP	Ability-To-Pay
BIP	Balancing Incentive Program
BMI	Body Mass Index
BOE	Basis of Eligibility
CBSA	Core Based Statistical Area
CD	Code
CDIB	Certificate of Degree of Indian or Alaska Native Blood
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CHIP	Children’s Health Insurance Program

CHIPRA	Children's Health Insurance Program Reauthorization Act

Page 2 Acronym/Abbreviation	**Description**
CHPID	Controlling Health Plan Identifiers
CLIA	Clinical Laboratory Improvement Amendment
CMCS	Center for Medicaid, CHIP and Surveys and Certifications
CMHC	Community Mental Health Center
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
COBOL	Common Business Oriented Language
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1986
COLA	Cost-of-Living Adjustment
CORF	Comprehensive Outpatient Rehabilitation Facility
COV	Covered
CPE	Certified Public Expenditures
CPT	Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetists
CRVS	California Relative Value Study
CWF	Common Working File
DBA	Doing Business As
DEA	Drug Enforcement Agency
DED	Deductible
DME	Durable Medical Equipment
DO	Doctor of osteopathy
DRG	Diagnosis Related Group
DSH	Disproportionate Share Hospital
DSN	Data Set Name
DTL	Detail
DUR	Drug Utilization Review
EBCDIC	Extended Binary-Coded-Decimal Interchange Code
EDI	Electronic Data Interchange
EFF	Effective
EFT	Electronic Funds Transfer; or Electronic File Transfer

EPSDT	Early and Periodic Screening, Diagnosis, and Treatment

Page 3 Acronym/Abbreviation	**Description**
ESI	Employer Sponsored Insurance
ESRD	End Stage Renal Disease
FFP	Federal Financial Participation
FFS	Fee-for-Service
FFY	Federal Fiscal Year
FFYQ	Federal Fiscal Year Quarter
FI	Fiscal Intermediary
FL	Form Locator
FLF	Fixed Length Format
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
GME	Graduate Medical Education
HCBS	Home and Community-Based Services
HCC RA	Hierarchical Condition Category Risk Assessment
HCFA	Health Care Financing Administration
HCPCS	Health Care Procedural Coding System
HETS	HIPAA Eligibility Transaction System
HHA	Home Health Agency
HHPPS	Home Health Prospective Payment System
Hib	Haemophilus influenza type b
HIC	Health Insurance Claim
HICN	Health Insurance Claim Number
HIFA	Health Insurance and Flexibility and Accountability
HIO	Health Insuring Organization
HIPAA	Health Insurance Portability and Accountably Act of 1996
HIV	Human immunodeficiency virus
HMO	Health Maintenance Organization
HPV	Human Papillomavirus
IBM	International Business Machines, Inc.
ICD	International Classification of Diseases

ICD-10-CM	The 10th revision of the ICD

Page 4 Acronym/Abbreviation	**Description**
ICD-9-CM	The 9th revision of the ICD
ICF	Intermediate Care Facility
ICF-IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
ICN	Item Control Number
IGT	Intergovernmental Transfers
IHS	Indian Health Service
IHS-BCC	IHS-B
IHS-BIP	IHS-B
IMD	Institution for Mental Disease
INA	Immigration and Nationality Act
IND	Indicator
IP	Inpatient
IPFPPS	Inpatient Psychiatric Facility Prospective Payment System
IPPS	Acute Inpatient Prospective Payment System
IRFPPS	Inpatient Rehabilitation Facility Prospective Payment System
LN	Line
LPN	Licensed Practical Nurse
LPR	Lawful permanent residents
LT	Long Term
LTC	Long Term Care
LTCHPPS	Long Term Care Hospital Prospective Payment System
LTCLA	Long Term Care Living Arrangement
LTSS	Long Term Services and Support
MACPro	Medicaid and CHIP Program Data System
MAGI	Modified Adjusted Gross Income
MAS	Maintenance Assistance Status
MBI	Medicare Beneficiary Identifier
M-CHIP	Medicaid Expansion CHIP
MCO	Managed Care Organization
MCR	Managed Care Record

MD	Medical Doctor

Page 5 Acronym/Abbreviation	**Description**
MFP	Money Follows the Person
MH	Mental Health
MMA	Medicare Modernization Act
MMIS	Medicaid Management Information System
MOD	Modifiers
MRI	Magnetic resonance imaging
MS-DRG	Medicare Severity – Diagnosis Related Group
MSIS	Medicaid Statistical Information System
MSP	Medicare Secondary Payer
NAIC	National Association of Insurance Commissioners
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Code
NF	Nursing Facility
NHP-ID	National Health Plan Identifier
NPI	National Provider ID
OASDI	Old-Age, Survivors, and Disability Insurance
OEID	Other Entity Identifier
OIG	Office of Inspector General
OIS	Office of Information Services
OMB	Office of Management and Budget
OPPS	Outpatient Prospective Payment System
ORF	Other Rehabilitation Facility
OS	Operating System
OT	Other Type [of claim]
OTC	Over the counter
PACE	Program for All-Inclusive Care for the Elderly
PAHP	Prepaid Ambulatory Health Plan
PBM	Pharmacy Benefits Manager
PCCM	Primary Care Case Management
PERS	Personal Emergency Response System

PHP	Prepaid Health Plan

Page 6 Acronym/Abbreviation	**Description**
PHS	Public Health Service Act
PIHP	Prepaid Inpatient Health Plan
PL	Public Law
POA	Present on Admission
POP	Population
PPS	Prospective Payment System
PROV	Provider
PRTF	Psychiatric Residential Treatment Facilities Demonstration Grant Program
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996
PT/OT/ST	Physical Therapy/Occupational Therapy/Speech Therapy
QDWI	Qualified Disabled Working Individuals
QI	Qualified Individual
QIO	Quality Improvement Organization
QMB	Qualified Medicare Beneficiaries
RA	Remittance Advice
RBRVS	Resource-based relative value scale
REC	Record
RHC	Rural health clinic
RN	Registered Nurse
RRB	Railroad Retirement Board
RX	Prescription
SCHIP	State Children’s Health Insurance Program
SHPID	Sub-Health Plan Identifiers
SLMB	Specified Low-Income Medicare Beneficiaries
SNF	Skilled Nursing Facility
SNFPPS	Skilled Nursing Facility Prospective Payment System
SPA	State Plan Amendment
SSA	Social Security Administration
SSDI	Social Security Disability Insurance

SSI	Supplemental Security Income

Page 7 Acronym/Abbreviation	**Description**
SSP	State Supplemental Program
SSN	Social Security Number
SUD	Substance Use Disorders
T-18 SNF	Title 18 Skilled Nursing Facility
TANF	Temporary Assistance for Needy Families
TB	Tuberculosis
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982
TIN	Tax Identifier Number
T-MSIS	Transformed Medicaid Statistical Information System
TOT	Total
TPL	Third Party Liability
TWWIIA	Ticket to Work and Work Incentives Improvement Act
UB	Uniform Billing
URAC	Utilization Review Accreditation Commission
USC	United States Code
VA	Veterans Administration